

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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Page 1

[1] Volume I
[2] Pages 1 to 170
[3] Exhibits 1 to 2
[4] STATE OF OHIO
[5] COUNTY OF CUYAHOGA
[6] REVEREND STEPHEN J. WALICK,
Plaintiff,
[7] :307,479
[8] vs. :Judge
[9] :Celebrezze
[10] MICHAELS. EISENSTAT, M.D.,
[11] et al.,
Defendants.
[12] DEPOSITION OF DAVID L. CARR-LOCKE, M.D.,
[13] F.R.C.P., a witness called on behalf of the
Defendant David L. Gottesman, M.D., taken pursuant
[14] to the Ohio Rules of Civil Procedure, before William
J. Ellis, Registered Professional Reporter and
[15] Notary Public in and for the Commonwealth of
Massachusetts, at The Endoscopy Center, Brigham and
[16] Women's Hospital, 75 Francis Street, Boston,
Massachusetts, on Tuesday, December 9, 1997,
[17] commencing at 2:32 p.m.
[18] PRESENT:
[19] Linton & Hirshman
(by Tobias J. Hirshman, Esq.) Hoyt Block,
[20] Suite 300, 700 West St. Clair Avenue,
Cleveland, OH 44113-1230, for the
[21] Plaintiff.
[22] Jacobson, Maynard & Tuschman
(by Peter Voudouris, Esq.) 1001 Lakeside
[23] Avenue, Suite 1600, Cleveland, OH
44114-1192 for the Defendant David L.
[24] Gottesman, M.D.
(Continued on next page)

Page 2

[1] PRESENT (Continued):
[2] Reminger & Reminger
[3] (by James S. Casey, Esq.) The 113 St. Clair
Building, Cleveland, OH 44114, for the
[4] Defendant Meridia Hillcrest Hospital
[5] ALSO PRESENT: David L. Gottesman, M.D.
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[21]
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[24]

Page 3

[1] INDEX
[2] WITNESS: DIRECT CROSS REDIRECT RECROSS
[3] David L. Carr-Locke, M.D., F.R.C.P.
[4] (By Mr. Voudouris) 4 156.166
[5] (By Mr. Casey) 85 163
[6]
[7] EXHIBITS
[8] EX. NO. PAGE
[9] 1 Photocopy of curriculum vitae of 12
Dr. Carr-Locke.
[10] 2 Dr. Carr-Locke's folder concerning 168
Father Walick.
[11]
[12]
[13]
[14]
[15]
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[17]
[18]
[19]
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[21]
[22]
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<p style="text-align: right;">Page 4</p> <p>[1] PROCEEDINGS</p> <p>[2] DAVID L. CARR-LOCKE, M.D., F.R.C.P.</p> <p>[3] a witness called for examination by counsel for the</p> <p>[4] Defendant David L. Gottesman, M.D., being first duly</p> <p>[5] sworn, was examined and testified as follows:</p> <p>[6] DIRECT EXAMINATION</p> <p>[7] BY MR. VOUDOURIS:</p> <p>[8] Q: Could you state your name for the record,</p> <p>[9] please.</p> <p>[10] A: David Leslie Carr-Locke.</p> <p>[11] Q: Dr. Carr-Locke, my name is Peter</p> <p>[12] Voudouris. I introduced myself to you a few moments</p> <p>[13] ago. To my left, is Dr. Gottesman. We're here to</p> <p>[14] take your deposition here today.</p> <p>[15] Have you ever been deposed before?</p> <p>[16] A: I have.</p> <p>[17] Q: Okay. I basically have just two ground</p> <p>[18] rules. One, if I ask you a question and you don't</p> <p>[19] understand it, you bring it to my attention so we</p> <p>[20] can be on the same page.</p> <p>[21] A: I will.</p> <p>[22] Q: And, also, please answer everything</p> <p>[23] verbally for the court reporter and myself because</p> <p>[24] he can't take down nods of the head.</p>	<p style="text-align: right;">Page 6</p> <p>[1] A: Approximately ten years ago.</p> <p>[2] Q: How many cases would you estimate you</p> <p>[3] reviewed in your career?</p> <p>[4] A: More than twenty.</p> <p>[5] Q: More than thirty?</p> <p>[6] A: Possibly.</p> <p>[7] Q: More than forty?</p> <p>[8] A: No, probably not.</p> <p>[9] Q: Somewhere between thirty and forty?</p> <p>[10] A: Yes.</p> <p>[11] Q: Is that fair enough?</p> <p>[12] A: That's fair.</p> <p>[13] Q: Okay. The thirty to forty cases that you</p> <p>[14] reviewed in medical legal cases, do you have an idea</p> <p>[15] what percentage were on behalf of plaintiffs and</p> <p>[16] what percentage were on behalf of defendant doctor</p> <p>[17] or hospital?</p> <p>[18] A: Predominantly on behalf of the defendant.</p> <p>[19] I would say 75 percent were on behalf of the</p> <p>[20] defendant.</p> <p>[21] Q: Okay. And does that remain the same</p> <p>[22] percentage throughout your career?</p> <p>[23] A: Yes.</p> <p>[24] Q: The four or five cases that you were</p>
<p style="text-align: right;">Page 5</p> <p>[1] A: Okay.</p> <p>[2] Q: And if you answer a question, I'm going to</p> <p>[3] assume that you understood it. Is that fair enough?</p> <p>[4] A: Yes.</p> <p>[5] Q: You mentioned you've been deposed before?</p> <p>[6] A: Yes.</p> <p>[7] Q: Roughly how many times in your career have</p> <p>[8] you given a deposition?</p> <p>[9] A: Four or five.</p> <p>[10] Q: Okay. Were those four or five occasions in</p> <p>[11] a medical legal case such as this where you were</p> <p>[12] testifying as an expert?</p> <p>[13] A: They were medical legal cases not always</p> <p>[14] such as this.</p> <p>[15] Q: Okay. What do you mean by not always such</p> <p>[16] as this?</p> <p>[17] A: Some were to do with credentialing</p> <p>[18] privileges by a hospital of a physician.</p> <p>[19] Q: How many - before the five, what number of</p> <p>[20] those involved medical malpractice and not</p> <p>[21] credential?</p> <p>[22] A: All except one.</p> <p>[23] Q: Okay. And when did you begin reviewing</p> <p>[24] medical legal cases?</p>	<p style="text-align: right;">Page 7</p> <p>[1] deposed in, were those all on behalf of the</p> <p>[2] defendant doctor or hospital?</p> <p>[3] A: No.</p> <p>[4] Q: How many of those four or five were on</p> <p>[5] behalf of the plaintiff?</p> <p>[6] A: One.</p> <p>[7] Q: What was the issue in that case?</p> <p>[8] THE WITNESS: Am I obliged to give that</p> <p>[9] information?</p> <p>[10] MR. HIRSHMAN: He's allowed to ask you</p> <p>[11] about that now. If you recall, you can answer it.</p> <p>[12] And you don't have to give -</p> <p>[13] Q: You don't have to give patient names.</p> <p>[14] A: This was a case outside of this country</p> <p>[15] anyway. It was a case where the patient had been</p> <p>[16] injured during an endoscopic procedure, the result</p> <p>[17] of which he required surgery, an esophageal</p> <p>[18] perforation was the injury alleged; and the</p> <p>[19] plaintiff won the case.</p> <p>[20] Q: And that was not in the United States?</p> <p>[21] A: It was not.</p> <p>[22] Q: Where was that?</p> <p>[23] A: It was in Ireland.</p> <p>[24] Q: The other three or four medical legal</p>

<p style="text-align: right;">Page 8</p> <p>[1] cases, were they in the United States? [2] A: No, not all of them. [3] Q: Okay. Where were some of the others? [4] A: In England, which is where I practiced [5] until I came here. [6] Q: So one case was in Ireland, one was in [7] England. Were the other <i>two</i> or three in the United [8] States? [9] A: Two have been here, yes, in the U.S. [10] Q: Were they on behalf of the defendant [11] doctor, those two cases in the United States? [12] A: One each. One defense, one plaintiff. [13] Q: Were they here in Massachusetts? [14] A: No. [15] Q: What state? [16] A: One was in Montana, and the other was in [17] California. [18] Q: Do you remember the case in Montana when [19] you were deposed for that? [20] A: That is still ongoing. [21] Q: Do you remember any of the attorneys' names [22] involved in that? [23] A: I do not. [24] Q: Do you keep a list anywhere?</p>	<p style="text-align: right;">Page 10</p> <p>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.</p>
<p style="text-align: right;">Page 9</p> <p>[1] A: I do keep records, yes. [2] Q: You do. How about the California case? [3] A: The California case is also ongoing; [4] although my involvement in it may not be so. I [5] hope. It's a case of a hospital against a physician [6] whose privileges have been revoked. And I was [7] called upon to be the expert witness on behalf of [8] the hospital. [9] Q: The one in Montana, was that on behalf of a [10] patient plaintiff? [11] A: That was on behalf of the defendant [12] physician. [13] Q: I might be a bit confused. [14] Have you ever testified in a case in the [15] United States on behalf of a patient plaintiff? [16] A: No. [17] Q: Have you ever testified in court before? [18] A: Yes. [19] Q: In the United States? [20] A: No. [21] Q: Did the case in England and the case in [22] Ireland go to trial? [23] A: Yes. [24] Q: And did you fly over to testify in those</p>	<p style="text-align: right;">Page 11</p> <p>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 [20] 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,</p>

Page 12	Page 14
<p>111 one?</p> <p>122 MR. VOUDOURIS: Yes.</p> <p>133 (Document marked as Carr-Locke</p> <p>144 Exhibit 1 for identification)</p> <p>155 Q: Doctor, briefly looking at your CV, I</p> <p>166 understand that you were educated in England?</p> <p>177 A: Correct.</p> <p>188 Q: You want to basically tell me the</p> <p>199 difference between the educational system in England</p> <p>210 to become an M.D. as opposed to the United States.</p> <p>221 A: The fundamentals are pretty much the same.</p> <p>232 The sequence may be a little different.</p> <p>243 I chose one of the many pathways that one</p> <p>254 can take in medical education in the U.K. which was</p> <p>265 to go to a university first - Cambridge</p> <p>276 University - obtain my degree, and then go to</p> <p>287 medical school for a further three years, making the</p> <p>298 whole course six years in length.</p> <p>309 An alternative is to go to medical school</p> <p>320 directly, in which case, it can be done in five</p> <p>331 years.</p> <p>342 Q: So you didn't go directly?</p> <p>353 A: I did not.</p> <p>364 Q: Okay. What did you do in between the gap</p>	<p>111 Q: All right. Are you board certified in</p> <p>122 internal medicine?</p> <p>133 A: I am not.</p> <p>144 Q: Are you board certified in any medical</p> <p>155 specialty in the United States?</p> <p>166 A: I am not.</p> <p>177 Q: Did you complete a fellowship?</p> <p>188 A: Yes. The equivalent of a fellowship, yes.</p> <p>199 Q: In the United States?</p> <p>210 A: No.</p> <p>221 Q: What was your fellowship in England?</p> <p>232 A: It would be described here as general</p> <p>243 medicine and gastroenterology.</p> <p>254 Q: And how long was that?</p> <p>265 A: Five years.</p> <p>276 Q: The fellowship itself was five years?</p> <p>287 A: I said, "Equivalent," because that term is</p> <p>298 not used in the United Kingdom. I was appointed as</p> <p>309 a lecturer in medicine with an interest in</p> <p>320 gastroenterology, which is, at the University of</p> <p>331 Leicester, the closest thing to a fellowship.</p> <p>342 Q: I'm sorry. You might have told me. You</p> <p>353 came to the United States in what year?</p> <p>364 A: 1989.</p>
Page 13	Page 15
<p>1 of the two universities that you attended?</p> <p>2 A: No. It's continuous. There's no gap.</p> <p>3 Q: Okay. I misunderstood you.</p> <p>4 When did you come to the United States?</p> <p>5 A: 1989 permanently.</p> <p>6 Q: Did you do what we call an internship in</p> <p>7 the states or in England?</p> <p>8 A: I completed my internship and the</p> <p>9 equivalent of residency and fellowship training all</p> <p>10 in England other than one year which I spent in</p> <p>11 Boston in 1979.</p> <p>12 Q: So when you came to the United States, were</p> <p>13 you required to take another one-year internship?</p> <p>14 A: I was not.</p> <p>15 Q: Okay. Were you required to take another</p> <p>16 residency?</p> <p>17 A: I was not.</p> <p>18 Q: What type of exam did you have to take to</p> <p>19 come to the United States?</p> <p>20 A: None initially. But in order to obtain a</p> <p>21 permanent Massachusetts license, I took the flex</p> <p>22 exam in 1991.</p> <p>23 Q: Okay. Did you pass that on the first try?</p> <p>24 A: I did.</p>	<p>1 Q: All right. So in 1984, where were you</p> <p>2 practicing?</p> <p>3 A: At the University of Leicester in England.</p> <p>4 Q: And what was your practice like in 1984?</p> <p>5 What did you do on a daily basis?</p> <p>6 A: Very much what I do now except in a</p> <p>7 different health care system. I would be the</p> <p>8 equivalent of a faculty position here. They're</p> <p>9 termed a consultant physician working in the</p> <p>10 National Health Service but in an academic</p> <p>11 institution.</p> <p>12 Q: So - I'm sorry. Go ahead.</p> <p>13 A: Just to describe my - my work would be</p> <p>14 predominantly clinical practice with whatever</p> <p>15 research I could also fit into the time available.</p> <p>16 Q: So in 1984, you were seeing patients?</p> <p>17 A: Yes.</p> <p>18 Q: Okay. On a daily basis?</p> <p>19 A: Yes.</p> <p>20 Q: Okay. What percentage of your work</p> <p>21 time - your professional time was devoted to</p> <p>22 seeing patients?</p> <p>23 A: 100 percent.</p> <p>24 Q: Did you have any teaching responsibilities</p>

<p style="text-align: right;">Page 16</p> <p>[1] then?</p> <p>[2] A: Yes, but that is considered part of the</p> <p>[3] clinical work.</p> <p>[4] Q: Okay. What were your teaching</p> <p>[5] responsibilities in '84?</p> <p>[6] A: I had trainee physicians on my team and</p> <p>[7] residents and higher trainees that would come to</p> <p>[8] endoscopic training.</p> <p>[9] Q: 1997. What's your average work week like</p> <p>[10] now?</p> <p>[11] A: How would you like me to describe it?</p> <p>[12] Q: Tell me what you do on a weekly, monthly</p> <p>[13] basis just so I get an idea of what your practice is</p> <p>[14] like.</p> <p>[15] A: I work at least a twelve-hour day every day</p> <p>[16] other than weekends. I'm a participant of the</p> <p>[17] Brigham & Women's Hospital Gastroenterology Division</p> <p>[18] faculty. My work is principally clinical. I spend</p> <p>[19] really almost a hundred percent of my time in</p> <p>[20] clinical practice.</p> <p>[21] I act as a director of endoscopy so I do</p> <p>[22] have some administrative responsibility, but this is</p> <p>[23] in a clinical area.</p> <p>[24] My teaching responsibilities are to the</p>	<p style="text-align: right;">Page 18</p> <p>[1] currently sees over 8,000 patients a year. And I am</p> <p>[2] responsible for running that unit and providing the</p> <p>[3] facilities necessary for that to happen. That</p> <p>[4] involves, obviously, a great many things which I</p> <p>[5] could detail for you.</p> <p>[6] Q: How many physicians in the endoscopy group?</p> <p>[7] A: The Endoscopy Center has approximately</p> <p>[8] fifty physicians that use the center. The Brigham &</p> <p>[9] Women's GI faculty is - clinical faculty is six</p> <p>[10] physicians. There is also an HMO that works with</p> <p>[11] us, and that's another seven gastroenterologists.</p> <p>[12] Q: So in your office here, are you one of six</p> <p>[13] physicians?</p> <p>[14] A: I'm one of six of our faculty, yes.</p> <p>[15] Q: Okay. Again, on a daily basis or a weekly</p> <p>[16] basis, you mentioned you see patients the majority</p> <p>[17] amount of your time. What type of procedures do you</p> <p>[18] do?</p> <p>[19] A: I do two outpatient clinics a week. That</p> <p>[20] probably adds up to forty patients a week from which</p> <p>[21] a number of endoscopic procedures are required, plus</p> <p>[22] the referrals that I receive for - specifically for</p> <p>[23] endoscopy. And I both perform and train others in</p> <p>[24] all of the gastrointestinal endoscopy procedures</p>
<p style="text-align: right;">Page 17</p> <p>[1] trainee fellows who are learning gastroenterology in</p> <p>[2] our division. And I am training director for their</p> <p>[3] endoscopy training.</p> <p>[4] Q: So there's a fellowship program here?</p> <p>[5] A: There is.</p> <p>[6] Q: Is that one year?</p> <p>[7] A: It's three years.</p> <p>[8] Q: It's three years.</p> <p>[9] A: And there is an additional year for</p> <p>[10] advanced training, which is also attached to me.</p> <p>[11] Q: Is there also a residency program here in</p> <p>[12] addition to a fellowship program?</p> <p>[13] A: There is in the hospital but not in</p> <p>[14] gastroenterology. That is an elective topic.</p> <p>[15] Q: I see. So you only deal with fellows;</p> <p>[16] correct?</p> <p>[17] A: Principally, yes.</p> <p>[18] Q: You're the director of The Endoscopy</p> <p>[19] Center?</p> <p>[20] A: That's correct.</p> <p>[21] Q: What does it entail to be the director?</p> <p>[22] A: The Endoscopy Center at this hospital</p> <p>[23] provides a facility for physicians to perform both</p> <p>[24] gastrointestinal and pulmonary endoscopy. The unit</p>	<p style="text-align: right;">Page 19</p> <p>[1] that are in practice.</p> <p>[2] Again, I can list them for you if you wish.</p> <p>[3] Q: Please do.</p> <p>[4] A: Gastroscopy, also known as EGD, which is</p> <p>[5] both diagnostic and has many therapeutic components,</p> <p>[6] which, again, we both perform and teach.</p> <p>[7] Colonoscopy, sigmoidoscopy and their</p> <p>[8] therapeutic aspects. And then ERCP, which is what</p> <p>[9] we're known for here, which is endoscopy of the</p> <p>[10] biliary tract and pancreas, and, again, the</p> <p>[11] therapeutic techniques that come with that.</p> <p>[12] Q: Judging from your CV, is that - would you</p> <p>[13] call that your specialty, ERCP?</p> <p>[14] A: Yes.</p> <p>[15] Q: How much of your practice is involved with</p> <p>[16] performing ERCPs?</p> <p>[17] A: As a time component, probably 20 percent of</p> <p>[18] my week is spent in that procedure.</p> <p>[19] Q: Okay. What about the other 80 percent?</p> <p>[20] What do you do?</p> <p>[21] A: That's divided between the other endoscopic</p> <p>[22] procedures, particularly colonoscopy, and our clinic</p> <p>[23] work and the inpatient service.</p> <p>[24] Q: Can you give me an idea how many</p>

<p style="text-align: right;">Page 20</p> <p>[1] colonoscopies you did last year?</p> <p>[2] A: Approximately 400.</p> <p>[3] Q: And how long have you been doing 400 a</p> <p>[4] year?</p> <p>[5] A: Twenty – about twenty-two years.</p> <p>[6] Q: So in 1984, you were doing about 400 a</p> <p>[7] year?</p> <p>[8] A: Probably more in 1984.</p> <p>[9] I should point out that in that time when I</p> <p>[10] was in England, I was the only gastroenterologist</p> <p>[11] for a population of a million people, which was</p> <p>[12] busy.</p> <p>[13] Q: What type of equipment did you have in 1984</p> <p>[14] to perform colonoscopies?</p> <p>[15] A: Fiber-optic endoscopy came in in the 1970s</p> <p>[16] when I started performing it. And in the mid-1980s</p> <p>[17] at the time that you're asking about, the equipment</p> <p>[18] was not very different from the most recent</p> <p>[19] fiber-optic instruments that we used until quite</p> <p>[20] recently, and some people still use.</p> <p>[21] Of course in the last decade, they've given</p> <p>[22] way to video endoscopes, which are what we use now.</p> <p>[23] Q: When did you start using video endoscopes?</p> <p>[24] A: About ten years ago.</p>	<p style="text-align: right;">Page 22</p> <p>[1] A: In the mid-1970s.</p> <p>[2] Q: And today you mentioned your involvement</p> <p>[3] with the fellows here at the Brigham. Do you have</p> <p>[4] any teaching responsibilities in the classroom?</p> <p>[5] A: What do you mean by the classroom?</p> <p>[6] Q: In a medical school setting.</p> <p>[7] A: I have an appointment to Harvard Medical</p> <p>[8] School, and I have taught undergraduates; but that</p> <p>[9] is not my primary responsibility.</p> <p>[10] Q: Okay. When was the last time that you've</p> <p>[11] taught at Harvard?</p> <p>[12] A: Well, I teach at Harvard every day here in</p> <p>[13] the clinical setting.</p> <p>[14] Q: Right.</p> <p>[15] A: But in a preclinical setting, I have not</p> <p>[16] been required to do that for the last four years.</p> <p>[17] Q: Your CV lists several publications,</p> <p>[18] presentations, abstracts. Are there any that in</p> <p>[19] particular you feel relate to this case?</p> <p>[20] A: No.</p> <p>[21] Q: Do you know when Mr. Hirshman first</p> <p>[22] contacted you about this case?</p> <p>[23] A: I would have to check my file.</p> <p>[24] MR. CASEY: It looks like 3/26/96. I</p>
<p style="text-align: right;">Page 21</p> <p>[1] Q: And why did you make the switch?</p> <p>[2] A: It was the next technological development</p> <p>[3] that was an advance on what we had before. The</p> <p>[4] mechanics of the instruments did not change that</p> <p>[5] much, but the way the image is displayed for a</p> <p>[6] teaching situation was a huge advance for us.</p> <p>[7] Q: Can you give me an idea how the visual</p> <p>[8] display was better with the new technology than with</p> <p>[9] just the fiber-optic scope.</p> <p>[10] A: Optical instruments allow an operator or</p> <p>[11] endoscopist to view through an eyepiece. If more</p> <p>[12] than one person needs to view at the same time, it's</p> <p>[13] possible to split the image by adding a piece to</p> <p>[14] allow one person, and sometimes more than one</p> <p>[15] person, to watch. Or one can attach a TV camera</p> <p>[16] which is often what we did. The quality of that</p> <p>[17] image, however, is not always ideal.</p> <p>[18] When video endoscopes came in, as they are</p> <p>[19] now, the image is electronic and can be displayed on</p> <p>[20] one or more television monitors either within the</p> <p>[21] room or at a remote location such as the one we're</p> <p>[22] sitting in.</p> <p>[23] Q: I'm sorry. When did you first start</p> <p>[24] performing colonoscopies?</p>	<p style="text-align: right;">Page 23</p> <p>[1] pulled that letter out.</p> <p>[2] Q: Did you get a phone call preceding the</p> <p>[3] letter of March 26, 1996?</p> <p>[4] A: I think so. I'd have to check my file to</p> <p>[5] see if –</p> <p>[6] Q: Please do.</p> <p>[7] A: – it told me so, but I have a recollection</p> <p>[8] that I did receive a phone call.</p> <p>[9] (Witness reviews documents)</p> <p>[10] A: Yes, I did.</p> <p>[11] Q: What is it upon your review of your chart</p> <p>[12] that makes you come to the conclusion that you got a</p> <p>[13] phone call?</p> <p>[14] A: The letter from Mr. Hirshman dated</p> <p>[15] March 26, 1996, refers to a telephone conversation</p> <p>[16] that we had at some point prior to that date.</p> <p>[17] Q: Okay. From memory, do you have any idea</p> <p>[18] when that conversation was, telephone?</p> <p>[19] A: I don't recall exactly. It must have been</p> <p>[20] close to the date of this letter, however.</p> <p>[21] Q: Okay. Within a month, would you say?</p> <p>[22] A: I would guess so, yes.</p> <p>[23] Q: And you have no idea how Mr. Hirshman got</p> <p>[24] your name?</p>

Page 24

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

Page 25

[1] testimony is dated October 2.
[2] **MR. HIRSHMAN:** By "testimony," you mean
[3] their expert reports?
[4] **THE WITNESS:** Their expert reports.
[5] **A:** I think that's all.
[6] **Q:** That's fine. Did you perform any
[7] independent medical research in reviewing this case?
[8] **A:** No.
[9] **Q:** Okay. Were you provided any medical
[10] literature or research by Mr. Hirshman?
[11] **A:** No.
[12] **Q:** Did you consult any other physician in
[13] reviewing this case?
[14] **A:** No.
[15] **Q:** This is your only report, February 26, '97?
[16] **A:** It is.
[17] **Q:** Okay. Did you produce any rough drafts?
[18] **A:** If I did, I no longer own them.
[19] **Q:** Okay. Is it your usual custom and practice
[20] to produce rough drafts in these types of cases?
[21] **A:** I will often make notes from voluminous
[22] documents such as hospital reports. But once the
[23] final copy has been produced, I usually do not keep
[24] them.

Page 26

[1] **Q:** Okay. Did you make notes in this case?
[2] **A:** I probably did.
[3] **Q:** And where are they?
[4] **A:** I no longer have those.
[5] **Q:** Are they still in existence?
[6] **A:** No.
[7] **Q:** Why did you throw them out?
[8] **A:** I just do not have space to store all of
[9] this information, including hospital records
[10] [indicating].
[11] **Q:** Did anyone help you in drafting this report
[12] of February 26, '97?
[13] **A:** No.
[14] **Q:** Did you talk to Mr. Hirshman before you
[15] drafted this report?
[16] **A:** Only from the initial contact about the
[17] case. Of course, his request that I produce it.
[18] **Q:** Okay. Did you review the contents of this
[19] report with Mr. Hirshman before you finalized it?
[20] **A:** No. Only after I documented it.
[21] **Q:** I notice you have a bill in there?
[22] **A:** Yes.
[23] **Q:** Could you briefly tell me what you're
[24] charging Mr. Hirshman for reviewing this case.

Page 27

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

Page 28

[1] been reviewing documents, yes, other ~~than~~ today.
[2] Q: What do you charge an hour for your
[3] deposition?
[4] A: I would probably charge the same amount.
[5] Q: Do you have a different fee if you testify
[6] live in court?
[7] A: Not particularly. As I've mentioned
[8] previously, most of my court appearances have been
[9] abroad. Sometimes there's no fee involved.
[10] Q: Okay. Why is that?
[11] A: Because the rules are different in
[12] different countries. Sometimes one doesn't expect a
[13] fee from court appearance.
[14] Q: Would you get paid travel expenses over to
[15] those countries?
[16] A: Yes.
[17] Q: Here in America, have you had to travel
[18] anywhere for a deposition?
[19] A: No.
[20] Q: Have you had to give video testimony
[21] before?
[22] A: Yes.
[23] Q: Okay. That was used in court?
[24] A: It has not been used yet.

Page 29

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

Page 30

[1] A: I do.
[2] Q: Okay. Now, I've read your report; and -
[3] well, first of all, do you have any criticisms of
[4] Dr. Gottesman's care and treatment in this case?
[5] A: Perhaps I should ask if we're - are we
[6] going to go through the chronology of this case step
[7] by step? In which case I can answer your question
[8] in that way; otherwise, I'm happy to do it now.
[9] Q: I'm just asking you if you have any
[10] criticisms of Dr. Gottesman's care and treatment in
[11] this case.
[12] A: My only concerns from the
[13] gastroenterologist's point of view concern the
[14] diagnosis of the colonic lesion in question - in
[15] other words, the polyp of the hepatic flexure - and
[16] the continuing responsibility to the patient once
[17] the referral was made to a surgical colleague.
[18] I think that summarizes my concerns.
[19] Q: I need to know in what ways you believe
[20] that Dr. Gottesman deviated from accepted standards
[21] of care for a gastroenterologist in 1984. You used
[22] the word "concern," but I need to know if you
[23] believe he deviated from accepted standards of
[24] care.

Page 31

[1] A: I believe that a gastroenterologist's
[2] responsibility is to make - is to perform a
[3] procedure requested or that the gastroenterologist
[4] feels is appropriate, and I have no question with
[5] the procedures that were carried out here. They
[6] were very appropriate, the initial sigmoidoscopy and
[7] the subsequent colonoscopy.
[8] The responsibility is also to make an
[9] accurate diagnosis and to provide treatment when
[10] appropriate. The sequence of events in this case
[11] are such that there was not sufficient time between
[12] the diagnostic procedure and the subsequent surgical
[13] treatment for that accurate diagnosis to be
[14] available and, as far as I can tell, discussed with
[15] the patient, keeping in mind that I'm going on the
[16] records that I mentioned that were available to me.
[17] The second issue that I mentioned just now
[18] is that to me, the responsibility to the patient
[19] continues both before and after referral to a
[20] colleague. And if a course of treatment is advised
[21] by a colleague with which I disagreed, I would not
[22] only discuss that with the colleague but also with
[23] the patient.
[24] So to answer your question, Dr. Gottesman

Page 32

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

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

[19] **A:** You mention 1984. I think the timing
[20] probably doesn't make any difference because the
[21] same decisions would have to be made today as in
[22] 1984. So, yes, I think that - those two elements I
[23] mentioned were below the standard of care of
[24] providing an accurate diagnosis which led to the

Page 34

[1] believe providing an accurate diagnosis of a colonic
[2] lesion in this case, that there is a deviation in
[3] that regard.

[4] **A:** The - the records show that this patient
[5] presented with at least two symptoms, one, rectal
[6] bleeding, and, secondly, diarrhea intermittent
[7] diarrhea. Although, that part of the history seems
[8] to vary from chart to chart depending on who took
[9] the history.

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

[16] At both examinations - both endoscopic
[17] examinations, he recorded the presence of up to six
[18] polyps throughout the colon, one of which caused him
[19] concern, namely, the lesion at the hepatic flexure
[20] because of its size and appearance, as he
[21] described. And that concern led him to the
[22] possibility of there being cancer in that lesion or
[23] that it might be precancerous.

[24] Biopsies were taken of that lesion, and

Page 33

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

[4] **Q:** Okay. You use the word "think" in there.
[5] Again, I need to know if you have an opinion to a
[6] reasonable degree of medical certainty or
[7] probability -

[8] **A:** I believe -

[9] **Q:** - whether Dr. Gottesman deviated from
[10] accepted standards of care.

[11] **A:** I believe that's what I just stated.

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

[16] **A:** Yes, in those two elements that I
[17] mentioned.

[18] **Q:** And one is providing - I don't want to put
[19] words in your mouth.

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

[24] **Q:** Okay. Could you explain for me why you

Page 35

[1] some of the other polyps were either biopsied or
[2] removed at the colonoscopy. And that was performed
[3] on November 6, 1984.

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

[11] During that conversation with the patient
[12] and the consultation that took place with the
[13] surgical colleagues, a decision was made to proceed
[14] to surgery. That surgery was decided preoperatively
[15] to be an extensive resection. In other words, a
[16] subtotal colectomy as I think was stated in
[17] Dr. Eisenstat's chart.

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

[24] So the importance of the decision to

Page 36

[1] operate at all and what sort of surgery **would be**
[2] undertaken is totally dependent on the concerns
[3] about the lesion in question, about the other
[4] lesions that were present; and that **is** the
[5] responsibility of the diagnosing physician, who **is**
[6] Dr. Gottesman.
[7] (Witness' pager sounds)
[8] **MR. HIRSHMAN:** Do you have to get that?
[9] **THE WITNESS:** Can I answer that, please?
[10] **MR. VOUDOURIS:** You sure can,
[11] (Recess taken)
[12] **BY MR. VOUDOURIS:**
[13] **Q:** All right. Doctor, we were talking about
[14] your first criticism, failure to provide an accurate
[15] diagnosis of the colonic lesion; correct?
[16] **A:** Correct.
[17] **Q:** All right. Briefly, what does that mean?
[18] **A:** I think it's pretty explicit what that
[19] means. It means that the suspicion that this was a
[20] cancerous lesion was not subsequently borne out by
[21] the biopsies, and yet decisions were taken and
[22] requested of a surgical colleague to perform a
[23] colonic resection which may not have been required
[24] at all.

Page 37

[1] **Q:** Do me a favor and look at your report.
[2] **A:** Yes.
[3] **Q:** On the second page, the second **full**
[4] paragraph, you say Father Walick was referred to
[5] Dr. Eisenstat for consideration of surgery which was
[6] performed on **11/7/84**.
[7] **A:** It does state that. Correct.
[8] **Q:** In your opinion, then, does that mean that
[9] at that point in time, no judgment had been made as
[10] to surgery?
[11] **A:** Quite the opposite. A judgment had been
[12] made.
[13] **Q:** By whom?
[14] **A:** That's why the request was made in the
[15] first place. If you want your patient to be
[16] considered for surgery, you ask a surgeon. If you
[17] don't want to consider that patient for surgery, you
[18] don't do that.
[19] There's also the question of timing. If
[20] you think a level of urgency is required for
[21] something to take place, obviously, you ask your
[22] surgical colleague to see your patient more urgently
[23] than not. I could not see the reason **for** that in
[24] the charts.

Page 38

[1] **Q:** Have you ever referred a patient to a
[2] surgeon before you had gotten pathology reports
[3] back?
[4] **A:** Yes.
[5] **Q:** Do you do that frequently?
[6] **A:** Yes.
[7] **Q:** Can you give me some occasions why you do
[8] that?
[9] **A:** Usually for convenience, because the
[10] patient may have to come a second time to see a
[11] particular surgeon. And if the patient is already
[12] here with me, I can save time by getting the patient
[13] to see that surgeon if he is available. It doesn't
[14] mean I want the patient operated on immediately.
[15] It's usually a convenience for the patient so they
[16] doesn't have to travel again to come to the
[17] hospital.
[18] But no decisions are taken until all the
[19] information is available. And, often, the biopsies
[20] alone may not be enough to make those decisions
[21] final. It doesn't mean we shouldn't discuss the
[22] options. And that's what I'm trying to imply here,
[23] that the options did not seem to be discussed with
[24] Father Walick at the time as far as I can tell.

Page 39

[1] **Q:** So you've referred patients to general
[2] surgeons before you've gotten pathology back;
[3] correct?
[4] **A:** I have done, yes.
[5] **Q:** ~~All~~ right. Okay. And was that partly
[6] because you envision that surgery might be necessary
[7] for that patient?
[8] **A:** That's correct.
[9] **Q:** In all the times that you referred a
[10] patient to a general surgeon, have you known exactly
[11] the date **and** time when that general surgeon was
[12] going to perform surgery?
[13] **A:** No.
[14] **Q:** Is there any indication in any of the
[15] records, any of the materials that you reviewed that
[16] Dr. Gottesman was aware of when Dr. Eisenstat
[17] planned to do surgery?
[18] **MR. HIRSHMAN:** Are you suggesting Eisenstat
[19] was a runaway surgeon here?
[20] **Q:** Can you answer my question.
[21] **A:** I do not recall seeing it documented that
[22] the date was - that knowledge of the date was made
[23] available to Dr. Gottesman. However, there is very
[24] little documentation of what was discussed following

<p style="text-align: right;">Page 40</p> <p>[1] the colonoscopy other than I think what was stated [2] by the - by Reverend Walick that the results were [3] discussed in the presence of Dr. Eisenstat following [4] the colonoscopy at which time surgery was discussed. [5] MR. CASEY: Wait. Wait. Wait. Just so I [6] understand, when I wrote this down earlier, he [7] didn't review Father Walick's deposition. [8] MR. HIRSHMAN: Sure he did. [9] MR. CASEY: I mean I did not get that on [10] the list of things you reviewed. [11] MR. HIRSHMAN: I think it's on the list in [12] one of the letters as a matter of fact. [13] MR. CASEY: I just didn't write it down, [14] Toby. That's why I stopped it. [15] THE WITNESS: Sorry. I don't recall [16] whether I mentioned it. [17] MR. HIRSHMAN: Whether it's in the letter [18] or not - and I'm not sure it is - it's right here. [19] Q: So, Doctor, back to my original question. [20] Do you find anything in the medical records [21] that would indicate or support the fact that [22] Dr. Gottesman was aware of the time - the exact [23] time and date that Dr. Eisenstat planned to do the [24] surgery?</p>	<p style="text-align: right;">Page 42</p> <p>[1] A: No. But I'm asking you a hypothetical [2] question with a hypothetical answer. In that case, [3] it would be important to know the date and time. [4] Q: I'm asking you a factual question. Does [5] anything in the records indicate to you that [6] Dr. Gottesman was made aware by Dr. Eisenstat the [7] exact time and date that surgery was going to be [8] performed? [9] A: No. I see no documentation. [10] Q: And you just told me that the standard of [11] care does not require a gastroenterologist to be [12] aware of the exact date and time of when a general [13] surgeon is going to perform surgery; correct? [14] A: That's correct. [15] Q: As a gastroenterologist, do you tell your [16] patients the risks and benefits of certain surgical [17] procedures? [18] A: If I am cognizant with them, then I do, [19] yes. [20] Q: If you're not cognizant of them, you leave [21] that to the general surgeon? [22] A: I do. [23] Q: Do you perform surgery yourself? [24] A: Not general surgery, no.</p>
<p style="text-align: right;">Page 41</p> <p>[1] A: No, I do not. [2] Q: Okay. Do you believe that the standard of [3] care requires that gastroenterologist to know when a [4] general surgeon is going to perform surgery on one [5] of his patients? And when I say "know," I mean the [6] exact time of day. [7] A: It may not be the standard of care, but [8] it's how our medical system works. If I ask a [9] colleague to do something, I like to know when it's [10] going to happen. If you were my patient, I'd [11] certainly like that to be the case. [12] Q: I want to understand if you believe it's a [13] standard of care for a gastroenterologist to be [14] aware of the exact date and time when a general [15] surgeon is going to perform surgery on one of his [16] patients. [17] A: If you phrase the question like that, no. [18] However, if the surgeon chose to operate the same [19] day and, therefore, I did know the date and time and [20] I disagreed, then it would become very important. [21] Or the next day. [22] Q: Did that happen in this case? [23] A: It occurred the next day. [24] Q: It didn't happen the same day?</p>	<p style="text-align: right;">Page 43</p> <p>[1] Q: Have you ever performed general surgery? [2] A: During my training, I did, yes. [3] Q: Okay. How many years ago was that? [4] A: Of the type of surgery that you're asking [5] me, and excluding endoscopic surgery, the last time [6] was 1972. [7] Q: Okay. [8] A: I'm sorry. 1973. [9] Q: Do you think it's within the standard of [10] care and reasonable for a gastroenterologist to [11] defer questions on risks of procedures, specifically [12] one that was done in this case in 1984, to the [13] general surgeon? [14] A: Which procedures are we referring to? [15] Q: To either some type of colon surgery, [16] general surgery, open or laparotomy? [17] A: Well, that's not just one question, [18] though. I think you have to be clear about what [19] type of surgery we're discussing. You can discuss [20] the risks and - risks and benefits of a laparotomy [21] which you just mentioned; however, there are many [22] types of colonic resection, each one carrying [23] different types of risks. [24] Q: I understand. And you don't perform those</p>

Page 44

[1] types of surgery, do you?
[2] A: No.
[3] Q: And to the best of your knowledge,
[4] Dr. Gottesman doesn't perform those types of
[5] surgery?
[6] A: To the best of my knowledge, he doesn't.
[7] Q: And to the best of your knowledge, he
[8] didn't perform those in 1984, did he?
[9] A: Not as far as I know.
[10] Q: So it's reasonable for a gastroenterologist
[11] to defer questions on surgical risks, techniques,
[12] complications to the general surgeon who's doing the
[13] surgery; correct?
[14] A: Yes.
[15] Q: Have you ever in your career referred a
[16] patient to a general surgeon without getting
[17] pathology reports back based on what you visibly
[18] observed during a colonoscopy?
[19] A: Yes. You asked me that just now.
[20] Q: Okay. And why did you do that?
[21] A: For the reason that if I'm suspicious that
[22] the patient has a cancer, which is often the reason
[23] for such a referral, I may ask for the surgeon to
[24] meet the patient when that patient is still here in

Page 46

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

Page 45

[1] the hospital, usually for convenience as I mentioned
[2] earlier. There are very few situations where it
[3] requires such a degree of urgency that it has to be
[4] done.
[5] I want to make it clear it's for
[6] convenience, but decisions are often not taken at
[7] that point as to exactly what is required.
[8] Q: Well, who makes the final decision as to
[9] surgery? The gastroenterologist or the general
[10] surgeon?
[11] A: That's - in my practice, that's often a
[12] joint decision based on the nature of the case, the
[13] nature of the pathology, the patient's wishes, the
[14] nature of the disease. All those issues have to be
[15] taken into account.
[16] Q: Okay.
[17] A: Often, we change our minds. Surgery may
[18] not be the most appropriate treatment for someone
[19] even though it may be considered so initially.
[20] Q: Do you think it's unreasonable that a
[21] general surgeon makes a final determination as to
[22] surgery?
[23] A: In general, no, it's not unreasonable. It
[24] depends on the surgeon.

Page 47

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

<p style="text-align: right;">Page 48</p> <p>[1] A: Within two days, I cannot recall a patient [2] right now. The only situation where that might be [3] relevant for a colon cancer is where the cancer is [4] obstructing and an emergency procedure is required [5] to decompress the colon. Although we have methods [6] for treating that endoscopically also now so - in [7] other words, those are emergency situations. [8] Q: Right. Earlier, you talked about one of [9] the reasons you refer to a general surgeon before [10] you get pathology back. But in instances where [11] you've seen suspicious nodes or polyps is for [12] convenience; right? [13] A: It's not nodes. You did not see nodes. [14] Q: Polyps? Masses? [15] A: Yes. [16] Q: And it's for convenience sake; correct? [17] A: Yes. [18] Q: Convenience for the patient? [19] A: Yes. [20] Q: Okay. How so? [21] A: In general, if you perform a colonoscopy [22] and you're suspicious of cancer, if you wait for the [23] biopsy to come back to be absolutely sure and then [24] make the determination several days later, the</p>	<p style="text-align: right;">Page 50</p> <p>[1] after a decision that a colonoscopy is required is [2] the patient will be given written instructions [3] referring to preparation. And they will take some [4] sort of cleansing procedure, of which we have a [5] range of different ones, prior to their attendance [6] at The Endoscopy Center. [7] Q: Okay. They have to drink something - [8] A: Yes. [9] Q: - that basically flushes their system? [10] A: Correct. [11] Q: Do you know what that tastes like? [12] A: I do know what it tastes like, yes. [13] Q: What does it taste like? [14] A: There are three commercially available [15] preparations that we use that are of the same [16] electrolyte solution, and they are salty in taste. [17] Some of them are flavored; some of them are not. [18] There's an additional type of preparation [19] that's smaller in volume than the electrolyte [20] solutions that is pretty tasteless but does the same [21] job, and that's actually the one we use most often [22] here. [23] Q: Do you know what Reverend Walick <i>drank</i> in [24] 1984?</p>
<p style="text-align: right;">Page 49</p> <p>[1] patient then has to come to the institution again, [2] meet the surgeon. A discussion has to take place [3] and a decision made. [4] Often, I will put the patient in contact [5] with the surgeon at the time if I think it's [6] appropriate just so they at least meet. [7] But the patient is sedated so that's an [8] absolute taboo for making any firm decisions about [9] anything. And that's why I say it's for [10] convenience. It's not to make final decisions. [11] It's really for no other reason than the two parties [12] to meet each other. [13] I work particularly with one surgeon who is [14] often in our endoscopy center, and I use him for [15] that purpose. [16] Q: What's that surgeon's name? [17] A: David Brooks. [18] Q: What is involved in your patients prior to [19] a colonoscopy? What do they have to do? [20] A: In what respect? [21] Q: Well, they have to clean out their bowel; [22] correct? [23] A: Oh, preparation. Sure. Our traditional [24] preparation - which has changed over the years -</p>	<p style="text-align: right;">Page 51</p> <p>[1] A: I'd have to check. But as far as I recall, [2] he received something called Go Lightly. [3] Q: Have you ever had patients take that [4] before? [5] A: Yes. [6] Q: What did they tell you about it? [7] A: I can't think anybody would like it, and [8] nobody would choose to <i>drink</i> a gallon or four liters [9] of solution. But, surprisingly, most patients seem [10] to manage to do it and tolerate it reasonably well. [11] Q: Obviously, colonoscopy is not a very [12] pleasant experience? [13] A: Correct. [14] Q: I'm sure you've gotten patient complaints [15] about colonoscopy and how it feels? [16] A: Yes. [17] Q: Okay. What are some of those complaints? [18] A: Most patients - remembering that they [19] are - the majority are sedated, although not all, [20] for colonoscopy - complain that it is [21] uncomfortable, even painful at times; that it causes [22] bloating because of the sensation of the air and [23] inflation that we use in the colonoscopy and the [24] stretching of the colon that takes place.</p>

<p style="text-align: right;">Page 52</p> <p>[1] Of course, they have already undergone a [2] preparation which is also unpleasant. And they have [3] to attend an unfamiliar place to undergo the [4] examination, which carries its own anxieties. [5] So there are a number of reasons that [6] patients might not like what they're about to [7] undergo. [8] Q: Have you ever had a patient say to you [9] after a colonoscopy, "I don't want to go through [10] that again"? [11] A: Yes. [12] Q: Have you ever had a patient who underwent a [13] colonoscopy who you wanted to come back for a repeat [14] colonoscopy just not come back because of the pain [15] or the misery associated with the colonoscopy? [16] A: Have I ever? There must be patients. I [17] can't think of any right now. But having [18] colonoscoped many thousands, yes, that must have [19] happened. [20] Q: You believe that's happened? [21] A: Yes. [22] Q: Would one of the reasons for an immediate [23] referral to a general surgeon - and we're talking [24] about convenience - the fact that if surgery is to</p>	<p style="text-align: right;">Page 54</p> <p>[1] A: What <i>size</i> is the first one? [2] Q: One centimeter. [3] A: We choose one centimeter for a good reason [4] in that we know that polyps smaller than one [5] centimeter when they're alone carry a very small [6] risk of there being a second or more polyps [7] elsewhere in the colon. Although that is still [8] being studied even today. [9] As soon as the polyp is one centimeter or [10] greater, the risk increases. And that's why our [11] advice when we find a single polyp of that <i>size</i> on [12] sigmoidoscopy is to perform a colonoscopy. [13] Q: Do you know what the risk is that there [14] will be a second adenomatous polyp if you already [15] found one that is one centimeter in size? [16] A: You want a percentage risk? [17] Q: Yes, based on your knowledge. [18] A: Well, our knowledge may be changing from [19] studies that we're doing here; but I think the [20] general belief is that there is at least a 20 [21] percent risk that there will be a second polyp [22] somewhere else in the colon, and that risk is [23] sufficient to look for it. [24] MR. HIRSHMAN: Synchronous? Or are we</p>
<p style="text-align: right;">Page 53</p> <p>[1] be done, that the patient has already been prepped, [2] their bowel is pretty much clean, basically they [3] don't have to go through the same thing twice for [4] the surgery because they've just been through it for [5] the colonoscopy? [6] A: What's your question? Is that a reason? [7] Q: For convenience. [8] A: There's a big difference between [9] convenience of a bowel prep and having a colon [10] resection the next day for convenience. I mean [11] that's a big operation we're talking about. [12] If all of the answers are in place, and the [13] decisions can be made, then, of course, it's very [14] convenient for the patient not to have to undergo a [15] bowel preparation all over again. However, that's [16] not the reason to do it at that time. [17] Q: At the time in 1984, I believe the Reverend [18] Walick was 41 years old. So let's take a patient [19] hypothetically of that age. [20] A: Yes. [21] Q: Okay. If you had a patient around that age [22] who had one adenomatous polyp, do you have any idea [23] what the chances are that he would have a second [24] such polyp?</p>	<p style="text-align: right;">Page 55</p> <p>[1] talking about - [2] THE WITNESS: Synchronous, I presume. [3] Q: Now, suppose you have two adenomatous [4] polyps. What's the chance of having a third? Do [5] you know? [6] A: Both are one centimeter or greater? [7] Q: Yes. [8] A: The chances are at least 20 percent and [9] could be greater. The data are not accurate if [10] you're going to ask me a series of questions about [11] numbers of polyps. [12] Q: What about in 1984? Did you know what the [13] data said in 1984? [14] A: There was obviously less data than there [15] are today, but there was still quite a lot of [16] evidence particularly from Saint Mark's Hospital [17] where much of this work was performed in London from [18] the late '70s and early '80s where the evidence was [19] even more so than today that we would look for [20] further polyps if you found one in the rectum or the [21] sigmoid colon. [22] At that time, we did not have the [23] information about size. So even small polyps were [24] pursued more so than today.</p>

<p style="text-align: right;">Page 56</p> <p>[1] Now we have the confidence that smaller [2] polyps are of less of a concern. [3] Q: I want to give you a hypothetical. I want [4] you to assume that you have a patient roughly [5] Mr. Walick's age, 41, at the time who had two [6] adenomatous polyps and a two and a half centimeter [7] villus appearing polyp. Absent pathology, what [8] would you think that third two and a half centimeter [9] lesion would be? [10] A: Are we discussing Father Walick or [11] something else? [12] Q: I just want to know if you have a patient [13] roughly that age and you perform a colonoscopy - [14] A Yes. [15] Q: -you see two adenomatous polyps one [16] centimeter in size - [17] MR. HIRSHMAN: I will object to that as [18] being unrelated to the facts in this case. [19] Q: - and you see a two and a half centimeter [20] villus appearing polyp, without getting anything [21] back from pathology, what would you think would be [22] the likely etiology of that two and a half [23] centimeter polyp? [24] A: Well, I have to qualify your question</p>	<p style="text-align: right;">Page 58</p> <p>[1] reasonable to refer that patient to a surgeon before [2] you get pathology back? [3] MR. HIRSHMAN: Let me object to that [4] question, too, unless you can tell me how you know [5] that the two polyps are adenomatous and where you [6] get your information that the villus polyp is one [7] centimeter in size or greater. [8] With those exceptions, you're free to [9] answer the question. [10] A: Well, as I stated in your previous [11] hypothetical question, often one does not know [12] they're adenomatous until they're removed and [13] examined. [14] Q: And you've referred patients to a general [15] surgeon just based on what your observation is, your [16] suspicion; correct? [17] A: Of polyps? [18] Q: Correct. [19] A: No. [20] Q: Well, you have never referred a patient to [21] a general surgeon after colonoscopy in which you [22] observed polyps that you thought were suspicious for [23] cancer? [24] A: Never, because that's not the question you</p>
<p style="text-align: right;">Page 57</p> <p>[1] because you called the first two adenomatous. [2] Obviously, we don't know what they are. [3] Q: Okay. [4] A: Certainly, in the 1980s, we wouldn't have [5] had the techniques available or the endoscopic [6] appearances documented that you could tell just by [7] looking what they were. [8] But that aside, polyps of that size [9] somewhere in the distal colon and then a lesion of [10] two and a half centimeters which you've called [11] villus at the hepatic flexure would obviously cause [12] concern because of its size. [13] Now, you've not told me anything else about [14] the polyp so I can't really answer your question any [15] more accurately. But those lesions could still all [16] be benign. [17] Q: Why would it cause you concern? [18] A: Because we know that polyps, the larger [19] they are, the more likely they are to harbor [20] malignancy in general. [21] Q: In such a situation where you found two [22] adenomatous polyps and another two and a half [23] centimeter polyp that you thought might be villus [24] and that you could not resect, would it be</p>	<p style="text-align: right;">Page 59</p> <p>[1] asked me earlier. [2] Q: Okay. What's the difference? [3] A: If I think the patient has a cancer, for [4] convenience, as I mentioned, I may refer the patient [5] before pathology is back. However, if it's a polyp, [6] and for some reason I can't remove it or I think [7] it's unsafe to remove it, then I will wait for [8] biopsies to tell me what it is first before I refer [9] the patient because at that stage, I'm not sure what [10] the appropriate treatment is. [11] Q: Do you think it's a deviation from the [12] standard of care for a gastroenterologist to refer a [13] person to a surgeon in that situation? [14] A: No, for an opinion. [15] Q: Exactly, for a surgical opinion - [16] A: Yes. [17] Q: - by the general surgeon. [18] A: Yes. That's not the same as referring for [19] surgery. No, that's perfectly acceptable. [20] Q: Well, what's the difference? [21] A: Well, I'm not sure we're talking [22] hypothetically or about this case now. [23] Q: Well, let's talk specifically about this [24] case.</p>

<p style="text-align: right;">Page 60</p> <p>[1] A: Okay. This polyp, the one in question [2] that's two and a half centimeters in diameter was [3] not described as villus in Dr. Gottesman's report as [4] far as I recall. He described it as [5] multilobulated. The surgeon described it as villus [6] many times even in correspondence to the primary [7] care physician. At no time is the pathology [8] described as villus, and I don't think Dr. Gottesman [9] described it in that way.</p> <p>[10] So I think it's a little misleading to be [11] discussing a villus lesion that may not have been [12] present.</p> <p>[13] Q: Okay. Do you recall -</p> <p>[14] A: Just so that we're clear, villus [15] architecture in a polyp does carry certain [16] connotations. And we know that villus tumors - [17] benign villus tumors carry a higher malignant [18] potential than tubular adenomas. And sometimes you [19] can tell the difference by examination of [20] colonoscopy.</p> <p>[21] Q: Okay. You read the doctor's deposition, [22] Dr. Gottesman's deposition?</p> <p>[23] A: Yes.</p> <p>[24] Q: Do you recall him ever in that deposition</p>	<p style="text-align: right;">Page 62</p> <p>[1] principally of the nuclei of cells in certain [2] contexts. The context in which it is seen is very [3] important because the interpretation of atypia may [4] be very different depending on that context.</p> <p>[5] When it's seen in an adenomatous tissue, [6] atypia, which is a word used by some pathologists, [7] or dysplasia, which is a similar term used by other [8] pathologists, is used to denote a higher degree of [9] abnormality, in other words, a tendency towards [10] malignancy.</p> <p>[11] However, it's important to note that atypia [12] when in the presence of inflammation may mean very [13] little. So the context in which it is seen is very [14] important.</p> <p>[15] Q: Well, can you have inflammation and atypia [16] at the same time?</p> <p>[17] A: Yes.</p> <p>[18] Q: Can you have inflammation and an [19] adenomatous polyp at the same time?</p> <p>[20] A: Yes, it's possible.</p> <p>[21] Q: Just so I'm clear, do you believe it was [22] unreasonable or below the standard of care for [23] Dr. Gottesman in this case to refer this patient to [24] a general surgeon before Dr. Gottesman got the</p>
<p style="text-align: right;">Page 61</p> <p>[1] referring to the polyp that he cannot remove as [2] appearing villus to him?</p> <p>[3] A: I don't recall. I'm basing it on what he [4] originally described in his endoscopy report, which [5] I think was - did not contain the word "villus," [6] but I may be -</p> <p>[7] (Witness reviews documents)</p> <p>[8] A: I can quote from the endoscopy report of [9] 11/6/84 that at the hepatic flexure or distal [10] ascending colon, there was a multilobulated, flat, [11] two and a half cm polyp with some satellite lesions [12] which was biopsied. The word "villus" is not [13] mentioned.</p> <p>[14] Q: Okay. I ask do you recall reading in [15] Dr. Gottesman's deposition where he described that [16] larger polyp that he could not remove as appearing [17] villus?</p> <p>[18] A: I don't recall, but I do remember that the [19] word "villus" was subsequently used by Dr. Eisenstat [20] and Dr. Gottesman.</p> <p>[21] Q: Okay. What does severe architectural [22] atypia mean to you?</p> <p>[23] A: Atypia is a pathological term used to [24] describe appearances under the microscope</p>	<p style="text-align: right;">Page 63</p> <p>[1] pathology back?</p> <p>[2] A: No, that was not unreasonable.</p> <p>[3] Q: Going back to your report, Doctor, if I [4] look under the opinion section, first paragraph, [5] last line: In 1984, colonoscopic surveillance would [6] have been the management of choice.</p> <p>[7] All right. When you say "management of [8] choice," does that mean that there are also at that [9] time other reasonable treatment options?</p> <p>[10] A: For what?</p> <p>[11] Q: For this type of polyp or these polyps.</p> <p>[12] A: You didn't read the rest of the sentence.</p> <p>[13] Q: Okay. We can read it. I don't want to be [14] unfair to you.</p> <p>[15] With or without treatment of co-existing [16] inflammatory bowel disease if this was [17] substantiated.</p> <p>[18] A: You see we haven't really discussed the [19] other interpretation of this lesion which, as you [20] know, turned out to be inflammatory and not [21] neoplastic at all; that this was inflammatory bowel [22] disease. And you will recall at the beginning I [23] mentioned that invariably, there had been documented [24] in his history that he had suffered from diarrhea</p>

Page 64	Page 66
<p>[1] prior to presentation to Dr. Gottesman,raising the</p> <p>[2] possibility that there may be inflammatory bowel</p> <p>[3] disease as a cause of both the bleeding and the</p> <p>[4] diarrhea.And that's why we come back to the whole</p> <p>[5] issue of accurate diagnosis.</p> <p>[6] If the polyp is not adenomatous,then</p> <p>[7] diagnosis may determine appropriate therapy which</p> <p>[8] may not involve surgery.And the other polyps that</p> <p>[9] were seen at the time of the colonoscopy could</p> <p>[10] easily be removed endoscopically; and,indeed, most</p> <p>[11] of them were.</p> <p>[12] So in that case, endoscopic surveillance or</p> <p>[13] colon endoscopic surveillance would be the</p> <p>[14] management of choice rather than removal of the</p> <p>[15] colon.</p> <p>[16] Q: By your term "managementof choice," I take</p> <p>[17] that to mean that that's not the sole treatment that</p> <p>[18] would have been within the standard of care. In</p> <p>[19] other words, would a surgical consult and removal -</p> <p>[20] partial removal of the colon been within the</p> <p>[21] standard of care if the patient desired so?</p> <p>[22] A. It's possible that partial removal of a</p> <p>[23] lesion that was suspicious for cancer or suspicious</p> <p>[24] of a premalignant lesion that could not be removed</p>	<p>[1] yourself, would rely that a surgeon would do so?</p> <p>[2] A: Yes.</p> <p>[3] Q: I think - I believe you already told us</p> <p>[4] that you don't know the exact surgery schedule,</p> <p>[5] exact time, that a patient that you have referred is</p> <p>[6] going to be operated on by a general surgeon; right?</p> <p>[7] A: I usually do, yes.</p> <p>[8] Q: But you don't know all of them, do you?</p> <p>[9] A: At the time that I refer the patient, no;</p> <p>[10] but I always know subsequently.</p> <p>[11] Q: Okay. Prior to surgery?</p> <p>[12] A: Oh, yes.</p> <p>[13] Q: But do you believe that the standard of</p> <p>[14] care requires the gastroenterologist to be aware of</p> <p>[15] the exact time and date?</p> <p>[16] A: No.</p> <p>[17] Q: Do you agree with me that Dr. Gottesman had</p> <p>[18] a right to rely on Dr. Eisenstat that Dr. Eisenstat</p> <p>[19] would check the pathology before operating on this</p> <p>[20] patient?</p> <p>[21] A: Yes, I think that's a reasonable</p> <p>[22] expectation.</p> <p>[23] Q: You mentioned earlier that you had read the</p> <p>[24] report of Dr. Gottesman's expert, Dr. Thomas; is</p>
Page 65	Page 67
<p>[1] through surgery could be resected, yes.</p> <p>[2] Q: And that would have been within the</p> <p>[3] standard of care?</p> <p>[4] A: Of course.</p> <p>[5] Q: You mentioned inflainmatory bowel disease.</p> <p>[6] What evidence do you have that in 1984 this</p> <p>[7] gentleman had inflammatory bowel disease?</p> <p>[8] A: None prior to the colonoscopy which the</p> <p>[9] biopsies from which documented that he had features</p> <p>[10] of inflammatory bowel disease in that polyp at the</p> <p>[11] hepatic flexure.</p> <p>[12] Q: Before the pathology came back, was there</p> <p>[13] any indication that this guy had inflammatory bowel</p> <p>[14] disease?</p> <p>[15] A: Not from what is documented, no.</p> <p>[16] Q: There's nothing in Dr. Gottesman's</p> <p>[17] operative report of the colonoscopy that suggested</p> <p>[18] inflammatory bowel disease, is there?</p> <p>[19] A: No.</p> <p>[20] Q: Is it fair to assume that a general surgeon</p> <p>[21] would make himself or herself aware of all pathology</p> <p>[22] results prior to performing surgery?</p> <p>[23] A: I would hope so.</p> <p>[24] Q: Okay. And as a gastroenterologist, you,</p>	<p>[1] that correct?</p> <p>[2] A: Yes.</p> <p>[3] Q: Do you know Dr. Thomas?</p> <p>[4] A: I do not.</p> <p>[5] Q: Have you ever heard of his name before?</p> <p>[6] A: I haven't.</p> <p>[7] Q: I want you to refer to the first page of</p> <p>[8] his report. It's dated June 26, 1997.</p> <p>[9] A: Yes. I have that.</p> <p>[10] Q: Do you disagree with his second sentence?</p> <p>[11] And I'll read it.</p> <p>[12] "It is quite common and certainly within</p> <p>[13] the standard of practice for gastroenterologist to</p> <p>[14] refer patients to surgery based on the gross</p> <p>[15] appearance of a large sessile polyp, which cannot be</p> <p>[16] removed with a colonoscopic snare polypectomy." Do</p> <p>[17] you agree with that?</p> <p>[18] A: Where is that?</p> <p>[19] Q: Last paragraph, second sentence. Take your</p> <p>[20] time.</p> <p>[21] MR. HIRSHMAN: Last paragraph of the</p> <p>[22] report?</p> <p>[23] MR. VOUDOURIS: First page.</p> <p>[24] (Witness reviews document)</p>

<p style="text-align: right;">Page 68</p> <p>[1] A: That statement is true; however, no attempt [2] was made to remove this polyp so we don't know that [3] it's not removable. Nobody attempted it. [4] Q: Well, is there any reason for you to [5] believe that Dr. Gottesman could have removed that [6] polyp if he said he could not? [7] A: I don't know that he made the attempt. He [8] was concerned about its appearance, which I accept, [9] and did the appropriate thing, which was to biopsy [10] it. However, if time had allowed that biopsy to be [11] reviewed, maybe the sequence of events would have [12] been different. [13] But it turned out not to be an adenomatous [14] polyp so it would not be necessary to remove. [15] Q: Well, does the standard of care require you [16] to remove that at that time not knowing what it was? [17] A: No. I'm not saying that he should have. [18] Q: Have you had situations where you have seen [19] a polyp that you have not attempted to remove? [20] A: Yes. [21] Q: And why was that? [22] A: Usually because of its size and extent, but [23] I may have done so on a separate occasion once I [24] knew the nature of the pathology or that it didn't</p>	<p style="text-align: right;">Page 70</p> <p>1] to undergo a right hemicolectomy, which I believe 2] were his words. 3] So it sounded like he had made the decision 4] for surgery even during the colonoscopy. 5] Q: Then why would he even bother taking 6] biopsies? 7] A: You'll have to ask him. I don't think it's 8] appropriate for me to answer that question. 9] Q: Why not? 10] A: Because he took them. I can't tell you 11] what his thinking was. 12] MR. HIRSHMAN: You're asking him to read 13] Dr. Gottesman's mind. 14] Q: I'm asking you in your opinion why would a 15] gastroenterologist bother to make biopsies if the 16] decision for surgery had already been made? Don't 17] you understand? 18] A: I do understand; and I would have taken 19] biopsies, also. But I'm telling you that in his 20] report, it sounds like he's made the decision for 21] the patient to undergo surgery 22] Q: So you're basing your opinion solely on the 23] impression from the report? 24] A: It's not an impression. It's a statement.</p>
<p style="text-align: right;">Page 69</p> <p>[1] require removal. [2] Q: Okay. And I believe you've already told me [3] you agree with this, but let's just double-check. [4] The second page of Dr. Thomas' report, the [5] first full sentence on the top of the page, "It is [6] certainly appropriate, in my opinion, for [7] Dr. Gottesman to have referred this patient to [8] surgery." [9] Do you agree with that statement? [10] A: Not as it's worded, no. [11] Q: Why not? [12] A: I would accept that it's appropriate for [13] him to consult with a surgical colleague for an [14] opinion but not necessary to refer the patient to [15] surgery, which suggests that the decision has [16] already been made. That's how I read that [17] statement. [18] Q: Is there anything - any fact that you're [19] relying upon that Dr. Gottesman had said, "You're [20] going to have surgery," that it was solely [21] Dr. Gottesman's call? [22] A: As I recall, in his very first endoscopy [23] report, which I quoted in my report, polyps five and [24] six were left alone because the patient would have</p>	<p style="text-align: right;">Page 71</p> <p>[1] The patient would have to undergo a right [2] hemicolectomy. [3] Q: Okay. Did he undergo it? [4] A: No. He underwent something much more [5] extensive. [6] Q: So he didn't undergo that procedure? [7] A: No, not by name. [8] Q: Let's go to the next paragraph in [9] Dr. Thomas' report, Page 2. Again, we might already [10] know the answer. [11] "I do not find fault with Dr. Gottesman's [12] care of this patient, nor his referral to a surgeon [13] after seeing the gross appearance of a large right [14] sided colonic polyp." [15] Do you agree with that statement? [16] A: This is different wording. I can agree [17] with that statement, yes. Referral to a surgeon. [18] Q: All right. Well, you've had an opportunity [19] to look at the report of Dr. Thomas; correct? [20] A: Yes. [21] Q: Before today? [22] A: I saw it today. [23] Q: Okay. You had an opportunity to read it [24] before the deposition?</p>

<p style="text-align: right;">Page 72</p> <p>[1] A: Yes.</p> <p>[2] Q: Any statements in here that you disagree</p> <p>[3] with?</p> <p>[4] MR. HIRSHMAN: You know, if you want to ask</p> <p>[5] him about a particular statement, do it. I'm not</p> <p>[6] going to - I don't think that's a fair question.</p> <p>[7] There's a lot of sentences in there. Why don't you</p> <p>[8] just go through the report and pick out whatever you</p> <p>[9] want him to opine about.</p> <p>[10] Q: I don't think it's that long, Doctor.</p> <p>[11] Is there any statement in here that you've</p> <p>[12] read that you disagree with, in Dr. Thomas' report?</p> <p>[13] MR. HIRSHMAN: Note my objection to the</p> <p>[14] question.</p> <p>[15] A: Well, much of the large paragraph on Page 1</p> <p>[16] is factual -</p> <p>[17] Q: Correct.</p> <p>[18] A - is the chronology of the case. And I</p> <p>[19] see no objection to that. It documents the</p> <p>[20] colonoscopy. It documents the subsequent surgery.</p> <p>[21] And it documents the pathology.</p> <p>[22] I would object to the statement that the</p> <p>[23] large sessile polyp could not be removed as we</p> <p>[24] discussed just now as no attempt was made to do</p>	<p style="text-align: right;">Page 74</p> <p>[1] If you want to ask him about specific</p> <p>[2] statements, go ahead. I'm not going to ask him -</p> <p>[3] I'm not going to let you ask him to opine about the</p> <p>[4] report in general terms. If you want to go through</p> <p>[5] it sentence by sentence, that's your prerogative.</p> <p>[6] Go ahead. Be my guest.</p> <p>[7] Q: Doctor, we were at the last paragraph on</p> <p>[8] the first page. You said you disagreed with the</p> <p>[9] statement that the polyp could not be removed;</p> <p>[10] a correct?</p> <p>[11] A: Correct.</p> <p>[12] Q: All right. Keep reading. Tell me when you</p> <p>[13] get to a statement that you disagree with.</p> <p>[14] (Witness reviews document)</p> <p>[15] A: Some of these statements are hypothetical</p> <p>[16] such as the statement about a biopsy reported as</p> <p>[17] showing no malignancy but there remaining a question</p> <p>[18] whether or not a polyp could harbor malignancy.</p> <p>[19] That's true but not strictly relevant to this</p> <p>[20] patient.</p> <p>[21] We've already discussed the two statements</p> <p>[22] about referral to surgery which Dr. Thomas expresses</p> <p>[23] in two slightly different ways. Maybe he means the</p> <p>[24] same on both occasions, but I would interpret them</p>
<p style="text-align: right;">Page 73</p> <p>[1] that.</p> <p>[2] Q: What do you base that on, that no attempt</p> <p>[3] was made to remove it?</p> <p>[4] A: Because there's no statement in the</p> <p>[5] endoscopy report that an attempt was made.</p> <p>[6] Q: You told me that the standard of care</p> <p>[7] didn't require it to be removed; correct?</p> <p>[8] A: No. But for something to be stated as not</p> <p>[9] removable or that cannot be removed, there either</p> <p>[10] should be a statement that an attempt was made and</p> <p>[11] it's impossible or the reasons for that failure. I</p> <p>[12] haven't seen that.</p> <p>[13] Q: If I understood you, though, you mentioned</p> <p>[14] a little bit earlier that there have been occasions</p> <p>[15] where you have not removed a polyp because you</p> <p>[16] thought it was unsafe to do so; correct?</p> <p>[17] A: At the time.</p> <p>[18] Q: That's fine.</p> <p>[19] Oh, please continue.</p> <p>[20] A: But as I say, it doesn't mention that in</p> <p>[21] this report. The reason that it was not removed is</p> <p>[22] that surgery would be required. I'm just</p> <p>[23] reiterating what I read.</p> <p>[24] MR. HIRSHMAN: Let me stop you.</p>	<p style="text-align: right;">Page 75</p> <p>[1] differently. Referring to surgery and referring to</p> <p>[2] a surgeon are not necessarily the same thing. It</p> <p>[3] may be a semantic distinction in his view.</p> <p>[4] I certainly don't object to taking biopsies</p> <p>[5] from the polyp, as we've already discussed; and I</p> <p>[6] think we've discussed everything else here.</p> <p>[7] Obviously, we disagree about the standard</p> <p>[8] of care as, again, we've already discussed.</p> <p>[9] Q: Now, we talked mostly about your first</p> <p>[10] criticism which was providing an adequate diagnosis</p> <p>[11] of the colonic lesion. And then you had a second</p> <p>[12] criticism dealing with the responsibility - the</p> <p>[13] continued responsibility of the gastroenterologist</p> <p>[14] once the referral is made?</p> <p>[15] A: Yes.</p> <p>[16] Q: What do you mean by that?</p> <p>[17] A: Well, in most clinical care situations,</p> <p>[18] unless it's an emergency and completely outside the</p> <p>[19] control of the initial physician, the responsibility</p> <p>[20] for care continues. It doesn't stop the moment you</p> <p>[21] ask somebody else to see your patient.</p> <p>[22] A referral for an opinion is exactly that.</p> <p>[23] It does not mean that you pass on the care of that</p> <p>[24] patient to another physician unless that's what you</p>

<p style="text-align: right;">Page 76</p> <p>[1] wish. And with two different specialties, that's [2] usually not the case. [3] Now, if the care was being transferred to [4] another physician - in this case, Dr. Eisenstat - [5] I didn't see any documentation of that. [6] So if it were myself, I would still take [7] responsibility for that patient's management up [8] until the time that it no longer depended upon me. [9] In this case, it would be the surgery. Although as [10] we've already discussed, that was probably not [11] warranted, particularly if I didn't agree with the [12] opinion that I was seeking because I am the advocate [13] for my patient. And if I disagree with the opinion [14] that's been sought, even if it's a colleague that I [15] trust and work with regularly, then it's my [16] responsibility to tell the patient so. And that [17] does happen from time to time. [18] Q: But you as a gastroenterologist obviously [19] would have to be made aware of the opinion of the [20] general surgeon and made aware of that opinion [21] before surgery - [22] A: Correct. [23] Q: - to interject; correct? [24] A: Of course.</p>	<p style="text-align: right;">Page 78</p> <p>[1] were just now. [2] If I refer a patient; and the surgeon says, [3] "I'm going to operate tomorrow," and I think that [4] that's not appropriate, then I will voice that [5] opinion. And I might even document it in the [6] chart. I will certainly tell the patient and [7] discuss it with him or her. [8] Now, I have an opportunity to read Father [9] Walick's statement; and I do not get that [10] impression. [11] Q: I want you to assume that Dr. Gottesman, [12] once a referral was made to Dr. Eisenstat, did not [13] know when Dr. Eisenstat planned to take this [14] gentleman to surgery; was never told by [15] Dr. Eisenstat the time that this gentleman was going [16] to be taken to surgery; that Dr. Gottesman was never [17] made aware that Dr. Eisenstat, if the case be true, [18] did not look at the pathology report before taking [19] this gentleman to surgery, then how can you say that [20] Dr. Gottesman deviated from the standard of care [21] once the referral was made to Dr. Eisenstat? [22] A: Because it would be my responsibility if I [23] were in that situation to know that all those things [24] were taken care of. That's exactly my point is that</p>
<p style="text-align: right;">Page 77</p> <p>[1] Q: Okay. And you already said it was [2] reasonable for Dr. Gottesman to refer this patient [3] to the general surgeon even before he got results [4] back from pathology; correct? [5] A: It was reasonable to seek that opinion. [6] Sure. [7] Q: And it was also reasonable for [8] Dr. Gottesman to rely on the fact that Dr. Eisenstat [9] would look at the pathology before taking this [10] patient to surgery; correct? [11] A: Yes. [12] Q: And you also told me there's nothing in the [13] record that indicates that Dr. Eisenstat told [14] Dr. Gottesman at exactly what time and when he was [15] taking this patient to surgery? [16] A: Correct. That is not in the record. [17] Unfortunately. [18] Q: Well, are you saying that Dr. Gottesman had [19] a responsibility for making sure that this person [20] did not go to surgery? [21] A: That's a slightly unusual question. I [22] think it's the responsibility of the referring [23] physician to ensure that his patient gets the best [24] treatment. Now, let's speak hypothetically as we</p>	<p style="text-align: right;">Page 79</p> <p>[1] once you ask for an opinion, it does not devolve you [2] of responsibility to that patient. Otherwise, [3] anybody can do anything they want and just not tell [4] you. I don't think that's a reasonable standard of [5] care. [6] Q: All right. But you have to be made aware [7] of those facts before they happen to have any impact [8] on the decision; correct? [9] A: Well, you can always ask the patient. If [10] you have no other way of knowing, the patient [11] usually knows when they sign a consent, when they're [12] told things are going to happen to them. I mean [13] that's the last source of information within an [14] institution and shows that communications are not [15] very good, which is perhaps a criticism of what [16] happened here. [17] And perhaps Dr. Gottesman is in a very [18] awkward position because of another colleague's [19] actions, and that's what you're telling me [20] happened. I don't think that completely removes [21] responsibility, however, of the primary physician, [22] who is the gastroenterologist in this case, to that [23] patient. [24] If this situation happened to me in this</p>

Page 80

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

Page 81

[1] sentence? I want to be fair to you. I don't want
[2] to cut you off.
[3] **A:** No.
[4] **Q:** I want you to assume that Dr. Gottesman
[5] made the referral to Dr. Eisenstat on Wednesday
[6] afternoon. Dr. Gottesman does his other work, goes
[7] home, comes back to the hospital on Thursday at
[8] whatever time and finds out that the surgery has
[9] already been done. I want you to assume that.
[10] **A:** All right. I shall assume that.
[11] **Q:** Okay. Then do you believe that
[12] Dr. Gottesman deviated from an accepted standard of
[13] care in terms of following this patient once the
[14] referral was made?
[15] **A:** It was - was the patient in the hospital
[16] at the time?
[17] **Q:** Yes.
[18] **A:** Then who saw the patient that evening?
[19] Does he have other staff? I mean I don't know the
[20] arrangements in the hospital. If he has junior
[21] staff to care for his patients, then obviously he
[22] can communicate with them.
[23] **Q:** I want you to assume that it's a private
[24] hospital and he does not.

Page 82

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

Page 83

[1] Thursday?
[2] **A:** Yes, I do.
[3] **Q:** Why is that?
[4] **A:** Because the patient was admitted under his
[5] care, and he made the referral. Therefore, he took
[6] the responsibility of asking a colleague to take
[7] that action.
[8] **Q:** Okay. I want you to assume that the
[9] patient was not admitted under Dr. Gottesman's
[10] care. Do you still hold that position?
[11] **A:** Well, how was the admission arranged? I
[12] mean somebody has to take - if you're telling me it
[13] was Dr. Eisenstat, I'll have to accept that. And,
[14] therefore, his care was differed from if that's how
[15] things are done at Hillcrest Hospital.
[16] **MR. HIRSHMAN:** I think the service was the
[17] internist if I'm not mistaken.
[18] **THE WITNESS:** That's certainly not the way
[19] things are done here, or what I've been familiar
[20] with in the past.
[21] **Q:** Well, I want you to assume that the
[22] responsibility of the patient was transferred from
[23] Dr. Gottesman to Dr. Eisenstat on Wednesday, early
[24] afternoon. Are you still critical of Dr. Gottesman

<p style="text-align: right;">Page 84</p> <p>[1] for what transpired the next day?</p> <p>[2] A: I'm still critical of the way it happened,</p> <p>[3] but I can then say it was not below the standard of</p> <p>[4] care because he's then transferring care. It may be</p> <p>[5] bad judgment and a bad way to perform medicine; but,</p> <p>[6] again, I cannot criticize him.</p> <p>[7] Q: You can't say that was a deviation?</p> <p>[8] A: No. In that situation, no.</p> <p>[9] Maybe I can just add something.</p> <p>[10] I do appreciate that colleagues can put us</p> <p>[11] in very awkward positions. And if that's the way</p> <p>[12] things happened, then I'm sorry that Dr. Gottesman</p> <p>[13] was put in that position. Hopefully, it hasn't</p> <p>[14] happened ever again.</p> <p>[15] But from the outside, I have to view what</p> <p>[16] happened to that individual patient in a 24-hour</p> <p>[17] period.</p> <p>[18] Q: Doctor, I probably have some questions; but</p> <p>[19] I am going to let Mr. Casey ask you some questions</p> <p>[20] now. Okay?</p> <p>[21] A: Very well.</p> <p>[22] MR. HIRSHMAN: Mr. Casey is here, and he's</p> <p>[23] going to be asking you questions presumably on</p> <p>[24] behalf of the hospital and on behalf of</p>	<p style="text-align: right;">Page 86</p> <p>[1] medicine in any state of the United States?</p> <p>[2] A: That's correct.</p> <p>[3] Q: Upon what do you base your belief or your</p> <p>[4] knowledge base on the standard of care for</p> <p>[5] physicians within the United States during the year</p> <p>[6] 1984?</p> <p>[7] A: I base that on my knowledge of having</p> <p>[8] worked in this country now for eight years and being</p> <p>[9] very much a part of the professional organizations</p> <p>[10] that help establish the standards of care for the</p> <p>[11] practice of endoscopy and gastroenterology; having</p> <p>[12] also been very much involved in similar</p> <p>[13] circumstances in the United Kingdom prior to 1989,</p> <p>[14] keeping in mind that the standard of care is very</p> <p>[15] similar in the two countries.</p> <p>[16] Q: Are you saying that the standards of care</p> <p>[17] for physicians in the United States in 1984 were the</p> <p>[18] same as the standards of care for physicians in the</p> <p>[19] U.K. in 1984?</p> <p>[20] A: Well, that's a very big question. There</p> <p>[21] are many similarities, particularly within</p> <p>[22] gastroenterology, which is a well-defined field with</p> <p>[23] similar levels of development in the two countries</p> <p>[24] at that time and even today.</p>
<p style="text-align: right;">Page 85</p> <p>[1] Dr. Eisenstat.</p> <p>[2] MR. CASEY: Since you're trying to hold the</p> <p>[3] hospital for Dr. Eisenstat's scare, I guess I would</p> <p>[4] have to.</p> <p>[5] MR. HIRSHMAN: I just want him to know</p> <p>[6] who's asking the questions.</p> <p>[7] MR. CASEY: I'll be asking the questions.</p> <p>[8] CROSS EXAMINATION</p> <p>[9] BY MR. CASEY:</p> <p>[10] Q: Doctor, in 1984, were you licensed to</p> <p>[11] practice medicine in any state of the United States?</p> <p>[12] A: No.</p> <p>[13] Q: At any time prior to 1984, had you been</p> <p>[14] licensed to practice medicine in any state of the</p> <p>[15] United States?</p> <p>[16] A: Yes.</p> <p>[17] Q: For one year, from '78 to '79?</p> <p>[18] A: That's correct.</p> <p>[19] Q: And you had provisional privileges -</p> <p>[20] A: Yes.</p> <p>[21] Q: - for a fellowship?</p> <p>[22] A: Yes.</p> <p>[23] Q: But at the time the procedures in this case</p> <p>[24] took place, you were not licensed to practice</p>	<p style="text-align: right;">Page 87</p> <p>[1] Q: Does the U.K. even recognize a concept that</p> <p>[2] we know as standard of care?</p> <p>[3] A: It does today. Maybe in the mid-1980s the</p> <p>[4] concept was different. However, I was very much</p> <p>[5] aware of the situation here traveling to the United</p> <p>[6] States many times prior to my move here.</p> <p>[7] Q: So in 1984 when you were practicing in the</p> <p>[8] U.K., that country did not even recognize the same</p> <p>[9] legal terminology in terms of standard of care</p> <p>[10] medicine?</p> <p>[11] A: It did. And even to this day, it probably</p> <p>[12] uses different terminology. That's correct.</p> <p>[13] Q: The system for bringing lawsuits and for</p> <p>[14] prosecuting those suits is much different in the two</p> <p>[15] countries; correct?</p> <p>[16] A: Yes.</p> <p>[17] Q: Medicine in the U.K. is socialized;</p> <p>[18] correct?</p> <p>[19] A: There are a number of different ways</p> <p>[20] patients can be treated. There is a socialized</p> <p>[21] system. It's not the only one.</p> <p>[22] Q: Were you operating in the socialized system</p> <p>[23] in 1984?</p> <p>[24] A: I was salaried in the National Health</p>

<p style="text-align: right;">Page 88</p> <p>[1] Service which is the socialized system you're [2] referring to. I was also performing private [3] practice. [4] Q: So if I understand your testimony, your [5] basis for what the standard of care required of [6] gastroenterologists in 1984 is based mostly on your [7] experience in the United States since 1989; is that [8] fair? [9] A: That's partly fair. I mean I did have [10] colleagues who were here in the 1980s before I [11] moved. So I wasn't completely unaware of the [12] situation in the United States at that time. [13] Q: And you feel comfortable commenting on what [14] the standard of care required for a [15] gastroenterologist in 1984 for Dr. Gottesman in [16] Cleveland, Ohio? [17] A: Yes. I've been asked to do that, and I'm [18] comfortable doing so. [19] Q: And even though you were practicing nearly [20] 4,000 or 5,000 miles away? [21] A: Yes. Actually, 4,000. [22] Q: You have told us that you have but for a [23] limited surgical experience during your early [24] training not done any general surgery since about</p>	<p style="text-align: right;">Page 90</p> <p>[1] Your criticism of both Dr. Eisenstat and [2] what I have been hearing about Dr. Gottesman is that [3] this patient was taken to surgery presumably before [4] the results of the histopathology were back? [5] A: That's correct. [6] Q: If the results of the histopathology were [7] back and had been communicated both to Dr. Eisenstat [8] and to the patient, and the patient was given the [9] option of continued colonoscopies or surgery, do you [10] have any criticisms of either Dr. Gottesman or [11] Dr. Eisenstat? [12] A: You're limiting your options. Those may [13] not have been the only two options, and you have to [14] define for me what you mean by continuing [15] colonoscopies. [16] Q: Well, surveillance colonoscopies. We will [17] repeat the colonoscopies if you so wish, and we will [18] continue to monitor this lesion that we can't get [19] to. Or - [20] A: I would disagree with that statement. [21] Q: Well, do you have anything in the records [22] that would suggest to you that this lesion at the [23] hepatic flexure was resectable? [24] A: You're assuming that it required</p>
<p style="text-align: right;">Page 89</p> <p>[1] 1972; is that fair? [2] A: That's correct. [3] Q: Do you feel qualified to comment on the [4] standard of care for a surgeon in Cleveland, Ohio, [5] in 1984 when Dr. Eisenstat was contemplating taking [6] this patient to surgery? [7] A: Yes, because throughout my professional [8] career from 1974 onwards, I've worked almost [9] exclusively with general surgeons both on inpatient [10] and outpatient bases and during the developments of [11] endoscopy. And I do to this day. [12] Q: So even though you have never done [13] colorectal surgery, you can and will give opinions [14] in this case regarding the standard of care for [15] Dr. Eisenstat? [16] A: I'm prepared to give opinions on the [17] decisions as to whether surgery is appropriate. [18] Obviously, I cannot give an opinion about the [19] technique - technical aspects of surgery which I [20] have not performed for a long time. [21] Q: I think I understand your criticisms [22] regarding whether or not surgery was appropriate in [23] this case. And let me see if I can paraphrase it [24] and whether you agree.</p>	<p style="text-align: right;">Page 91</p> <p>[1] resection. It's not a neoplasm. [2] Q: I understand that that is what we know now [3] in retrospect. But we didn't know that on [4] November 6, did we, of 1984? [5] A: No. That's exactly my point. [6] Q: And even when the biopsy results came back [7] on November 7 of 1984, we still didn't know for sure [8] that that was not a neoplasm; isn't that fair? [9] A: First of all, we don't know that the [10] biopsies came back on November the 7th. [11] Q: Well, we know that the report was dictated [12] and typed on November 7, don't we? [13] A: It was dated November 7. I do not know [14] when it was made available to the medical staff. [15] Q: I understand. But you and I can agree that [16] the report is typed and dated November 7; correct? [17] A: But I disagree with the other half of your [18] statement, that we still don't know that there is [19] a - whether this is a - I forget what term you [20] used. [21] Q: A neoplasm. [22] A: Yes. [23] Q: So you do not give any credence to the fact [24] that this biopsy may have been sampling error?</p>

<p style="text-align: right;">Page 92</p> <p>[1] MR. HIRSHMAN: To the fact or to the [2] assertion? [3] Q: Well, on November 7, before we had taken it [4] out and before the pathologist had looked at it and [5] before. We know today that it wasn't. [6] A: Well, that's precisely my point. It's [7] because we didn't know that he should not have [8] proceeded to surgery as there was no hurry to do so. [9] Q: My question is: On November 7 of 1984 when [10] the biopsy results came back and were made [11] available - let's assume just for a moment that [12] they were made available before the surgery. [13] A: Okay. [14] MR. HIRSHMAN: To whom? To Dr. Eisenstat? [15] MR. CASEY: To Dr. Eisenstat because [16] Dr. Gottesman has said that he does not ever recall [17] hearing those before the surgery. [18] Q: Assuming that those results had come back [19] and been communicated, knowing how Dr. Gottesman had [20] described the lesion, and knowing that two other [21] polyps within that same colon had come back [22] adenomatous, would that give you any cause for [23] concern that this biopsy may have been in fact [24] sampling error?</p>	<p style="text-align: right;">Page 94</p> <p>[1] It is the appropriate treatment for a neoplasm. [2] Obviously, I agree with that approach. [3] Q: So in a repeat biopsy, how much of the [4] tissue would have had to have been gotten to make [5] sure that this lesion was not an adenoma - did not [6] have a portion of adenoma in it? [7] A: Well, I can't give you a percentage. And [8] it's unfortunate that the photographs of lesion [9] which Dr. Gottesman took are not reproduced in an [10] interpretable way in the charts. That would have [11] helped enormously. [12] But a large proportion of a lesion such as [13] this can be removed for what we call excision [14] biopsy. And it's the same technique that we use for [15] polypectomy, and it certainly was available in [16] 1984. [17] Do we have to remove a hundred percent of [18] it? No, we don't. If you remove 50 percent and it [19] all shows the same inflammatory tissue, one can make [20] a reasonably confident diagnosis that the lesion is [21] not adenomatous. [22] The question was raised earlier whether [23] inflammatory tissue and adenomatous tissue can [24] coexist; and, of course, it can. And that's why we</p>
<p style="text-align: right;">Page 93</p> <p>[1] A: I would be concerned that that lesion [2] seemed to be different from the others, and one [3] interpretation can be sampling error. Another [4] interpretation could be it's a completely different [5] lesion and, therefore, further information is [6] required. [7] So I can partly agree with you, yes. [8] Q: Okay. And even in doing a repeat [9] colonoscopy and a repeat biopsy of that lesion, [10] without excision, without the ability to resect the [11] entire lesion, could the doctors be certain in [12] assuring Father Walick that there was no adenomatous [13] portion to the inflamed tissue at the hepatic [14] flexure? [15] A: Well, we have to define exactly what you [16] mean by excision. You can take very large biopsies [17] from the colon which increases the accuracy of the [18] diagnosis. We do this all the time. [19] If your question is do we always need to [20] remove every single piece of tissue to be absolutely [21] sure, no, we don't. If we are convinced that a [22] lesion is inflammatory, as this lesion turned out to [23] be, then, clearly, we do not need to resect it [24] because resection is not the appropriate treatment.</p>	<p style="text-align: right;">Page 95</p> <p>[1] take large biopsies, to ensure that sampling error [2] is excluded. [3] Q: So regardless of how many biopsies we did, [4] the possibility of sampling error can never be [5] eliminated; is that fair? [6] A: No, that's not fair. Because the more [7] biopsies you take, and the larger biopsies you take, [8] the less likely the sampling error is going to be [9] present. [10] Q: If you were the doctor who's talking with [11] Father Walick on November 7 of 1984 after the [12] results of this pathology come back, could you [13] guarantee Father Walick that the polyp at the [14] hepatic flexure was not in any way precancerous? [15] A: On that day, I can't guarantee it, no; but [16] I would make my job one to ensure that was or went [17] on a subsequent occasion. [18] Q: So you would recommend to Father Walick a [19] repeat colonoscopy. [20] A: I - [21] Q: Do we know or do you have an opinion as to [22] what Father Walick's individual fear of cancer was [23] in regard to the average patient? Would you say it [24] was higher or lower?</p>

Page 96

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

he same pathology.

So in answer to your question about what
the 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
[20] 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

Page 98

Page 97

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

Page 99

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

Page 100	Page 102
<p>[1] that Dr. <i>Gottesman</i> removed. They were five [2] millimeters, five millimeters, eight millimeters, [3] fifteen millimeters – which was a little larger – [4] but they were all removed. And only two of those [5] were adenomatous. In fact, the small ones, one was [6] normal tissue.</p> <p>[7] So I'm talking about two lesions that were [8] previous to adenomatous which were removed in their [9] entirety, which is standard colonoscopic practice.</p> <p>[10] We don't tell patients that they're going [11] to get cancer having removed them. That's why we [12] remove them.</p> <p>[13] Q: To tell Father Walick that those polyps [14] were indeed precancerous, would that be a deviation [15] from the standard of care by –</p> <p>[16] A: No.</p> <p>[17] Q: – either –</p> <p>[18] MR. HIRSHMAN: Which polyps are we talking [19] about now?</p> <p>[20] MR. CASEY: The two that came back [21] adenomatous.</p> <p>[22] A: No, that would not – that would be an [23] accurate statement.</p> <p>[24] Q: So if the doctors indeed told Father Walick</p>	<p>[1] Q: <i>All</i> right. So we know on the 7th that the [2] pathology report came back and said that the – that [3] the hepatic flexure lesion, the biopsy that was [4] taken, turned out to be inflammatory; is that fair?</p> <p>[5] A: That's correct.</p> <p>[6] MR. HIRSHMAN: Printed on the 7th I think [7] is what he indicated.</p> <p>[8] MR. CASEY: Right. Printed on the 7th.</p> <p>[9] Q: We don't know what time that came back?</p> <p>[10] MR. HIRSHMAN: Came back is ambiguous. [11] Came back implies that a doctor had it in his hand [12] and read it.</p> <p>[13] MR. CASEY: I understand. Let's deal with [14] that right now.</p> <p>[15] Q: The information that you get from [16] pathology, can you get that in an oral form over the [17] phone?</p> <p>[18] A: Yes, of course.</p> <p>[19] Q: Is it within the standard of care to [20] receive that information from a pathologist over the [21] phone?</p> <p>[22] A: That's very much dependent on the [23] institution arrangements. We would expect it here [24] if it showed malignancy. However, if it did not</p>
Page 101	Page 103
<p>[1] on the 7th of November that there was a situation in [2] his colon that was precancerous or that had been [3] precancerous, they would not be deviating from [4] acceptable standards of care?</p> <p>[5] MR. HIRSHMAN: Objection. The conversation [6] didn't take place on the 7th. It took place on the [7] 6th.</p> <p>[8] MR. CASEY: I understand that –</p> <p>[9] MR. HIRSHMAN: There's a big difference in [10] this case between the 6th and the 7th.</p> <p>[11] MR. CASEY: I understand that's your [12] position, Toby; and I don't know that that's going [13] to turn out to be the factual situation at trial. [14] That's what I want to explore with the doctor.</p> <p>[15] MR. HIRSHMAN: Okay. Go ahead.</p> <p>[16] A: There are two questions you just asked me. [17] Yes, I would agree that it was not a great [18] way; but if they stated that the patient had had [19] precancerous lesions removed, they had been present, [20] I would accept that.</p> <p>[21] If they told him that he still remained in [22] a situation where the precancerous lesions were [23] present in the colon, I would not accept that.</p> <p>[24] You asked both questions.</p>	<p>[1] show malignancy, we would not expect it to be called [2] unless we'd asked it to be done so.</p> <p>[3] Q: My point is if Dr. Eisenstat got the [4] information over the phone from a pathologist –</p> <p>[5] A: <i>Yes</i>.</p> <p>[6] Q: – on November 7 before he took the patient [7] to surgery, would that be adequate to meet the [8] standard of care in your mind?</p> <p>[9] A: Of assuring that he had the pathology, yes.</p> <p>[10] Q: Now, what he did with it is another [11] matter. But at least in getting the pathology [12] results, he could have gotten that in one of two [13] ways, either the written report that we see here, or [14] he could have gotten a verbal report from the [15] pathologist. Fair?</p> <p>[16] A: That's fair.</p> <p>[17] Q: Now, assuming he got this information that [18] the biopsy came back as inflammatory, and that [19] information was communicated to the patient before [20] he was taken to surgery, would it be a deviation [21] from the standard of care to offer that patient, [22] Father Walick, a surgical option at that point in [23] time?</p> <p>[24] A: You have to define what you mean by that.</p>

Page 104

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

Page 106

[1] telling me about, the pathology was not available;
[2] and nobody knew what that lesion was that worried
[3] Dr. Gottesman at the time of the colonoscopy.
[4] Q: I think you said earlier in your deposition
[5] something to the effect of - and I wrote it down.
[6] And I don't want to misquote you - if you want the
[7] patient to be considered for surgery, you can ask a
[8] surgeon. If you don't, you don't.
[9] Does that sound about what you might have
[10] said?
[11] A: It sounds like it.
[12] Q: So you think that on the 6th, it was okay
[13] to ask a surgeon to consider surgery; but on the
[14] 7th, once the pathology came back, it was no longer
[15] within the standard of care for that surgeon to
[16] consider going forward with the surgery?
[17] A: That's absolutely correct. You defined it
[18] exactly.
[19] Q: And you say that despite the fact that you
[20] are not a surgeon?
[21] A: I'm not sure of the relevance of that
[22] question.
[23] Q: What caused the cecal lesion at the hepatic
[24] flexure?

Page 105

[1] A: Two.
[2] Q: - the multiple polyps within the colon -
[3] A: Two. Two adenomatous polyps.
[4] Q: There were six polyps in the colon.
[5] A: But there were only two adenomatous.
[6] Q: I understand. But there were six polyps in
[7] the colon.
[8] A: That's correct.
[9] Q: Two of those turned out to be adenomatous;
[10] correct?
[11] A: Correct.
[12] Q: And by your indication, there was in that
[13] pathology report some suggestion that the patient
[14] may have inflammatory bowel disease; is that fair?
[15] A: Correct.
[16] Q: So a patient that had two adenomatous
[17] polyps, six polyps total, and inflammatory bowel
[18] disease, your opinion is that it's not within the
[19] standard of care to offer that patient surgery?
[20] A: That's correct.
[21] Q: Then why is it appropriate to ask a surgeon
[22] to come in and consult?
[23] A: Because at the time that that question was
[24] raised, which was the day before the one that you're

Page 107

[1] What caused the lesion at the hepatic
[2] flexure? Sorry.
[3] A: What caused it?
[4] Q: Yes.
[5] A: I can't tell you what caused it. I can
[6] tell you its pathology, which has many features
[7] suggesting Crohn's disease.
[8] Q: Did he have early Crohn's disease?
[9] A: I can't tell you. I've not been involved
[10] in his care. But the pathology of that lesion is
[11] very suggestive, and Crohn's disease can affect
[12] segments of the bowel without affecting other
[13] parts. So it is certainly compatible with what was
[14] seen.
[15] Q: Do you know what the pathology of the
[16] lesion in the cecum was?
[17] A: Well, I searched for that in the pathology
[18] report; and it was really not made clear what that
[19] was.
[20] Q: So we don't know if it was adenomatous or
[21] if it was inflammatory?
[22] A: We know that it was not. There was a
[23] statement in the pathology report that I think says
[24] there is no adenomatous tissue in the resected

Page 108

[1] colon.

[2] **Q:** But we don't know – you looking through
[3] the pathology report couldn't figure out what the
[4] pathology was for that lesion itself?

[5] **A:** Well, remember, this was described as a six
[6] millimeter sessile polyp in the cecum, Polyp No. 6.
[7] And if the pathologist says there's no adenomatous
[8] tissue, then I have to assume that it's something
[9] else. It either means that it's hyperplastic, it's

[10] normal, or it's inflammatory.

[11] **Q:** Do you know Dr. Thomas Gouge? —

[12] **A:** I do not.

[13] **Q:** Do you know of him?

[14] **A:** No.

[15] **Q:** If I told you that he was the director of
[16] the residency program for surgery at the NYU Medical
[17] Center, would you suspect that he's a competent
[18] surgeon?

[19] **A:** I would suspect that, yes.

[20] **Q:** NYU is a competent and credible facility?

[21] **DR. GOTTESMAN:** Better than competent.

[22] **A:** Yes.

[23] **DR. GOTTESMAN:** It's my alma mater.

[24] **Q:** In regard to whether a physician – a

Page 109

[1] surgeon was within the standard of care in offering
[2] a surgical option to this patient, once the
[3] pathology results had come back, would you defer to
[4] someone like Dr. Gouge for that opinion?

[5] **A:** I don't know Dr. Gouge, but I would
[6] certainly respect his opinion and read it and
[7] discuss it with him.

[8] **Q:** I mean would – if his opinion differed
[9] from yours under the same set of circumstances,
[10] would you defer your opinion to his?

[11] **MR. HIRSHMAN:** On the issue of the

[12] indications for proceeding with –

[13] **MR. CASEY:** On this indication.

[14] **MR. HIRSHMAN:** – procedure as opposed to
[15] another?

[16] **MR. CASEY:** No. Let me explain.

[17] **Q:** My understanding of what Dr. Gouge has
[18] testified to –

[19] **MR. HIRSHMAN:** He doesn't know what
[20] Dr. Gouge has testified to.

[21] **Q:** Well, I'm going to give it to you right
[22] now.

[23] My understanding of what Dr. Gouge has
[24] testified to – and I may be wrong when the

Page 110

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

Page 111

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
[22] 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.

Page 112

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

Page 114

[1] you reciting the deposition of Dr. Gouge, or do you
[2] want to ask this gentleman a question?
[3] MR. CASEY: I want him to hear all of the
[4] testimony in this case.
[5] MR. HIRSHMAN: It doesn't matter what the
[6] testimony is. You're asking him for his testimony.
[7] Ask him a question about his opinions.
[8] MR. CASEY: Toby, I'll take my deposition.
[9] You take your deposition.
[10] MR. HIRSHMAN: It's ridiculous.
[11] MR. CASEY: And we'll go from there.
[12] MR. HIRSHMAN: I think you're asking a
[13] ridiculous question, as well as an inaccurate
[14] question.
[15] MR. CASEY: This physician has a right to
[16] understand all of the testimony in this case. That
[17] testimony includes the testimony of Dr. Gouge.
[18] MR. HIRSHMAN: All right. Tell him what
[19] the testimony is if you have such a specific and
[20] accurate recollection of it.
[21] MR. CASEY: I have my notes right here.
[22] I've gone through them for the last hour.
[23] THE WITNESS: I have not seen this
[24] testimony.

Page 113

[1] Dr. Gouge.
[2] A: I don't think that's a fair question. If
[3] you don't give all the options, how can you expect
[4] me to give you a fair answer?
[5] Q: My question to you is: Is surgery one of
[6] the options that can be given to the patient among
[7] all of the other ones that you're talking about?
[8] A: Obviously, I understand what you're asking
[9] me. But you're not - if it's hypothetical, then I
[10] think we should cover all of the options; and,
[11] clearly, you're not doing that in your questions -
[12] MR. HIRSHMAN: Nor did you in your
[13] questions to Dr. Gouge.
[14] A: - so that I think that's an unfair
[15] question. And I must make that clear.
[16] Then, yes, there might be a surgical option
[17] for removing a suspicious polyp that there is
[18] concern about. A local resection might be one of
[19] the many options. But that's not the situation that
[20] existed. So that's not strictly relevant to this
[21] case.
[22] Q: The other opinion that Dr. Gouge gave last
[23] week -
[24] MR. HIRSHMAN: What are we doing here? Are

Page 115

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

<p style="text-align: right;">Page 116</p> <p>[1] within the standard of care for Father Walick?</p> <p>[2] A: But that's not a realistic question. I'm</p> <p>[3] sorry. It's like saying you have five ways you can</p> <p>[4] turn, but you can only take these two. That's not</p> <p>[5] fair. That's not a realistic hypothetical</p> <p>[6] situation.</p> <p>[7] I would not face my patient and say,</p> <p>[8] "Look. You've only got these options. I'm not</p> <p>[9] going to tell you about the others."</p> <p>[10] Q: I'm not asking you to assume that those</p> <p>[11] were all of the options that were available -</p> <p>[12] A: Then I can't answer that question.</p> <p>[13] Q: My question is: Would those options -</p> <p>[14] subtotal colectomy, right hemicolectomy or segmental</p> <p>[15] colectomy - be within the options that would be</p> <p>[16] available to a surgeon for use on Father Walick on</p> <p>[17] November 7 after he had the pathology report?</p> <p>[18] A: And for what condition are those options</p> <p>[19] the treatment?</p> <p>[20] Q: For Father Walick's condition.</p> <p>[21] A: What is the disease that you are treating?</p> <p>[22] You tell me, and then I'll answer your question.</p> <p>[23] Q: Father Walick's condition as he was found</p> <p>[24] on November 7, 1984, including all of the polyps</p>	<p style="text-align: right;">Page 118</p> <p>[1] that's what he says?</p> <p>[2] A: Then I disagree.</p> <p>[3] MR. HIRSHMAN: You just can't restrain</p> <p>[4] yourself from bringing Dr. Gouge into it. You just</p> <p>[5] can't restrain yourself.</p> <p>[6] A: You changed your question about three</p> <p>[7] times. I thought I was going to be able to agree</p> <p>[8] with you because you included a lesser procedure</p> <p>[9] which might be one of the many options. But if you</p> <p>[10] make the only option a subtotal colectomy, then, no.</p> <p>[11] Q: For purposes of my questions, just so that</p> <p>[12] you and I are communicating, I am not asking you to</p> <p>[13] assume that the subtotal colectomy was the only</p> <p>[14] option given. What I'm asking you to opine on is</p> <p>[15] whether giving that option among all of the other</p> <p>[16] options was within the standard of care.</p> <p>[17] A: No, I disagree with that based on what was</p> <p>[18] known.</p> <p>[19] Q: Can you and I agree that Father Walick's</p> <p>[20] wound infection, his ileus, and his subsequent</p> <p>[21] development of a hernia were postoperative</p> <p>[22] complications?</p> <p>[23] A: We can agree on that.</p> <p>[24] Q: There was no deviation from the standard of</p>
<p style="text-align: right;">Page 117</p> <p>[1] that had been removed, the adenomatous nature of the</p> <p>[2] two polyps, the fact that there was still a polyp in</p> <p>[3] there that couldn't be taken out, the biopsy had</p> <p>[4] come back and said it was inflammatory, and we still</p> <p>[5] didn't know what the biopsy of the cecum would</p> <p>[6] say -</p> <p>[7] A: Then I disagree.</p> <p>[8] Q: - under those circumstances, would it be</p> <p>[9] appropriate to offer Father Walick among the various</p> <p>[10] options the ability to go to surgery and to have a</p> <p>[11] subtotal colectomy?</p> <p>[12] A: Well, you started to change your question.</p> <p>[13] You said, "Among the various options."</p> <p>[14] Q: And that's what I'm asking. Among those</p> <p>[15] various options -</p> <p>[16] A: That's not what you asked me just now.</p> <p>[17] Q: That's what I'm - it's my fault, then,</p> <p>[18] because I'm not asking good questions.</p> <p>[19] Among the various options that could be</p> <p>[20] given to Father Walick and be within the standard of</p> <p>[21] care, would those options include an operation that</p> <p>[22] would be a subtotal colectomy?</p> <p>[23] A: No.</p> <p>[24] Q: Okay. Then you disagree with Dr. Gouge if</p>	<p style="text-align: right;">Page 119</p> <p>[1] care in the causation of those items themselves if</p> <p>[2] the jury believes that the first surgery was</p> <p>[3] warranted?</p> <p>[4] A: That's true. If the first surgery was</p> <p>[5] warranted, then the others were a direct</p> <p>[6] consequence, yes.</p> <p>[7] Q: Can you and I agree that all of Father</p> <p>[8] Walick's complications from 1984 until now are</p> <p>[9] complications and not deviations from accepted</p> <p>[10] medical standards if the jury believes the first</p> <p>[11] surgery was warranted?</p> <p>[12] A: I can't comment on all of the treatments</p> <p>[13] that he's had subsequently; but I can agree with you</p> <p>[14] that they are consequences of his first operation,</p> <p>[15] yes.</p> <p>[16] Q: And if the jury believes that the first</p> <p>[17] surgery was warranted, you would not be of the</p> <p>[18] opinion that any of those subsequent injuries or</p> <p>[19] subsequent damages that he suffered were caused by a</p> <p>[20] deviation from any doctorate from acceptable medical</p> <p>[21] standards?</p> <p>[22] A: Well, there's one issue that perhaps I'm</p> <p>[23] not qualified to give expert testimony on, and</p> <p>[24] that's the use of the mesh in the repair of his</p>

Page 120	Page 122
<p>[1] incisional hernia, which I know there might be some [2] controversy about. [3] Q: So in that respect, you do not feel [4] qualified to render an opinion? [5] A: Not about that. But I agree with you that [6] they are all consequences of his original surgery. [7] Q: How about the 1995 surgeries for the small [8] bowel obstruction? Do you feel qualified to render [9] opinions as to the adequacy of those surgeries by [10] that surgeon? [11] A: Can you give me a name. [12] Q: Dr. Borison at Lake Hospital. [13] A: I believe that was appropriately based on [14] what information I was given. [15] Q: Did you understand that Dr. Borison took [16] the patient back to surgery within thirteen days of [17] the first surgery for the small bowel obstruction? [18] A: I was aware of that. [19] Q: So you do not have any criticisms as to the [20] timing of that surgery? [21] A: There are a number of different ways that [22] small bowel obstruction can be treated. Some [23] conservative, some surgical. [24] In the very complex situation that Father</p>	<p>[1] A: I don't think I was aware of that. [2] Q: Assuming that he did develop the fistula [3] after this second surgery in 1995, can you and I [4] agree that in all probability, had that surgery not [5] occurred, Father Walick probably would not have [6] developed that fistula? [7] A: I can't answer that. [8] Q: Because you don't have the information? [9] A: I can't tell you that it would not have [10] developed. [11] Q: You will not be rendering any opinions at [12] trial as to the causation of that fistula; is that [13] fair? [14] A: That's fair. [15] Q: How about the cholecystectomy? Do you [16] believe that the cholecystectomy was proximately [17] related to the surgery which was performed in 1984? [18] A: It's certainly possible because we know [19] that resection of the ileum increases your chances [20] of developing gallstones. [21] Q: As to the trial, do you have an opinion [22] which you base to a reasonable degree of medical [23] probability whether the cholecystectomy is related [24] to the surgery which was performed in 1984? What</p>
<p data-cs="2" data-kind="parent">Page 121</p> <p data-kind="ghost"></p> <p>[1] Walick was in at that time - and it's hard for me [2] to know how ill he was - but on the basis that he [3] was pretty ill so soon after an operation, I believe [4] that some surgeons would have treated that [5] conservatively in the hope that it would resolve and [6] avoid another operation. [7] Q: Can you and I agree that in retrospect, [8] that would have been a better way to manage that [9] problem? [10] A: It's possible. [11] Q: Can you and I agree that but for the second [12] surgery in 1995 to repair the small bowel [13] obstruction, Father Walick never would have [14] developed a fistula? [15] A: I'm not aware of a fistula. [16] Q: So you were not aware that Father Walick [17] had developed a fistula post the second 1995 [18] surgery? [19] A: Can you define what type of fistula it is. [20] I'm not aware of it. [21] Q: I don't have the records here in front of [22] me. [23] A: My records stop in 1995. [24] Q: I believe it was an enterocutaneous.</p>	<p>[7] Q: You still could have biliary tract disease [8] that required the removal of the gallbladder? [9] A: That's true. [10] Q: But in Father Walick's case, we know that [11] he had it removed because he had gallstones; is that [12] fair? [13] A: That's correct. [14] Q: So do you have an opinion which you base to [15] a reasonable degree of medical probability - that [16] is, 51 percent - that if Father Walick had not had [17] surgery in 1984, he would not have subsequently [18] developed those gallstones and would not have [19] subsequently needed that cholecystectomy? [20] A: No, I cannot prove that. [21] Q: You agree with me that pancreatitis and [22] small bowel obstruction are known complications of [23] cholecystectomy? [24] A: That's correct. Well, complication of</p>

<p style="text-align: right;">Page 124</p> <p>[1] gallstones and cholecystectomy. You have to [2] distinguish the two. [3] Q: Will you be rendering an opinion in this [4] case as to whether Father Walick's subsequent [5] pancreatitis after cholecystectomy is proximately [6] related to the surgery which occurred in 1984? [7] A: I cannot prove that, either. [8] Q: And the same question as to the small bowel [9] obstruction. [10] A: I would have to review the operative [11] details of the two laparotomies as to the cause of [12] the small bowel obstruction, which I assume was [13] adhesions and their site. But my recollection is [14] that they are almost certainly related to the [15] primary operation. [16] Q: So it is your opinion that the small bowel [17] obstruction which occurred in 1995 would not have [18] occurred but for the operation which took place in [19] 1984? [20] A: Correct. [21] MR. VOUDOURIS: Which one in '84? Which [22] surgery in '84? [23] MR. CASEY: Well, there was only one [24] surgery in '84.</p>	<p style="text-align: right;">Page 126</p> <p>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. 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?</p>
<p style="text-align: right;">Page 125</p> <p>[1] Q: There was a second surgery in '87; correct? [2] A: Yes. [3] Q: What is your understanding of Father [4] Walick's limitations as a result of the damages that [5] he has suffered resultant to the 1984 surgery? [6] A: As of today, you mean? [7] Q: Yes. [8] MR. VOUDOURIS: Objection. But go ahead. [9] A: I'm not sure I've been made aware of what [10] you're asking. [11] Q: What are his limitations? [12] A: And where is that stated? [13] Q: That's what I want to know from you is when [14] you come into trial and you're asked, "Doctor, what [15] injuries and damages or limitations does Father [16] Walick now have as a result of the surgery which [17] took place in 1984," what will your answer be? [18] A. Well, I've never met Father Walick; and, of [19] course, his medical records stop in 1995. Up until [20] that time, many symptoms are documented, principally [21] diarrhea and the consequences of urgency in diarrhea [22] that he seems to have suffered ever since 1984. [23] I've never interviewed him personally so I [24] can't answer that question directly. I did read his</p>	<p style="text-align: right;">Page 127</p> <p>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.</p>

<p style="text-align: right;">Page 128</p> <p>[1] Q: Do you have an opinion as to whether or not [2] Father Walick would have developed this type of [3] diarrhea regardless of whether he would have had [4] surgery in 1984? [5] A: I think it's extremely unlikely as I don't [6] have all of the investigations that were done for [7] the diarrhea subsequent to his surgery. But based [8] on what I know, I think it's extremely likely that [9] it's a direct consequence of his original operation. [10] MR. HIRSHMAN: You think that it's highly [11] unlikely? That it is or is not? [12] THE WITNESS: That it is. [13] Q: Do you have any information in this case as [14] to the disabling nature of that diarrhea on Father [15] Walick? [16] A: Directly, no, because I have not [17] interviewed him. But even in the medical record as [18] far as I can recall, many times it's documented that [19] he's been severely incapacitated by it. And I know [20] from experience of patients having twelve or [21] thirteen loose bowel movements a day, particularly [22] with little control, that that's a severely [23] incapacitating problem. [24] Q: Do you have any idea whether or not his</p>	<p style="text-align: right;">Page 130</p> <p>[1] at an increased risk for developing adenomatous [2] polyps in the future? [3] A: Increased above what? [4] Q: The general population. [5] A: Yes, but at decreased risk of cancer. [6] Q: Because those adenomatous polyps had been [7] removed and could not cause him cancer? [8] A: Correct. [9] Q: We know that cancer can develop [10] spontaneously in the colon; is that fair? It [11] doesn't have to come through a polyp? [12] A: It's controversial. It's thought to be [13] possible. It's probably very rare. [14] Q: You have told me that offering Father [15] Walick a subtotal colectomy after the results of the [16] pathology came back was outside of the standard of [17] care. My question now is: Would offering Father [18] Walick a right hemicolectomy under those [19] circumstances be outside the standard of care? [20] A: For what condition? [21] Q: For the condition that Father Walick had on [22] November 7 as diagnosed by pathology. [23] A: Yes. At that stage, I think that was [24] inappropriate, also.</p>
<p style="text-align: right;">Page 129</p> <p>[1] career or his chosen profession has been hindered in [2] any way because of this limitation? [3] A: I'm not directly aware of what effect that [4] has had. [5] Q: Do you have any opinion as to whether or [6] not his life expectancy has been affected by this [7] condition? [8] A: That's very hard to answer. Clearly, he [9] has been through a great deal in the last thirteen [10] years. He has already developed some complications [11] of his original surgery. Whether he will develop [12] further complications, I cannot predict. But all of [13] those can have an effect on life expectancy. [14] Q: You were asked earlier about if a person [15] has one polyp, what's the likelihood they're going [16] to have a second adenomatous polyp. What I want to [17] know is if a person - Father Walick in this case we [18] know had two adenomatous polyps in his colon; [19] correct? [20] A: Correct. [21] Q: One was nine millimeters, almost one [22] centimeter, and the other was I think six [23] millimeters or five millimeters, something like [24] that. With those polyps removed, was Father Walick</p>	<p style="text-align: right;">Page 131</p> <p>[1] Q: Inappropriate? [2] A: Yes. [3] Q: Can you and I agree that if a right [4] hemicolectomy had been done in this case - and I [5] understand that you think it would have been [6] inappropriate to recommend or to give that as an [7] option - but if that had been done in this case, [8] can you and I agree that the consequences for Father [9] Walick most likely would have been the same? [10] MR. HIRSHMAN: As a subtotal? [11] MR. CASEY: As a subtotal. [12] A: Can you specify - [13] Q: The complications that he has suffered, [14] being the diarrhea, the wound infection, the [15] subsequent hernia, incisional hernia, those probably [16] all would have been the same if he had been given a [17] right hemicolectomy? [18] A: I can't answer that. [19] Q: The incision would have been the same; [20] correct? [21] A: The incision would be similar. It may not [22] be exactly the same; but, yes, they would - it [23] would be almost the same. [24] Q: So do you have an opinion in all</p>

Page 132

[1] probability whether his course would have been the
[2] same or not?
[3] **MR. HIRSHMAN:** As to the incisional
[4] injuries or –
[5] **A:** As to everything?
[6] **Q:** As to his subsequent course of conduct,
[7] that being his wound infection, his incisional
[8] hernia, the subsequent repair, and the diarrhea
[9] which he suffered.
[10] **A:** No. I think it would have been different.
[11] **Q:** Upon what do you base your opinion that his
[12] course would have been different if he had been
[13] given a right hemicolectomy as opposed to a subtotal
[14] colectomy?
[15] **A:** Because they're very different operations.
[16] If you look at the surgical literature, you'll find
[17] that the complication rates are very different. The
[18] leakage rate of the anastomosis is different. The
[19] wound infection rate is different. The incidence of
[20] diarrhea is different.
[21] **Q:** Well, in Father Walick – with all due
[22] respect, Doctor – he had either a 100 percent
[23] chance of developing wound infection or a zero
[24] percent chance; is that fair?

Page 133

[1] **A:** No, it's not fair.
[2] **Q:** In that individual patient, that's not a
[3] fair statement?
[4] **A:** You mean –
[5] **Q:** Either he does or he doesn't.
[6] **MR. HIRSHMAN:** Well, it's after the fact
[7] not before the fact.
[8] **MR. CASEY:** I understand.
[9] **Q:** But we know that he did develop a wound
[10] infection after the surgery.
[11] **A:** He developed – a wound infection is a
[12] spectrum of problems.
[13] **Q:** And he developed that in all probability
[14] because of the nature of his abdomen; is that fair?
[15] **A:** That is one element in the causation of
[16] wound infections, yes.
[17] **Q:** As to his diarrhea, if he had undergone a
[18] right hemicolectomy as opposed to a subtotal
[19] colectomy, could we expect the results experienced
[20] by Father Walick to have been relatively the same?
[21] **A:** No. We would have expected them to be very
[22] different.
[23] **Q:** And less?
[24] **A:** Less or no diarrhea.

Page 134

[1] **Q:** So the fact that the ileocecal valve would
[2] be removed in a right hemicolectomy would have no
[3] effect on the subsequent diarrhea in this patient?
[4] **A:** I didn't say it would have no effect, I
[5] said the ultimate outcome might be different. There
[6] are many patients who have right hemicolectomies for
[7] cancer who do not have diarrhea thirteen years
[8] later.
[9] **Q:** In fairness, Father Walick was either going
[10] to develop diarrhea or not develop diarrhea after
[11] this surgery; is that true?
[12] **MR. HIRSHMAN:** Which surgery?
[13] **MR. CASEY:** Whatever surgery he underwent
[14] on November 7 –
[15] **MR. HIRSHMAN:** Objection.
[16] **MR. CASEY:** – be it a right hemicolectomy
[17] or a subtotal colectomy.
[18] **A:** Yes, I suppose. It's an odd question; but,
[19] yes.
[20] **Q:** And whether he underwent a subtotal
[21] colectomy or a right hemicolectomy, he was still at
[22] risk for developing diarrhea?
[23] **A:** Yes, hypothetically; but not if he had no
[24] surgery.

Page 135

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

<p style="text-align: right;">Page 136</p> <p>[1] A: I think by now you should have gathered [2] that I did not think the surgery was appropriate at [3] all. [4] Q: I understand that. But what facts or what [5] options – what informed consent needed to be given [6] to Father Walick in order to take him to that [7] surgery? [8] MR. HIRSHMAN: I think he's telling you [9] that he doesn't think he should have been taken, [10] period. [11] THE WITNESS: No. [12] Q: So the father's wishes or his desires [13] regarding whether he wanted to have this surgery [14] would play no effect in the doctor's decision? He [15] should not have offered surgery; is that your [16] opinion? [17] A: That's correct. [18] Q: So the fact that the father may have said, [19] "I don't want to go through a repeat colonoscopy. [20] I want to have surgery. I want to get this thing [21] out of me," should have played no effect and been [22] given no consideration by Dr. Eisenstat? [23] MR. HIRSHMAN: That is a hypothetical I [24] take it?</p>	<p style="text-align: right;">Page 138</p> <p>[1] came back and said it wasn't; that an option to him [2] was given for a repeat biopsy; and that the father [3] advised the physician that he did not want to have a [4] repeat biopsy; that he did not want to have repeat [5] colonoscopies; and that he wanted to have surgery; [6] he wanted to get this lesion out of him. [7] Is it your testimony that such a wish by [8] the patient would be given no weight by the [9] physician in deciding whether to offer an option of [10] surgery? [11] A: Under the circumstance you just described, [12] of course it would not be given weight; but I would [13] not follow it. I would not take the patient's [14] advice for his own operation, no, under that [15] circumstance. [16] Q: Surveillance colonoscopies have risks; is [17] that fair? [18] A: That's fair. [19] Q: What are those risks? [20] A: Surveillance for polyps or for colitis [21] or – [22] Q: How often should repeat colonoscopies have [23] been done on Father Walick in 1984? [24] MR. VOUDOURIS: Assuming?</p>
<p style="text-align: right;">Page 137</p> <p>[1] MR. CASEY: I understand. [2] MR. HIRSHMAN: Well, where are you getting [3] those facts from? Is that from some deposition [4] somewhere? Put it as a hypothetical. That's what [5] it is. [6] Q: If that happened, Doctor, if the father had [7] been given the information and he spoke to the [8] doctor and said, "I do not want to undergo repeat [9] colonoscopies. I don't like these procedures. I [10] want to get this thing out of me, and I want to have [11] surgery," you're telling me that the doctor should [12] not have considered that under those circumstances [13] and never should have offered the option of surgery? [14] A: We're now talking about a totally different [15] situation as to what this thing in me is. [16] But you're suggesting to me that a patient [17] has been told that there is something in the colon [18] that has to be removed. Now, of course, if you tell [19] somebody that, they're going to elect to have it [20] removed. [21] Q: I'm suggesting to you that he had been told [22] that the pathologic diagnosis had come back as [23] inflammatory; that the doctors had seen it, thought [24] it was villous, a villus adenoma; that the pathology</p>	<p style="text-align: right;">Page 139</p> <p>[1] MR. CASEY: Assuming the situation as it [2] was found on November 7 and he didn't go to [3] surgery. [4] A: I'll have to start again. [5] Q: Let me start the question again. [6] A: No. I understand your question, but what I [7] need to convey is that this patient has two [8] conditions. Let's make it hypothetical if you [9] wish. [10] He has two polyps, two relatively small [11] polyps, which Dr. Gottesman successfully removed [12] completely. And, as I just mentioned, that reduces [13] his risk of cancer like any other patient with [14] colonic polyps that we treat daily and have been [15] doing so for a long time. [16] In addition, another lesion was detected [17] which initially was concerned and was thought to be [18] neoplastic, subsequently found to be not so. The [19] next step should be the clarification of that [20] lesion. [21] Now, the options for treatment will be [22] based on what that lesion represents. If it's [23] Crohn's disease, the treatment might be purely [24] medical. It might never involve surgery. That</p>

<p style="text-align: right;">Page 140</p> <p>[1] lesion may not require repeated colonoscopies over a [2] long period of time, may not require surveillance. [3] If you're asking about surveillance [4] colonoscopies for polyps, at that time, in 1984, it [5] was being offered on an annual basis. Today, we do [6] it differently because we have further information. [7] Q: Would the size of the polyp at the hepatic [8] flexure of two and a half centimeters have [9] influenced that decision on whether to have repeat [10] colonoscopies? [11] A: For diagnosis, yes, of course. I already [12] mentioned that. [13] Q: So the size alone - [14] A. But not surveillance. That's a different [15] question. [16] Q: Well, that's what I'm asking. Would the [17] size alone have required surveillance? [18] A. That's a different issue here. The term [19] "surveillance" is used for something quite [20] different, [21] Q: Would it have required repeat colonoscopies [22] to check its size and to continue to biopsy it? [23] A: Well, you don't need to continue to biopsy [24] it. You need to make an accurate diagnosis, which</p>	<p style="text-align: right;">Page 142</p> <p>[1] and what would have happened? [2] A: Well, at - I can give you a spectrum of [3] answers because you're asking me to guess. [4] Q: Well, I want to know your opinion to a [5] reasonable degree of medical certainty because [6] that's the question that you'll be asked at trial. [7] A: All right. Then at the best end of the [8] spectrum, he would have been healthy. He would have [9] had clarification of the inflammatory polyp and [10] perhaps medical treatment for it. He would have had [11] biopsies taken from the remainder of his colon not [12] affected by polyps, which was not done. And he [13] would have had at that time an annual colonoscopy [14] for the follow-up of his polyps. [15] Subsequently, the data has shown that [16] annual visits are not required. We do it every [17] three years. So that would have changed. [18] Q: It would have changed when? [19] A: When the data became available, which is [20] about five years ago. [21] Q: So in 1992, he would have then changed to [22] every three years? [23] A: Yes. [24] Q: So from 1984 until 1992, Father Walick</p>
<p style="text-align: right;">Page 141</p> <p>[1] I've already gone into that. Once you know what it [2] is, it does not require any further endoscopic [3] treatment or biopsy. You don't keep doing it for [4] that reason. So this lesion might have healed on [5] medical treatment. [6] Q: Medical treatment being what? [7] A: Let's assume if it was Crohn's disease, [8] maybe steroids would have been appropriate. I don't [9] know because that diagnosis was never made. [10] Q: Well, the diagnosis that was made was that [11] it was an inflammatory polyp; correct? [12] A: Correct, but it had certain features that [13] were a little bit different from other inflammatory [14] polyps. It had a granuloma. It had crypt [15] abscessus, features of inflammatory bowel disease. [16] Q: We didn't know that on the superficial [17] biopsy, did we? [18] A: We knew about crypt abscessus, yes. It was [19] mentioned in the biopsy report. Granuloma was [20] mentioned in the resection. [21] Q: So if Father Walick never goes to surgery [22] in 1984, my question to you is: In your opinion, [23] what would have been his course? What would have [24] happened to Father Walick? Where would he be today,</p>	<p style="text-align: right;">Page 143</p> <p>[1] would have undergone eight - [2] A: Yes, like thousands - [3] Q: - eight colonoscopies? [4] A: - and thousands of other patients, which [5] was standard practice. [6] Q: And then he would have had one in '92 and [7] one in '95 and again one in '98? [8] A: Possibly. [9] Q: By the time this case comes to trial, [10] Father Walick would have undergone eleven [11] colonoscopies? [12] A: Just as you would if you had polyps or I [13] would if I have polyps. That's no way different [14] from any other patient. [15] Q: And each of those colonoscopies would have [16] risks to those procedures; correct? [17] A: Yes, small. But, yes, there is always a [18] risk for any procedure. [19] Q: And what are those risks? [20] A: The principal risk of diagnostic [21] colonoscopy with or without biopsy is perforation. [22] That's the principal risk. And the risk that's [23] published is something like one in 10,000 [24] procedures.</p>

Page 144	Page 146
<p>[1] Q: And are there any other risks?</p> <p>[2] A: There are always potential risks of the</p> <p>[3] sedation, of the preparation. All of which are</p> <p>[4] extremely rare.</p> <p>[5] Q: Were there risks to Father Walick</p> <p>[6] subsequent to 1984 for the development of cancer,</p> <p>[7] colon cancer?</p> <p>[8] A: Subsequent to 1984?</p> <p>[9] Q: Yes. He never has the surgery, and he</p> <p>[10] continues to go on with his life. Is there anything</p> <p>[11] in his life or in his history that suggests to you</p> <p>[12] that he was at an increased risk for the development</p> <p>[13] of colon cancer?</p> <p>[14] A: His only risk was the finding of the two</p> <p>[15] adenomatous polyps. I don't know of any family</p> <p>[16] history. I don't know of any other conditions that</p> <p>[17] he or his family had that would increase his risk if</p> <p>[18] that's what you're asking.</p> <p>[19] Q: In 1985, were you aware that his father</p> <p>[20] underwent colon cancer surgery?</p> <p>[21] A: I was not aware of that.</p> <p>[22] Q: Assuming that that happened, can you and I</p> <p>[23] agree that Father Walick would have been at even a</p> <p>[24] higher risk for the development of colon cancer?</p>	<p>1] trial in this case?</p> <p>4 A: Yes.</p> <p>3] Q: There's nothing standing in the way of you</p> <p>4] coming in to testify live? Because I noticed a</p> <p>5] letter in your file that talked about a problem that</p> <p>6] you might have.</p> <p>7] A: Only about dates.</p> <p>8] Q: Okay.</p> <p>9] A: Depends when it is.</p> <p>0] Q: So if it's in January, your plan is to be</p> <p>1] there?</p> <p>2] A: Is that definite?</p> <p>3] MR. HIRSHMAN: No, it's not definite.</p> <p>4] Q: I mean if we go in January, there's nothing</p> <p>5] standing in your way?</p> <p>6] A: That depends on the date.</p> <p>7] MR. HIRSHMAN: Hold on a minute. There's</p> <p>8] someone in back of you.</p> <p>9] (Pause)</p> <p>0] Q: When you were asked about the chance of a</p> <p>1] second polyp and a third polyp regarding the</p> <p>2] colonoscopy which was performed in 1984, you used</p> <p>3] the word "synchronous." What does that mean?</p> <p>4] A: There are two types of lesion that we</p>
Page 145	Page 147
<p>[1] A: He does have an increased risk, but he's</p> <p>[2] already had his first colonoscopy the year before</p> <p>[3] that you just mentioned. And we do know that the</p> <p>[4] first colonoscopy is the most valuable one and, in</p> <p>[5] fact, reduces your cancer risk by the removal of</p> <p>[6] polyps which Dr. Gottesman had done successfully.</p> <p>[7] Q: Can you say in all probability that had</p> <p>[8] Father Walick undergone these repeat colonoscopies</p> <p>[9] as you suggest, given the fact that we know he</p> <p>[10] subsequently developed a family history and he had</p> <p>[11] two adenomatous polyps removed, that he would not</p> <p>[12] have developed cancer up until today?</p> <p>[13] A: Can I say that? No, of course I can't say</p> <p>[14] that. He might get a cancer of some other organ. I</p> <p>[15] can't say that, either. That's not a fair question.</p> <p>[16] (Pause)</p> <p>[17] THE REPORTER: When you come to a</p> <p>[18] convenient breaking point, could we take a very</p> <p>[19] short break, please?</p> <p>[20] MR. CASEY: We're at a convenient breaking</p> <p>[21] point.</p> <p>[22] (Recess taken)</p> <p>[23] BY MR. CASEY:</p> <p>[24] Q: Doctor, do you have plans to come to the</p>	<p>[1] describe both with respect to polyps and cancers</p> <p>[2] when they occur at the same time. In other words,</p> <p>[3] when you find one lesion when you do a procedure and</p> <p>[4] within a few days you find another lesion, we call</p> <p>[5] that synchronous.</p> <p>[6] When you find one lesion and then sometimes</p> <p>[7] weeks or months or sometimes years later you find</p> <p>[8] another one, we call that metachronous. In other</p> <p>[9] words, at another time.</p> <p>[10] Q: Metachronous?</p> <p>[11] A: Yes.</p> <p>[12] Q: In Father Walick's case, with the fact that</p> <p>[13] he had developed these two adenomatous polyps, do</p> <p>[14] you have an opinion which you base to a reasonable</p> <p>[15] degree of medical probability as to his chances for</p> <p>[16] metachronous development of adenomatous lesions?</p> <p>[17] A: I can't give you a percentage. We know</p> <p>[18] that patients who have adenomatous polyps are at</p> <p>[19] risk of developing polyps subsequently, and that's</p> <p>[20] why we keep them under surveillance. What the</p> <p>[21] recent data has shown us, as I suggested just now,</p> <p>[22] is that that risk is rather less than we used to</p> <p>[23] think and takes longer so that the interval between</p> <p>[24] colonoscopies can now be extended to longer</p>

<p style="text-align: right;">Page 148</p> <p>[1] intervals.</p> <p>[2] Q: So to tell a patient – specifically to</p> <p>[3] tell Father Walick in 1984 that because he has two</p> <p>[4] adenomatous polyps that have been removed, he is at</p> <p>[5] an increased risk for the development of further</p> <p>[6] polyps and potential cancer in future would not have</p> <p>[7] been a deviation from the standard of care?</p> <p>[8] A: No. That's correct.</p> <p>[9] Q: You were also asked about and you tried to</p> <p>[10] make a distinction in the colonoscopy report between</p> <p>[11] the way Dr. Gottesman had described the lesion at</p> <p>[12] the hepatic flexure as being multilobulated and</p> <p>[13] having satellite lesions and you somehow</p> <p>[14] distinguished that from a villus lesion. Is there a</p> <p>[15] distinction between those terms?</p> <p>[16] A: Yes. They're different descriptions.</p> <p>[17] Q: In what way? What do you perceive</p> <p>[18] Dr. Gottesman's words to have meant as he described</p> <p>[19] those lesions in his colonoscopy report?</p> <p>[20] MR. HIRSHMAN: Do you wish to look at the</p> <p>[21] report, again?</p> <p>[22] THE WITNESS: No, no.</p> <p>[23] A: Well, as I mentioned, a picture is worth a</p> <p>[24] thousand words; and it's such a shame that those two</p>	<p style="text-align: right;">Page 150</p> <p>[1] because it's also a pathological term. It's used in</p> <p>[2] two different contexts.</p> <p>[3] Q: Did you read in Dr. Gottesman's deposition</p> <p>[4] where in addition to how he described it in the</p> <p>[5] colonoscopy report, he believed the lesion to be</p> <p>[6] villus?</p> <p>[7] A: Yes. And that's different from saying it</p> <p>[8] looks villus. I think he's probably thinking in</p> <p>[9] pathological terms, and that increased the risk of</p> <p>[10] concern, of course. That was my interpretation of</p> <p>[11] what he said.</p> <p>[12] Q: The Lesion No. 2 that was removed from the</p> <p>[13] colon, the nine millimeter adenomatous polyp, was</p> <p>[14] described by the pathologist as having severe</p> <p>[15] architectural atypia. What is the significance of</p> <p>[16] that, if any?</p> <p>[17] A: I think we discussed this earlier this</p> <p>[18] afternoon, but No. 2 was five millimeters. Number 3</p> <p>[19] was nine.</p> <p>[20] Q: Okay.</p> <p>[21] A: But it doesn't really matter.</p> <p>[22] The presence of atypia implies a further</p> <p>[23] stage of neoplasia compared to when it's not</p> <p>[24] present. In other words, another stage towards</p>
<p style="text-align: right;">Page 149</p> <p>[1] photographs did not reproduce when they were</p> <p>[2] copied.</p> <p>[3] But I take Dr. Gottesman's description to</p> <p>[4] mean an area that is raised above the level of the</p> <p>[5] surrounding tissue, which makes it a polyp; and that</p> <p>[6] instead of being one continuous lump of tissue, it</p> <p>[7] has a number of different areas. In other words,</p> <p>[8] it's a lumpy appearance; and that's what</p> <p>[9] multilobulated means. That is the description</p> <p>[10] that's in his report.</p> <p>[11] Q: And when he says, "Satellite lesions"?</p> <p>[12] A: Satellite means there are separate lesions</p> <p>[13] apart from that main body of 2.5 centimeters that</p> <p>[14] are distinct from it and usually are a lot smaller,</p> <p>[15] and he does not say what size.</p> <p>[16] Q: And distinguish for me in your mind the</p> <p>[17] difference between that and villus.</p> <p>[18] A: Villus is a description that means</p> <p>[19] fingerlike. It's Latin for fingers. So that a</p> <p>[20] lesion that has protrusions that are thin and look</p> <p>[21] like – just like small fingers gives the</p> <p>[22] description villus. And sometimes we can see that</p> <p>[23] in colonoscopy if it's obvious enough, or the</p> <p>[24] pathologist tells us that it's a villus lesion</p>	<p style="text-align: right;">Page 151</p> <p>[1] malignancy.</p> <p>[2] Q: So in Father Walick at that time, he was</p> <p>[3] another stage towards malignancy on that lesion?</p> <p>[4] A: Yes, which was removed. And that's not an</p> <p>[5] uncommon finding.</p> <p>[6] Q: Would that increase – the fact that it had</p> <p>[7] gotten to that level, would that increase his risk</p> <p>[8] for subsequent development of adenomatous polyps?</p> <p>[9] A: No.</p> <p>[10] Q: So the fact that a particular lesion had</p> <p>[11] reached the point where it had severe dysplasia or</p> <p>[12] severe atypia or the fact that it had progressed to</p> <p>[13] the point where it is now a villus adenoma, those</p> <p>[14] things, if they are removed, do not increase the</p> <p>[15] risk of future adenomas in and of themselves if they</p> <p>[16] are removed; is that correct?</p> <p>[17] MR. HIRSHMAN: Are you trying to equate</p> <p>[18] villus adenomas with atypia?</p> <p>[19] MR. CASEY: No.</p> <p>[20] Q: These things have stages; correct? I take</p> <p>[21] it that a villus adenoma would be over and above an</p> <p>[22] adenoma with severe atypia?</p> <p>[23] A: No. We're talking about different things</p> <p>[24] here.</p>

Page 152

[1] I agree with your first statement or your
[2] first question that a tubular adenoma - let's
[3] distinguish the pathology.
[4] Adenomas come in basically two sources,
[5] tubular and villus; and sometimes they're mixed.
[6] We're always more concerned about villus
[7] because we know the malignance potential is greater
[8] size for size. But we know that *size* is probably
[9] the most important determinant, and that's why
[10] Dr. Gottesman was worried in the first place about
[11] that lesion in the hepatic flexure, because of its
[12] she.
[13] Tubular adenomas and villus adenomas have
[14] the potential of getting larger with time, and
[15] that's the progression towards cancer that we know
[16] exists in most patients. They do go through
[17] different stages, and sometimes we can detect that
[18] when we take out the polyp; and atypia or dysplasia
[19] is used to describe the grade of severity of that
[20] change. That's usually with respect to tubular
[21] adenomas.
[22] Villus adenomas are not quite so easy to
[23] characterize because the pathology is a little
[24] different. We often see dysplasia in villus

Page 153

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

Page 154

[1] for?
[2] A: I was not ~~until~~ I was informed during this
[3] afternoon because it was not documented.
[4] Q: So nowhere in the records do you have any
[5] opinion as to what the situation was between
[6] Dr. Eisenstat and Dr. Gottesman regarding whether he
[7] was to consult and advise, consult and co-manage, or
[8] consult and take over the care of the patient?
[9] A: No. As I just stated, that is not
[10] documented in the record.
[11] Q: Assuming a lack of documentation, would you
[12] by default go to one of the three?
[13] A: I'm sorry. Could you repeat that.
[14] Q: Assuming a lack of documentation in the
[15] file, would you by default go to one of the three?
[16] A: I can't. How can I guess what he was
[17] asking?
[18] Q: Okay. I mean I don't know if it's regular
[19] medical practice here that if you don't say one way
[20] or the other, you're to assume that you want
[21] co-management or you just want advice or the like.
[22] I mean is that your practice?
[23] A: No. I don't think one can make that
[24] assumption.

Page 155

[1] Q: Okay.
[2] A: Each situation is different.
[3] Q: Do you have any opinion as to whether or
[4] not Dr. Eisenstat had the pathology results before
[5] he took the patient to surgery?
[6] A: I have no way of knowing.
[7] Q: So if Dr. Eisenstat testifies at trial that
[8] he did have those results, you would not be in a
[9] position to disagree?
[10] A: Except that his deposition says that he
[11] can't remember.
[12] Q: I understand. But if he testifies that he
[13] did have those results at trial, would you be in a
[14] position to disagree?
[15] A: Well, how can I if that's what he states?
[16] Q: Okay. So you *will* not be coming in and
[17] telling the jury that based on X, Y, and Z, I don't
[18] think that he had those results?
[19] A: Well, you're asking me an impossible
[20] question.
[21] MR. HIRSHMAN: If you want to give him X,
[22] Y, and Z -
[23] A: If he says that's what he had, then that's
[24] what he had.

<p style="text-align: right;">Page 156</p> <p>[1] MR. GASEY: That's all I have.</p> <p>[2] MR. VOUDOURIS: Doctor, I just have a few</p> <p>[3] brief questions for you.</p> <p>[4] REDIRECT EXAMINATION</p> <p>[5] BY MR. VOUDOURIS:</p> <p>[6] Q: As I understand - and correct me if I'm</p> <p>[7] wrong - you have two criticisms of Dr. Gottesman in</p> <p>[8] this case. And the first is Dr. Gottesman - based</p> <p>[9] on the statement in his colonoscopy operative note</p> <p>[10] on November 6, it's your opinion that Dr. Gottesman</p> <p>[11] had already made up his mind that this patient</p> <p>[12] required surgery; correct?</p> <p>[13] A: That was my impression, yes.</p> <p>[14] Q: And that's the first criticism that you</p> <p>[15] have; correct?</p> <p>[16] A: No. It's not what we discussed earlier</p> <p>[17] today.</p> <p>[18] Q: What's your first criticism?</p> <p>[19] A: Remember I made two criticisms. One was</p> <p>[20] the accuracy of the diagnosis, and the other was the</p> <p>[21] continuation of care.</p> <p>[22] Q: Okay. What's accuracy of diagnosis again?</p> <p>[23] A: You want to go through this again?</p> <p>[24] Q: Yes, I do.</p>	<p style="text-align: right;">Page 158</p> <p>[1] the appearance may have been a concern, the true</p> <p>[2] diagnosis was that this was a benign inflammatory</p> <p>[3] lesion that did not require surgery.</p> <p>[4] Q: You only know that in retrospect; correct?</p> <p>[5] A: Well, we know it from the biopsies.</p> <p>[6] Q: Exactly. Which was retrospect; correct?</p> <p>[7] A: No. How can that be retrospect?</p> <p>[8] Q: The pathology that came from the biopsy.</p> <p>[9] A: Well, one usually waits for those. That's</p> <p>[10] why we do them.</p> <p>[11] Q: Exactly. But then I gave you the</p> <p>[12] hypothetical that Dr. Gottesman referred this</p> <p>[13] patient to Dr. Eisenstat, which you said was in</p> <p>[14] the - which was acceptable and reasonable -</p> <p>[15] A: For an opinion, yes.</p> <p>[16] Q: Right - and surgical consult, and that he</p> <p>[17] had a right to rely on - that Dr. Eisenstat would</p> <p>[18] check the pathology before he went ahead with</p> <p>[19] surgery; correct?</p> <p>[20] A: Yes. That's what you asked me previously,</p> <p>[21] and I agreed with that. I could also ask or could</p> <p>[22] pose the situation why ask for surgery at all at</p> <p>[23] that point? What's the hurry? Why go ahead at such</p> <p>[24] a short time frame? That I didn't understand.</p>
<p style="text-align: right;">Page 157</p> <p>[1] A: You will recall that the colonoscopy</p> <p>[2] revealed six lesions in different parts of the</p> <p>[3] colon, some of which were removed, some were</p> <p>[4] biopsied. The two polyps turned out to be adenomas</p> <p>[5] we've discussed many times. The lesion in the cecum</p> <p>[6] was not biopsied, and we don't know what that was.</p> <p>[7] One of the polyps turned out to be normal tissue.</p> <p>[8] Another polyp was hyperplastic.</p> <p>[9] The lesion of concern at the hepatic</p> <p>[10] flexure was interpreted by its appearance to be a</p> <p>[11] possible malignant or premalignant lesion. It was</p> <p>[12] described in the ways that we've discussed. It was</p> <p>[13] interpreted by the physicians concerned -</p> <p>[14] Dr. Gottesman and Dr. Eisenstat - as a possible</p> <p>[15] villus adenoma.</p> <p>[16] It was biopsied. The biopsy subsequently</p> <p>[17] showed this to be inflammatory, and it happens to be</p> <p>[18] confirmed by the resection specimen which also</p> <p>[19] showed it to be inflammatory with no adenomatous</p> <p>[20] tissue.</p> <p>[21] So the accuracy of diagnosis of that</p> <p>[22] lesion, which is the one lesion that really led to</p> <p>[23] all the decision making, is very critical to Father</p> <p>[24] Walick's care. And my criticism was that although</p>	<p style="text-align: right;">Page 159</p> <p>[1] Q: Well, Dr. Gottesman referred this patient</p> <p>[2] for Dr. Eisenstat to make that decision.</p> <p>[3] A: Okay. Well, you told me that's what</p> <p>[4] happened; and I have to accept that.</p> <p>[5] Q: That being the case, then I do not</p> <p>[6] understand your first criticism of how he deviated</p> <p>[7] from the standard of care in terms of accuracy of</p> <p>[8] diagnosis.</p> <p>[9] A: Well, did Dr. Gottesman - was he aware of</p> <p>[10] the result of the pathology before the patient had</p> <p>[11] surgery?</p> <p>[12] Q: Assume that Dr. Gottesman was not made</p> <p>[13] aware of - by Dr. Eisenstat or pathology - what</p> <p>[14] the results of the biopsies were.</p> <p>[15] A: But, you know, we take responsibility for</p> <p>[16] what we do. We can't say, 'Well, pathology didn't</p> <p>[17] tell me,' or 'The surgeon didn't tell me.'</p> <p>[18] If you generate tissue, you generate - you</p> <p>[19] ask people to get involved, you have to take some</p> <p>[20] responsibility for the consequences. You either</p> <p>[21] follow up something that you want the answer to, you</p> <p>[22] either ask your colleague what his decision was.</p> <p>[23] That I don't understand, either.</p> <p>[24] I mean we haven't discussed these issues,</p>

<p>Page 160</p> <p>[1] but – they’re not in the chart, but you’ve told me [2] that Dr. Eisenstat made all these decisions so I [3] have to accept them. But why didn’t Dr. Gottesman [4] know about them? [5] I presume these two physicians worked [6] together regularly in the same hospital, and I can’t [7] believe that that’s how they manage all their cases [8] together. [9] You know, if Dr. Gottesman is in this very [10] awkward position because of Dr. Eisenstat’s actions, [11] that’s unfortunate; but that’s what happened. [12] Q: Well, within less than a 24-hour period, if [13] Dr. Gottesman was never made aware of the pathology [14] report by either pathology or Dr. Eisenstat, and [15] unbeknownst to Dr. Gottesman, Dr. Eisenstat takes [16] this gentleman to surgery, then what is your [17] criticism of Dr. Gottesman in this case? [18] A: Well, but you’ve only revealed that to me [19] this afternoon. I did not know that from the [20] medical record; and, therefore, my criticisms were [21] based on what I was shown. [22] Q: Okay. [23] A: Now, I accept what you’re telling me is [24] me, although it’s not documented anywhere.</p>	<p>Page 162</p> <p>[1] Dr. Eisenstat – you already said that was [2] reasonable based on what he found visually from the [3] colonoscopy – [4] A: Yes. [5] Q: – that Dr. Gottesman was not made aware of [6] the pathology reports that evening, the biopsy, the [7] results of the biopsy; that he was not made aware of [8] them in the morning, the following morning; that [9] Dr. Eisenstat took this patient to surgery and did [10] not inform Dr. Gottesman that he was taking this [11] patient to surgery, do you still believe that [12] Dr. Gottesman deviated from the standard of care? [13] A: If what you tell me is true, then I have to [14] say no. I don’t think it’s very good judgment, and [15] I don’t think it’s very good clinical care; and [16] maybe that’s a hospital problem. [17] Q: But you don’t believe given the facts that [18] I asked you to assume that Dr. Gottesman deviated [19] from the standard of care? [20] A: That’s correct. I have to accept that. [21] MR. VOUDOURIS: Thank you. That’s all I [22] have. [23] MR. CASEY: Now I have to ask you another [24] question because of your last statement.</p>
<p>Page 161</p> <p>[1] Q: I want you to accept what I just told you [2] is true. If you accept those facts to be true, do [3] you have any criticisms in this case of [4] Dr. Gottesman? [5] A: I still have criticism that no follow-up [6] was made the same day for a patient who was in the [7] hospital. That’s not – it may not fall below the [8] standard of care because the patient was not [9] critically ill. Yet decisions were being taken, [10] albeit without his knowledge as you tell me. [11] But if I accept what you tell me, that it [12] was taken out of his hands for some reason, and [13] decisions were not made by Dr. Gottesman on any of [14] these accounts, then he’s presumably not responsible [15] for them. Although he’s still responsible for that [16] patient’s scare. That’s hard to reconcile with what [17] happened to him. [18] I would feel terrible if I was in that [19] situation and the patient has treatment that I know [20] nothing about, even though I may have initiated the [21] sequence of events. [22] Q: All right. Based on the facts that I want [23] you to assume earlier, that Dr. Gottesman, on that [24] afternoon of the 6th, had sought a referral with</p>	<p>Page 163</p> <p>[1] RECROSS EXAMINATION [2] BY MR. CASEY: [3] Q: If the factual scenario as Mr. Voudouris [4] has just given you does turn out to be true at [5] trial, do you have criticisms of the hospital itself [6] in the fact that you’ve never seen any of the [7] policies and procedures – you’ve never seen any of [8] that stuff – of the hospital itself for that [9] situation occurring? [10] A: Well, my criticisms – [11] Q: Wait. My caveat to it is that it’s not a [12] situation like you have here where you are employed [13] by the hospital. These are independent medical [14] practitioners who are given privileges to operate at [15] the hospital. [16] A: I’m not employed by the hospital, either. [17] Q: Okay. [18] A: My criticisms will almost entirely revolve [19] around communications because that’s what we’re [20] discussing, communication of – principally from [21] the surgeon to anyone else except the operating [22] room. [23] Q: And that doesn’t involve the hospital [24] personnel itself? That involves the two physicians</p>

<p style="text-align: right;">Page 164</p> <p>[1] in question; fair?</p> <p>[2] A: Well, it may involve more. I'd have to</p> <p>[3] give that some thought because certain arrangements</p> <p>[4] have to be made for a patient to go to the operating</p> <p>[5] room, a consent has to be obtained which was</p> <p>[6] obtained the previous day, on the same day that he</p> <p>[7] had a procedure involving sedation. So that has to</p> <p>[8] be questioned. Who obtained that consent? Who</p> <p>[9] explained the surgery to him? I don't think it was</p> <p>[10] Dr. Eisenstat.</p> <p>[11] So those are hospital issues. So it may be</p> <p>[12] more than just a communication between two</p> <p>[13] physicians. It may be hospital policies.</p> <p>[14] Q: Do you have any facts from which you will</p> <p>[15] render an opinion that any of the hospital personnel</p> <p>[16] deviated from acceptable standards of care in this</p> <p>[17] case? Have you seen anything or are you in a</p> <p>[18] position to render that opinion at this time?</p> <p>[19] A: No. Other than Dr. Eisenstat, no, I have</p> <p>[20] no evidence of that.</p> <p>[21] Q: Do you have an opinion that Dr. Eisenstat</p> <p>[22] was hospital personnel? Have you seen anything to</p> <p>[23] indicate that?</p> <p>[24] A: I have no idea who employs him or how his</p>	<p style="text-align: right;">Page 166</p> <p>[1] Q: And you probably sit on a lot of the</p> <p>[2] committees here?</p> <p>[3] A: I do.</p> <p>[4] Q: And you haven't heard of any of that</p> <p>[5] through your involvement in those committees?</p> <p>[6] A: That's correct.</p> <p>[7] MR. CASEY: Okay.</p> <p>[8] FURTHER REDIRECT EXAMINATION</p> <p>[9] BY MR. VOUDOURIS:</p> <p>[10] Q: Doctor, just a few housecleaning things.</p> <p>[11] Can you - we'll mark it as Exhibit 2 your</p> <p>[12] folder in this case. And if you could do me a</p> <p>[13] favor? Make a copy of everything in that folder. I</p> <p>[14] take it nothing has been removed; correct?</p> <p>[15] A: Correct.</p> <p>[16] Q: So we'll mark that as No. 2; and you can</p> <p>[17] just send a copy of that to Toby, and he'll pass it</p> <p>[18] along.</p> <p>[19] MR. HIRSHMAN: Yes.</p> <p>[20] Q: I also need an updated copy of your CV. If</p> <p>[21] you could also give that to Toby, and he'll pass it</p> <p>[22] along to us.</p> <p>[23] You said you keep a list of the cases that</p> <p>[24] you serve as a medical legal expert?</p>
<p style="text-align: right;">Page 165</p> <p>[1] contract is written. How would I know that?</p> <p>[2] Q: Now, if you review any subsequent materials</p> <p>[3] or if you come to any further opinions in this case</p> <p>[4] that you may be expressing at trial, will you please</p> <p>[5] let Mr. Hirshman know so that we can understand that</p> <p>[6] which you will be basing your opinion on and the</p> <p>[7] opinions that you have; is that fair?</p> <p>[8] A: Sure.</p> <p>[9] Q: And have you ever been involved in a case</p> <p>[10] or heard of a case here at your hospital where a</p> <p>[11] gastroenterologist has been accused of failing to</p> <p>[12] diagnose a cancer?</p> <p>[13] A: You mean in any organ?</p> <p>[14] Q: In the colon.</p> <p>[15] A: Have I been involved in such a case? No.</p> <p>[16] Q: Have you heard of those cases here at the</p> <p>[17] hospital?</p> <p>[18] A: Not while I've been here, no.</p> <p>[19] Q: So none of the gastroenterologists here</p> <p>[20] that you know of has ever been accused of failing to</p> <p>[21] catch something that was in the colon that turned</p> <p>[22] out to be a malignant neoplasm?</p> <p>[23] A: Not that I'm aware of, and I think that I</p> <p>[24] would be aware of that.</p>	<p style="text-align: right;">Page 167</p> <p>[1] A: I do not keep a list, no.</p> <p>[2] MR. HIRSHMAN: And if you want to go to the</p> <p>[3] court for that, you can.</p> <p>[4] A: I keep documents that I'm currently working</p> <p>[5] on, of course.</p> <p>[6] Q: The materials that you were sent?</p> <p>[7] A: Yes.</p> <p>[8] Q: Okay. You don't keep a list of the cases</p> <p>[9] that you've served as a medical legal expert?</p> <p>[10] A: I do not, no.</p> <p>[11] Q: I just want to make sure of one thing,</p> <p>[12] too. You're not going to be giving an opinion to</p> <p>[13] the reasonable degree of medical certainty as to</p> <p>[14] life expectancy of Mr. Walick at this trial, are</p> <p>[15] you?</p> <p>[16] A: I can't do that.</p> <p>[17] MR. VOUDOURIS: That's all I have.</p> <p>[18] MR. HIRSHMAN: It's up to you. Do you want</p> <p>[19] to read this three and a half hour deposition? It's</p> <p>[20] up to you. You have the right to read and file -</p> <p>[21] not to read and file.</p> <p>[22] You have the right to read this and make</p> <p>[23] corrections to it, or you can waive that right.</p> <p>[24] It's your decision.</p>

Page 168

[1] I don't know this gentleman so I can't tell
[2] you how reliable his transcript is so it's your
[3] decision.
[4] **THE WITNESS:** Would it be sent to me, or do
[5] I have to go -
[6] **MR. HIRSHMAN:** You'll make him a copy so he
[7] doesn't have to -
[8] **THE REPORTER:** May we go off the record so
[9] I can talk?
[10] **MR. HIRSHMAN:** Yes.
[11] (Discussion off the record)
[12] **MR. HIRSHMAN:** He's reading and signing.
[13] I'm going to get a copy. He'll use the copy to read
[14] and sign.
[15] (Folder marked as Carr-Locke
[16] Exhibit 2 for identification)
[17] (Whereupon the deposition was
[18] adjourned at 5:56 p.m.)
[19]
[20]
[21]
[22]
[23]
[24]

Page 169

[1] CERTIFICATE
[2] I, DAVID L. CARR-LOCKE, M.D., F.R.C.P., do
[3] hereby certify that I have read the foregoing
[4] transcript of my testimony, and further certify that
[5] said transcript (with/without) suggested corrections
[6] is a true and accurate record of said testimony.
[7] Dated at ___, this ___ day of ___,
[8] 19___.
[9]
[10]
[11]
[12] Sworn and subscribed to before me this ___ day
[13] of ___, 19___.
[14]
[15] Notary Public
[16] My commission expires:
[17]
[18]
[19]
[20]
[21]
[22]
[23]
[24]

Page 170

[1] COMMONWEALTH OF MASSACHUSETTS)
[2] SUFFOLK, SS.)
[3] I, William J. Ellis, Registered Professional
[4] Reporter and Notary Public in and for the
[5] Commonwealth of Massachusetts, do hereby certify
[6] that there came before me on the 9th day of Dec.,
[7] 1997, at 2:32 p.m., the person hereinbefore named,
[8] who was by me duly sworn to testify to the truth and
[9] nothing but the truth of his knowledge touching and
[10] concerning the matters in controversy in this cause;
[11] that he was thereupon examined upon his oath, and
[12] his examination reduced to typewriting under my
[13] direction; and that the deposition is a true record
[14] of the testimony given by the witness.
[15] I further certify that I am neither attorney or
[16] counsel for, nor related to or employed by, any
[17] attorney or counsel employed by the parties hereto
[18] or financially interested in the action.
[19] In witness whereof, I have hereunto set my hand
[20] and affixed my notarial seal this ___ day of
[21] December, 1997.
[22]
[23] Notary Public
[24] My commission expires: 1/17/03

Lawyer's Notes

\$	4	Absent 56:7 absolute 49:8 absolutely 46:17; 48:23; 93:20; 106:17 abstracts 11:15; 22:18 academic 15:10 accept 68:8; 69:12; 83:13; 101:20, 23; 159:4; 160:3, 23; 161:1, 2, 11; 162:20 acceptable 59:19; 99:15; 101:4; 119:20; 158:14; 164:16 accepted 30:20, 23; 32:17; 33:10, 14; 81:12; 82:22; 119:9 account 45:15 accounts 161:14 accuracy 93:17; 156:20, 22; 157:21; 159:7 accurate 31:9, 13; 32:2, 24; 33:21; 34:1; 36:14; 55:9; 64:5; 99:6, 8, 22; 100:23; 114:20; 140:24 accurately 57:15 accused 165:11, 20 act 16:21 action 80:1; 83:7 actions 79:19; 80:4; 160:10 Actually 29:2; 50:21; 88 21 add 80:24; 84:9 adding 21:13 addition 17:12; 139:16; 150:4 additional 17:9; 24:21; 50:18 additions 11:12 adds 18:20 adenoma 94:5, 6; 137:24; 151:13, 21, 22; 152:2; 157:15 adenomas 60:18; 151:15, 18; 152:4, 13, 13, 21, 22; 153:1, 8, 11; 157:4 adenomatous 53:22; 54:14; 55:3; 56:6, 15; 57:1, 22; 58:5, 12; 62:5, 19; 64:6; 68:13; 92:22; 93:12; 94:21, 23; 96:23, 24; 97:2, 2; 100:5, 8, 21; 105:3, 5, 9, 16; 107:20, 24; 108:7; 117:1; 129:16, 18; 130:1, 6; 144:15; 145:11; 147:13, 16, 18; 148:4; 150:13; 151:8; 157:19 adequacy 120:9 adequate 75:10; 103:7 adhesions 124:13 adjourned 168:18 administered 29:11 administrative 16:22 admission 83:11 admissions 24:7	admitted 83:4, 9 advance 21:3, 6 advanced 17:10 advice 54:11; 138:14; 154:21 advise 153:16; 154:7 advised 31:20; 138:3 advocate 76:12 affairs 82:3 affect 107:11 affected 129:6; 142:12 affecting 107:12 afternoon 81:6; 82:15; 83:24; 111:14; 150:18; 154:3; 160:19; 161:24 Again 18:15; 19:2, 6, 10; 33:5; 34:13; 35:19; 38:16; 49:1; 52:10; 53:15; 71:9; 75:8; 84:6, 14; 139:4, 5; 143:7; 148:21; 156:22, 23 against 9:5; 80:1 age 53:19, 21; 56:5, 13 agency 10:18 ago 4:13; 6:1; 20:24; 27:17; 43:3; 111:5; 142:20 agree 66:17; 67:17; 69:3, 9; 71:15, 16; 76:11; 89:24; 91:15; 93:7; 94:2; 96:16; 98:13; 101:17; 115:19, 23; 118:7, 19, 23; 119:7, 13; 120:5; 121:7, 11; 122:4; 123:21; 131:3, 8; 144:23; 152:1 agreed 158:21 ahead 15:12; 74:2, 6; 97:14; 101:15; 125:8; 158:18, 23 air 51:22 albeit 161:10 alleged 7:18 allow 21:10, 14; 135:10 allowed 7:10; 68:10 alma 108:23 almost 16:19; 89:8; 124:14; 129:21; 131:23; 163:18 alone 38:20; 54:5; 69:24; 140:13, 17 along 166:18, 22 already 38:11; 52:1; 53:1; 54:14; 66:3; 69:2, 16; 70:16; 71:9; 74:21; 75:5, 8; 76:10; 77:1; 81:9; 129:10; 140:11; 141:1; 145:2; 156:11; 162:1 alternative 12:19 although 9:4; 34:7; 48:5; 51:19; 54:7; 76:9; 157:24; 160:24; 161:15 always 5:13, 15; 21:17; 66:10; 79:9; 93:19; 143:17; 144:2; 152:6 ambiguous 102:10 America 28:17 among 113:6; 117:9, 13,	14, 19; 118:15 amount 18:17; 27:16; 28:4 anastomosis 126:9; 132:18 annual 140:5; 142:13, 16 answering 97:13 anxieties 52:4 anxiety 98:6 anxious 98:18 anybody 51:7; 79:3 anyone 26:11; 163:21 anyway 7:15 anywhere 8:24; 28:18; 32:9; 98:9; 160:24 apart 149:13 apparently 98:20 appearance 28:13; 34:20; 67:15; 68:8; 71:13; 149:8; 157:10; 158:1 appearances 28:8; 57:6; 61:24 appearing 56:7, 20; 61:2, 16 appointed 14:18 appointment 22:7 appreciate 84:10; 115:2 approach 94:2 appropriate 31:4, 6, 10; 34:15; 45:18; 49:6; 59:10; 64:7; 68:9; 69:6, 12; 70:8; 78:4; 89:17, 22; 93:24; 94:1; 104:5; 105:21; 110:18, 22; 117:9; 136:2; 141:8 appropriately 120:13 Approximately 6:1; 18:7; 20:2 architectural 61:21; 150:15 architecture 60:15 area 16:23; 149:4 areas 149:7 around 53:21; 82:15; 163:19 arranged 83:11 arrangements 81:20; 102:23; 164:3 ascending 61:10 aside 57:8 aspects 19:8; 89:19 assertion 92:2 associated 52:15 assume 5:3; 56:4; 65:20; 78:11; 81:4, 9, 10, 23; 83:8, 21; 92:11; 108:8; 116:10; 118:13; 124:12; 126:7; 135:11; 141:7; 154:20; 159:12; 161:23; 162:18 assuming 90:24; 92:18; 103:17; 104:10; 110:7; 115:11; 122:2; 126:22; 127:2; 138:24; 139:1; 144:22; 153:5; 154:11, 14
\$250 27:2, 4	4,000 88:20, 21 400 20:2, 3, 6 41 53:18; 56:5			
1	5			
1 11:2; 12:4; 24:11; 72:15 10,000 143:23 100 15:23; 132:22 11/6/84 61:9 11/7/84 37:6 1970s 20:15 1972 43:6; 89:1 1973 43:8 1974 89:8 1979 13:11 1980s 57:4; 88:10 1984 15:1, 4, 16; 20:6, 8, 13; 24:7; 30:21; 32:19, 22; 35:3; 43:12; 44:8; 50:24; 53:17; 55:12, 13; 63:5; 65:6; 85:10, 13; 86:6, 17, 19; 87:7, 23; 88:6, 15; 89:5; 91:4, 7; 92:9; 94:16; 95:11; 96:22; 111:10; 116:24; 119:8; 122:17, 24; 123:17; 124:6, 19; 125:5, 17, 22; 126:13; 128:4; 135:23; 138:23; 140:4; 141:22; 142:24; 144:6, 8; 146:22; 148:3 1985 144:19 1987 24:7 1989 13:5; 14:24; 86:13; 88:7 1990 24:7 1991 13:22 1992 142:21, 24 1995 24:9; 120:7; 121:12, 17, 23; 122:3; 124:17; 125:19 1996 23:3, 15; 27:1 1997 16:9; 24:19, 23; 67:8	5,000 88:20 50 94:18 51 123:16 5:56 168:18			
	6			
	6 35:3; 91:4; 97:1; 108:6; 156:10 6th 101:7, 10; 104:8; 106:12; 161:24			
	7			
	7 91:7, 12, 13, 16; 92:3, 9; 95:11; 96:22; 103:6; 112:9; 116:17, 24; 130:22; 134:14; 135:23; 139:2 70s 55:18 75 6:19 78 85:17 79 85:17 7th 91:10; 101:1, 6, 10; 102:1, 6, 8; 104:8; 106:14; 110:6			
	8			
	8,000 18:1 80 19:19 80s 55:18 84 16:5; 124:21, 22, 24 87 125:1			
	9			
	92 143:6 95 143:7 97 24:4; 25:15; 26:12 98 143:7			
	A			
	abdomen 133:14 ability 93:10; 117:10 able 118:7 abnormality 62:9 above 130:3; 149:4; 151:21 abroad 28:9 abscessus 141:15, 18			
2				
2 24:12, 23, 24; 25:1; 27:1; 71:9; 150:12, 18; 166:11, 16; 168:16 2.5 149:13 20 19:17; 54:20; 55:8 24-hour 84:16; 160:12 250 29:1 26 23:3, 15; 24:4, 19; 25:15; 26:12; 67:8				
3				
3 150:18 3/26/96 22:24				

<p>assumption 154:24 assumptions 104:16 assuring 93:12; 103:9 attach 21:15 attached 17:10 attempt 68:1, 7; 72:24; 73:2, 5, 10 attempted 68:3, 19 attend 52:3 attendance 50:5 attendances 11:16 attended 13:1 attention 4:19 attorneys 8:21; 10:8, 19, 19 atypia 61:22, 23; 62:3, 6, 11, 15; 150:15, 22; 151:12, 18, 22; 152:18 availability 35:19 available 15:15; 24:5; 31:14, 16; 32:9; 35:10; 38:13, 19; 39:23; 50:14; 57:5; 91:14; 92:11, 12; 94:15; 106:1; 115:7; 116:11, 16; 127:14; 135:9; 142:19 average 16:9; 95:23 avoid 121:6 aware 10:20, 24; 32:6; 35:19; 39:16; 40:22; 41:14; 42:6, 12; 65:21; 66:14; 76:19, 20; 78:17; 79:6; 87:5; 111:22; 120:18; 121:15, 16, 20; 122:1; 125:9; 126:3, 11; 129:3; 144:19, 21; 159:9, 13; 160:13; 162:5, 7; 165:23, 24 away 88:20 awkward 79:18; 84:11; 160:10</p>	<p>156:8; 160:21; 161:22; 162:2 bases 89:10 basically 4:17; 12:8; 27:22; 50:9; 53:2; 152:4 basing 61:3; 70:22; 165:6 basis 15:5, 18; 16:13; 18:15, 16; 32:4; 88:5; 121:2; 140:5 became 142:19 become 12:10; 41:20 begin 5:23 — beginning 46:16; 63:22 behalf 6:15, 16, 18, 19; 7:1, 5; 8:10; 9:7, 9, 11, 15; 84:24, 24 belief 54:20; 86:3 believe 24:14; 27:22; 30:19, 23; 31:1; 33:8, 11; 34:1; 41:2, 12; 52:20; 53:17; 62:21; 66:3, 13; 68:5; 69:2; 70:1; 81:11; 82:21; 104:12; 111:11; 120:13; 121:3, 24; 122:16; 160:7; 162:11, 17 believed 150:5 believes 119:2, 10, 16 below 32:23; 62:22; 84:3; 161:7 benefits 42:16; 43:20 benign 57:16; 60:17; 158:2 best 44:3, 6, 7; 77:23; 142:7 better 10:21; 21:8; 108:21; 121:8 big 53:8, 11; 86:20; 101:9 biliary 19:10 bill 26:21; 27:11, 15 billed 27:1 billiary 123:7 biopsied 35:1; 61:12; 157:4, 6, 16 Biopsies 34:24; 36:21; 38:19; 46:20; 59:8; 65:9; 70:6, 15, 19; 75:4; 91:10; 93:16; 95:1, 3, 7, 7; 142:11; 158:5; 159:14 biopsy 48:23; 68:9, 10; 74:16; 91:6, 24; 92:10, 23; 93:9; 94:3, 14; 102:3; 103:18; 117:3, 5; 138:2, 4; 140:22, 23; 141:3, 17, 19; 143:21; 157:16; 158:8; 162:6, 7 bit 9:13; 73:14; 141:13 bleeding 34:6, 10; 64:3 bloating 51:22 board 14:1, 4 body 149:13 Borison 24:18; 120:12, 15 borne 36:20 Boston 13:11 both 17:23; 18:23; 19:5,</p>	<p>5; 31:19; 34:15, 16, 16; 55:6; 64:3; 74:24; 89:9; 90:1, 7; 101:24; 147:1 bother 70:5, 15 bowel 47:19; 49:21; 53:2, 9, 15; 63:16, 21; 64:2; 65:5, 7, 10, 13, 18; 105:14, 17; 107:12; 120:8, 17, 22; 121:12; 123:22; 124:8, 12, 16; 126:14; 128:21; 141:15 break 145:19 breaking 145:18, 20 brief 156:3 briefly 12:5; 26:23; 36:17 Brigham 16:17; 18:8; 22:3 bring 4:19 bringing 87:13; 118:4 Brooks 49:17 browse 11:11 busy 20:12</p>	<p>11, 17; 97:4, 24; 98:10, 14; 100:11; 110:16; 130:5, 7, 9; 134:7; 139:13; 144:6, 7, 13, 20, 24; 145:5, 12, 14; 148:6; 152:15; 165:12 cancerous 36:20; 46:15, 18; 47:7 cancers 46:15; 147:1 care 15:7; 30:4, 10, 21, 24; 32:18, 23; 33:10, 14; 41:3, 7, 13; 42:11; 43:10; 59:12; 60:7; 62:22; 64:18, 21; 65:3; 66:14; 68:15; 71:12; 73:6; 75:8, 17, 20, 23; 76:3; 78:20, 24; 79:5; 81:13, 21; 82:22; 83:5, 10, 14; 84:4, 4; 85:3; 86:4, 10, 14, 16, 18; 87:2, 9; 88:5, 14; 89:4, 14; 100:15; 101:4; 102:19; 103:8, 21; 104:13, 19; 105:19; 106:15; 107:10; 109:1; 110:6, 9; 111:9; 112:13; 115:17; 116:1; 117:21; 118:16; 119:1; 130:17, 19; 148:7; 153:17; 154:8; 156:21; 157:24; 159:7; 161:8, 16; 162:12, 15, 19; 164:16 career 5:7; 6:3, 22; 44:15; 89:8; 129:1 CARR-LOCKE 4:2, 10, 11; 12:3; 80:21; 168:15 carried 31:5 carries 52:4 carry 54:5; 60:15, 17 carrying 43:22 case 5:11; 7:7, 14, 15, 19; 8:6, 18; 9:2, 3, 5, 14, 21, 21; 10:3, 3, 6, 14; 12:20; 22:19, 22; 25:7, 13; 26:1, 17, 24; 30:4, 6, 7, 11; 31:10; 32:18; 33:15; 34:2; 41:11, 22; 42:2; 43:12; 45:12; 47:13, 15; 56:18; 59:22, 24; 62:23; 64:12; 72:18; 76:2, 4, 9; 78:17; 79:22; 82:2; 85:23; 89:14, 23; 96:18; 97:8; 98:8; 101:10; 110:24; 112:5; 113:21; 114:4, 16; 115:7, 8; 123:10; 124:4; 128:13; 129:17; 131:4, 7; 135:8; 143:9; 146:1; 147:12; 153:24; 156:8; 159:5; 160:17; 161:3; 164:17; 165:3, 9, 10, 15; 166:12 cases 5:13, 24; 6:2, 13, 14, 24; 8:1, 11; 10:1, 4, 5, 8; 25:20; 29:4; 46:17; 47:18; 160:7; 165:16; 166:23; 167:8 CASEY 22:24; 27:11; 40:5, 9, 13; 84:19, 22; 85:2, 7, 9; 92:15; 100:20; 101:8, 11; 102:8, 13; 109:13, 16; 114:3, 8, 11, 15, 21; 115:1; 124:23; 131:11; 133:8; 134:13, 16;</p>	<p>137:1; 139:1; 145:20, 23; 151:19; 156:1; 162:23; 163:2; 166:7 catch 165:21 causation 119:1; 122:12; 133:15 cause 34:12; 57:11, 17; 64:3; 92:22; 124:11; 127:7; 130:7 caused 34:18; 106:23; 107:1, 3, 5; 119:19 causes 51:21; 126:5 caveat 163:11 cecal 106:23 cecum 107:16; 108:6; 117:5; 157:5 cells 62:1 Center 17:19, 22; 18:7, 8; 49:14; 50:6; 108:17 centimeter 54:2, 3, 5, 9, 15; 55:6; 56:6, 8, 16, 19, 23; 57:23; 58:7; 129:22 centimeters 57:10; 60:2; 140:8; 149:13 certain 42:16; 60:15; 62:1; 93:11; 141:12; 164:3 certainly 41:11; 46:5; 57:4; 67:12; 69:6; 75:4; 78:6; 83:18; 94:15; 107:13; 109:6; 122:18; 124:14 certainty 32:16; 33:6, 13; 142:5; 167:13 certified 14:1, 4 chance 55:4; 132:23, 24; 146:20 chances 53:23; 55:8; 122:19; 147:15 change 21:4; 45:17; 80:23; 117:12; 152:20 changed 49:24; 118:6; 142:17, 18, 21 changing 54:18 characterize 152:23 charge 27:6; 28:2, 4; 29:2, 3, 15 charging 26:24 chart 23:11; 34:8, 8; 35:17; 78:6; 160:1 charts 24:13, 17; 37:24; 94:10 check 11:19; 22:23; 23:4; 51:1; 66:19; 140:22; 158:18 choice 63:6, 8; 64:14, 16 cholecystectomy 122:15, 16, 23; 123:3, 19, 23; 124:1, 5 choose 51:8; 54:3 chose 12:13; 41:18 chosen 129:1 chronology 30:6; 72:18 circumstance 138:11, 15 circumstances 86:13;</p>
C				
<p>California 8:17; 9:2, 3 call 13:6; 19:13; 23:2, 8, 13; 69:21; 94:13; 147:4, 8 called 4:3; 9:7; 47:20; 51:2; 57:1, 10; 82:16, 17; 103:1 calls 24:2 Cambridge 12:15 came 8:5; 13:12; 14:23; 20:15; 21:18; 47:1; 65:12; 91:6, 10; 92:10; 100:20; 102:2, 9, 10, 11; 103:18; 106:14; 130:16; 138:1; 158:8 camera 21:15 can 4:20; 7:11; 12:14, 20; 19:2, 24; 21:7, 15, 19; 30:7; 31:14; 36:9, 10; 38:7, 12, 24; 39:20; 43:19; 46:12; 53:13; 58:4; 60:19; 61:8; 62:15, 18; 63:13; 71:16; 78:19; 79:3, 9; 80:6, 10; 81:22; 84:3, 9, 10; 87:20; 89:13, 23; 91:15; 93:3, 7, 16; 94:13, 19, 23, 24; 95:4; 97:11, 15, 16, 23; 98:5, 13; 102:16; 106:7; 107:5, 11; 113:3, 6; 116:3, 4; 118:19, 23; 119:7, 13; 120:11, 22; 121:7, 11, 19; 122:3; 126:7; 127:12, 18, 19; 128:18; 129:13; 130:9; 131:3, 8, 12; 135:19; 142:2; 144:22; 145:7, 13; 147:24; 149:22; 152:17; 154:16, 23; 155:15; 158:7; 165:5; 166:11, 16; 167:3, 23; 168:9 cancer 34:22; 44:22; 46:4, 6, 9, 24; 47:14, 16, 24; 48:3, 3, 22; 58:23; 59:3; 64:23; 95:22; 96:9,</p>				

109:9; 112:12; 117:8;
130:19; 137:12
clarification 112:22;
139:19; 142:9
clarify 99:18
classroom 22:4, 5
clean 49:21; 53:2
cleansing 50:4
clear 43:18; 45:5; 60:14;
62:21; 80:20; 107:18;
113:15
clearly 93:23; 96:12;
113:11; 129:8
Cleveland 88:16; 89:4
clinic 19:22
clinical 15:14; 16:3, 18,
20, 23; 18:9; 22:13; 75:17;
162:15
clinics 18:19
close 23:20
closed 126:22; 127:3, 10,
10
closest 14:21
cm 61:11
co-existing 63:15
co-manage 153:17;
154:7
co-management 154:21
coexist 94:24
cognizant 42:18, 20
colectomy 104:1, 2;
110:24; 115:14, 15;
116:14, 15; 117:11, 22;
118:10, 13; 126:9; 130:15;
132:14; 133:19; 134:17,
21
colitis 138:20
colleague 30:17; 31:20,
21, 22; 32:8; 35:5; 36:22;
37:22; 41:9; 69:13; 76:14;
82:3; 83:6; 159:22
colleague's 79:18
colleagues 35:13; 84:10;
88:10
colon 34:18; 43:15;
47:24; 48:3, 5; 51:24; 53:9;
54:7, 22; 55:21; 57:9;
61:10; 64:13, 15, 20;
92:21; 93:17; 96:18; 99:2,
14; 101:2, 23; 104:1;
105:2, 4, 7; 108:1; 129:18;
130:10; 137:17; 142:11;
144:7, 13, 20, 24; 150:13;
153:6, 11; 157:3; 165:14,
21
colonectomy 35:16
colonic 30:14; 33:22;
34:1; 36:15, 23; 43:22;
71:14; 75:11; 139:14
colonoscoped 52:18
colonoscopic 35:7;
46:19; 63:5; 67:16; 100:9
colonoscopies 20:1, 14;
21:24; 90:9, 15, 16, 17;
135:15; 137:9; 138:5, 16,
22; 140:1, 4, 10, 21; 143:3,

11, 15; 145:8; 147:24
Colonoscopy 19:7, 22;
31:7; 32:12; 34:14; 35:2;
40:1, 4; 44:18; 46:3; 47:11,
20; 48:21; 49:19; 50:1;
51:11, 15, 20, 23; 52:9, 13,
14, 15; 53:5; 54:12; 56:13;
58:21; 60:20; 64:9; 65:8,
17; 70:4; 72:20; 93:9;
95:19; 97:21; 106:3;
112:20; 136:19; 142:13;
143:21; 145:2, 4; 146:22;
148:10, 19; 149:23; 150:5;
156:9; 157:1; 162:3
colorectal 89:13
comfortable 88:13, 18
coming 82:24; 146:4;
155:16
comment 89:3; 119:12
commenting 88:13
commercially 50:14
committees 166:2, 5
common 67:12
communicate 81:22
communicated 90:7;
92:19; 97:3; 103:19;
104:12; 110:4, 12; 112:10;
115:12
communicating 99:16;
118:12
communication 163:20;
164:12
communications 79:14;
163:19
compared 150:23
compatible 107:13
competent 108:17, 20,
21
complain 51:20
complaints 51:14, 17
complete 14:7
completed 13:8
completely 11:14; 75:18;
79:20; 88:11; 93:4;
139:12; 153:6
complex 120:24
complication 123:24;
132:17
complications 44:12;
118:22; 119:8, 9; 123:22;
129:10, 12; 131:13
component 19:17
components 11:14; 19:5
concept 87:1, 4; 96:12
concern 30:13, 22;
34:19, 21; 56:2; 57:12, 17;
92:23; 113:18; 150:10;
157:9; 158:1
concerned 68:8; 93:1;
139:17; 152:6; 157:13
concerning 135:5
concerns 30:12, 18;
36:2; 96:17, 19
conclusion 23:12
condition 116:18, 20, 23;

127:6; 129:7; 130:20, 21
conditions 139:8; 144:16
conduct 132:6
confidence 56:1
confident 94:20
confirmed 157:18
confused 9:13
connotations 60:16
consent 79:11; 104:8;
136:5; 164:5, 8
consequence 119:6;
126:8; 128:9
consequences 119:14;
120:6; 125:21; 131:8;
159:20
conservative 120:23
conservatively 121:5
consider 37:17; 106:13,
16; 135:16
considerable 126:19
considerably 126:16
consideration 37:5;
104:22; 135:7; 136:22
considered 16:2; 37:16;
45:19; 106:7; 137:12
considering 115:10
consult 25:12; 64:19;
69:13; 105:22; 153:16, 16,
17; 154:7, 7, 8; 158:16
consultant 15:9
consultation 35:12
consulted 35:5
consulting 153:14
contact 26:16; 49:4
contacted 22:22
contain 61:5
contained 112:9
contemplating 89:5
contents 26:18
context 62:2, 4, 13
contexts 62:2; 150:2
continuation 156:21
continue 73:19; 90:18;
127:24; 140:22, 23
continued 75:13; 90:9
continues 31:19; 75:20;
144:10
continuing 30:16; 90:14
continuous 13:2; 149:6
contract 165:1
control 75:19; 80:4;
128:22
controlled 80:2
controversial 130:12
controversy 120:2
convenience 38:9, 15;
45:1, 6; 47:5; 48:12, 16,
18; 49:10; 52:24; 53:7, 9,
10; 59:4
convenient 53:14;
145:18, 20
conversation 23:15, 18;
35:11; 98:21; 101:5

convey 139:7
convinced 93:21
copied 149:2
copies 24:6, 10
copy 11:3, 10; 25:23;
29:24; 166:13, 17, 20;
168:6, 13, 13
corrections 167:23
correctly 34:11
correspondence 60:6
couldn't 108:3; 117:3
counsel 4:3
countries 28:12, 15;
86:15, 23; 87:15
country 7:14; 86:8; 87:8
course 12:18; 20:21;
261:7; 31:20; 46:19; 52:1;
53:13; 65:4; 76:24; 94:24;
98:3, 5; 102:18; 125:19;
132:1, 6, 12; 137:18;
138:12; 140:11; 141:23;
145:13; 150:10; 167:5
court 4:23; 9:17; 28:6, 8,
13, 23; 167:3
cover 113:10
credence 91:23
credential 5:21
credentialing 5:17
credible 108:20
critical 83:24; 84:2;
110:23; 157:23
critically 161:9
criticism 36:14; 75:10,
12; 79:15; 90:1; 156:14,
18; 157:24; 159:6; 160:17;
161:5
criticisms 30:3, 10;
89:21; 90:10; 120:19;
156:7, 19; 160:20; 161:3;
163:5, 10, 18
criticize 84:6
Crohn's 107:7, 8, 11;
112:23; 139:23; 141:7
CROSS 85:8
crypt 141:14, 18
cured 97:20
current 11:19
currently 18:1; 167:4
custom 25:19
cut 81:2
CV 11:10; 12:5; 19:12;
22:17; 166:20

D

daily 15:5, 18; 18:15;
139:14
damages 119:19; 125:4,
15; 126:12
Daniel 24:18
data 55:9, 13, 14; 142:15,
19; 147:21
date 11:15, 20; 23:16, 20;
27:8; 39:11, 22, 22; 40:23;

41:14, 19; 42:3, 7, 12;
56:15; 146:16
dated 23:14; 24:4, 23, 24;
25:1; 27:1; 67:8; 91:13, 16;
112:9
dates 146:7
DAVID 4:2, 4, 10; 24:11;
49:17
day 16:15, 15; 22:12;
32:12; 35:18; 41:6, 19, 21,
23, 24; 47:22; 53:10; 84:1;
87:11; 89:11; 95:15;
97:16; 99:9; 105:24;
126:2; 128:21; 161:6;
164:6, 6
days 47:12; 48:1, 24;
111:5; 120:16; 147:4
deal 17:15; 102:13; 129:9
dealing 75:12
decade 20:21
December 24:23, 24
decided 35:14
deciding 138:9
decision 35:13, 24; 45:8,
12; 49:3; 50:1; 69:15; 70:3,
16, 20; 79:8; 110:23;
135:2, 10; 136:14; 140:9;
157:23; 159:2, 22; 167:24;
168:3
decisions 32:21; 36:21;
38:18, 20; 45:6; 49:8, 10;
53:13; 82:4; 89:17; 160:2;
161:9, 13
decompress 48:5
decreased 130:5
default 154:12, 15
Defendant 4:4; 6:16, 18,
20; 7:2; 8:10; 9:11
defense 8:12; 10:19
defer 43:11; 44:11; 109:3,
10; 110:8; 111:15
define 90:14; 93:15;
103:24; 121:19
defined 106:17
definite 146:12, 13
definitive 47:1
degree 12:16; 32:16;
33:6, 13; 45:3; 62:8;
122:22; 123:15; 142:5;
147:15; 167:13
deletions 11:12
denote 62:8
departure 112:12
depended 76:8
dependent 36:2; 102:22
depending 34:8; 62:4;
104:3
depends 45:24; 146:9,
16
deposed 4:15; 5:5; 7:1;
8:19
deposition 4:14; 5:8;
11:22; 28:3, 18; 40:7;
60:21, 22, 24; 61:15;
71:24; 96:2; 106:4; 112:6;

<p>114:1, 8, 9; 115:3; 137:3; 150:3; 155:10; 167:19; 168:17</p> <p>depositions 24:10; 98:8</p> <p>describe 15:13; 16:11; 61:24; 99:7, 23; 147:1; 152:19</p> <p>described 14:12; 34:21; 35:7; 60:3, 4, 5, 8, 9; 61:4; 15; 92:20; 108:5; 138:11; 148:11, 18; 150:4, 14; 157:12</p> <p>description 149:3, 9, 18, 22</p> <p>descriptions 148:16</p> <p>desired 64:21</p> <p>desires 136:12</p> <p>despite 106:19</p> <p>detail 18:5</p> <p>details 124:11; 127:8</p> <p>detect 152:17</p> <p>detected 139:16</p> <p>determinant 152:9</p> <p>determination 45:21; 48:24</p> <p>determine 64:7</p> <p>develop 122:2; 129:11; 130:9; 133:9; 134:10, 10</p> <p>developed 121:14, 17; 122:6, 10; 123:18; 128:2; 129:10; 133:11, 13; 145:10, 12; 147:13</p> <p>developing 122:20; 130:1; 132:23; 134:22; 147:19; 153:8</p> <p>development 21:2; 86:23; 118:21; 123:2, 3; 144:6, 12, 24; 147:16; 148:5; 151:8</p> <p>developments 89:10</p> <p>deviate 115:17</p> <p>deviated 30:20, 23; 32:17; 33:9, 14; 78:20; 81:12; 82:22; 159:6; 162:12, 18; 164:16</p> <p>deviating 99:15; 101:3; 104:19</p> <p>deviation 34:2; 59:11; 84:7; 100:14; 103:20; 104:13; 118:24; 119:20; 148:7</p> <p>deviations 119:9</p> <p>devolve 79:1</p> <p>devoted 15:21</p> <p>diagnose 165:12</p> <p>diagnosed 130:22</p> <p>diagnoses 126:6</p> <p>diagnosing 36:5</p> <p>diagnosis 30:14; 31:9; 13:32; 2, 6, 24; 33:21; 34:1; 36:15; 47:1; 64:5, 7; 75:10; 93:18; 94:20; 112:22; 137:22; 140:11, 24; 141:9, 10; 156:20, 22; 157:21; 158:2; 159:8</p>	<p>diagnostic 19:5; 31:12; 143:20</p> <p>diameter 60:2</p> <p>diarrhea 34:6, 7; 63:24; 64:4; 125:21, 21; 126:1, 5, 8, 10; 127:16, 22; 128:3, 7, 14; 131:14; 132:8, 20; 133:17, 24; 134:3, 7, 10, 10, 22</p> <p>dictated 91:11</p> <p>differed 83:14; 109:8</p> <p>difference 12:9; 32:20; 53:8; 59:2, 20; 60:19; 101:9; 149:17; 153:15</p> <p>differences 153:19</p> <p>different 12:12; 15:7; 20:18; 28:5, 11, 12; 43:23; 47:22; 50:5; 62:4; 68:12; 71:16; 74:23; 76:1; 87:4, 12, 14, 19; 93:2, 4; 97:24; 98:18; 99:17; 111:10, 24; 120:21; 132:10, 12, 15, 17, 18, 19, 20; 133:22; 134:5; 137:14; 140:14, 18, 20; 141:13; 143:13; 148:16; 149:7; 150:2, 7; 151:23; 152:17, 24; 155:2; 157:2</p> <p>differently 75:1; 99:11; 140:6</p> <p>difficult 98:23</p> <p>DIRECT 4:6; 119:5; 126:13; 128:9</p> <p>directly 12:20, 22; 125:24; 128:16; 129:3</p> <p>director 16:21; 17:2, 18, 21; 108:15</p> <p>disabling 128:14</p> <p>disagree 67:10; 72:2, 12; 74:13; 75:7; 76:13; 90:20; 91:17; 115:19, 21; 117:7, 24; 118:2, 17; 155:9, 14</p> <p>disagreed 31:21; 41:20; 74:8</p> <p>discovered 96:23, 24</p> <p>discretion 29:12</p> <p>discuss 31:22; 32:4; 33:2; 38:21; 43:19; 78:7; 109:7</p> <p>discussed 31:14; 38:23; 39:24; 40:3, 4; 63:18; 72:24; 74:21; 75:5, 6, 8; 76:10; 96:9; 97:7, 9; 126:5, 11; 135:17, 22; 150:17; 156:16; 157:5, 12; 159:24</p> <p>discussing 43:19; 47:23; 56:10; 60:11; 163:20</p> <p>discussion 32:10; 49:2; 97:19; 112:22; 168:11</p> <p>disease 45:14; 47:19; 63:16, 22; 64:3; 65:5, 7, 10, 14, 18; 96:4, 14; 105:14, 18; 107:7, 8, 11; 112:23; 116:21; 123:7; 139:23; 141:7, 15</p> <p>display 21:8</p> <p>displayed 21:5, 19</p> <p>distal 57:9; 61:9</p>	<p>distinct 149:14; 153:3</p> <p>distinction 75:3; 148:10, 15</p> <p>distinguish 124:2; 149:16; 152:3</p> <p>distinguished 148:14</p> <p>divided 19:21</p> <p>Division 16:17; 17:2</p> <p>divisional 29:6, 7, 10</p> <p>doctor 6:16; 7:2; 8:11; 12:5; 27:12; 29:23; 36:13; 40:19; 63:3; 72:10; 74:7; 84:18; 85:10; 95:10; 101:14; 102:11; 111:6; 125:14; 132:22; 137:6, 8, 11; 145:24; 156:2; 166:10</p> <p>doctor's 60:21; 136:14</p> <p>doctorate 119:20</p> <p>doctors 29:8; 93:11; 100:24; 137:23</p> <p>document 11:9; 12:3; 67:24; 74:14; 78:5</p> <p>documentation 33:3; 39:24; 42:9; 76:5; 154:11, 14</p> <p>documented 26:20; 27:21; 32:9; 39:21; 57:6; 63:23; 65:9, 15; 125:20; 128:18; 154:3, 10; 160:24</p> <p>documents 23:9; 25:22; 27:3, 14; 28:1; 61:7; 72:19, 20, 21; 126:1; 167:4</p> <p>done 12:20; 39:4; 43:12; 45:4; 46:3; 53:1; 68:23; 81:9; 83:15, 19; 88:24; 89:12; 97:13; 103:2; 128:6; 131:4, 7; 138:23; 142:12; 145:6</p> <p>door 80:9</p> <p>double-check 69:3</p> <p>down 4:24; 40:6, 13; 106:5</p> <p>Dr 4:11, 13; 24:11, 18; 30:4, 10, 20; 31:24; 32:8, 17; 33:9, 13; 34:11; 35:5, 17; 36:6; 37:5; 39:16, 16, 23; 40:3, 22, 23; 42:6, 6; 44:4; 60:3, 8, 22; 61:15, 19, 20; 62:23, 24; 64:1; 65:16; 66:17, 18, 18, 24, 24; 67:3; 68:5; 69:4, 7, 19, 21; 70:13; 71:9, 11, 19; 72:12; 74:22; 76:4; 77:2, 8, 8, 13, 14, 18; 78:11, 12, 13, 15, 16, 17, 20, 21; 79:17; 80:3, 5, 21; 81:4, 5, 6, 12; 82:13, 14, 19, 21; 83:9, 13, 23, 23, 24; 84:12; 85:1, 3; 88:15; 89:5, 15; 90:1, 2, 7, 10, 11; 92:14, 15, 16, 19; 94:9; 98:9, 9; 99:12, 12; 100:1; 103:3; 104:11, 14; 106:3; 108:11, 21, 23; 109:4, 5, 17, 20, 23; 110:2, 9, 19; 111:8, 8, 19; 112:1; 113:1, 13, 22; 114:1, 17; 115:9; 117:24; 118:4; 120:12, 15; 135:7,</p>	<p>8; 136:22; 139:11; 145:6; 148:11, 18; 149:3; 150:3; 152:10; 153:13, 14; 154:6, 6; 155:4, 7; 156:7, 8, 10; 157:14, 14; 158:12, 13, 17; 159:1, 2, 9, 12, 13; 160:2, 3, 9, 10, 13, 14, 15, 15, 17; 161:4, 13, 23; 162:1, 5, 9, 10, 12, 18; 164:10, 19, 21</p> <p>drafted 26:15</p> <p>drafting 26:11</p> <p>drafts 25:17, 20</p> <p>drank 50:23</p> <p>drink 50:7; 51:8</p> <p>due 132:21</p> <p>duly 4:4</p> <p>during 7:16; 24:7; 35:11; 43:2; 44:18; 70:4; 86:5; 88:23; 89:10; 154:2</p> <p>duty 80:3</p> <p>dysplasia 62:7; 151:11; 152:18, 24</p>	<p>159:20, 22, 23; 160:14; 163:16</p> <p>elect 137:19</p> <p>elected 112:11</p> <p>elective 17:14</p> <p>electrolyte 50:16, 19</p> <p>electronic 21:19</p> <p>element 133:15</p> <p>elements 32:22; 33:16</p> <p>eleven 143:10</p> <p>eliminated 95:5</p> <p>else 46:8; 54:22; 56:11; 57:13; 75:6, 21; 108:9; 111:5; 163:21</p> <p>elsewhere 54:7</p> <p>embarrassment 126:20</p> <p>emergency 47:21; 48:4, 7; 75:18</p> <p>employed 163:12, 16</p> <p>employs 164:24</p> <p>end 142:7</p> <p>endoscopes 20:22, 23; 21:18</p> <p>endoscopic 7:16; 16:8; 18:21; 19:21; 34:16; 43:5; 57:5; 64:12, 13; 141:2</p> <p>endoscopically 48:6; 64:10</p> <p>endoscopist 21:11</p> <p>endoscopy 16:21; 17:3, 18, 22, 24; 18:6, 7, 23, 24; 19:9; 20:15; 49:14; 50:6; 61:4, 8; 69:22; 73:5; 86:11; 89:11</p> <p>engender 98:5</p> <p>England 8:4, 7; 9:21; 10:2; 12:6, 9; 13:7, 10; 14:11; 15:3; 20:10</p> <p>enormously 94:11</p> <p>enough 5:3; 6:11; 38:20; 149:23</p> <p>ensure 77:23; 95:1, 16</p> <p>entail 17:21</p> <p>enterocutaneous 121:24; 126:18; 127:2</p> <p>entire 93:11</p> <p>entirely 163:18</p> <p>entirety 100:9</p> <p>envision 39:6</p> <p>episode 126:16</p> <p>equate 151:17</p> <p>equipment 20:13, 17</p> <p>equivalent 13:9; 14:8, 17; 15:8</p> <p>ERCP 19:8, 13</p> <p>ERCPs 19:16</p> <p>error 91:24; 92:24; 93:3; 95:1, 4, 8</p> <p>esophageal 7:17</p> <p>establish 86:10</p> <p>estimate 6:2</p> <p>etiology 56:22</p> <p>even 45:19; 51:21; 54:8;</p>
---	---	---	---	---

55:19, 23; 60:6; 70:4, 5; 76:14; 77:3; 78:5; 86:24; 87:1, 8, 11; 88:19; 89:12; 91:6; 93:8; 96:23; 104:18; 128:17; 144:23; 161:20 evening 81:18; 82:8, 17; 162:6 events 31:10; 68:11; 161:21 every 16:15; 22:12; 82:8; 93:20; 97:16; 99:9; 142:16, 22 everything 4:22; 75:6; 104:22; 132:5; 166:13 evidence 55:16, 18; 65:6; 96:6; 164:20 exact 40:22; 41:6, 14; 42:7, 12; 66:4, 5, 15 exactly 23:19; 39:10; 45:7; 59:15; 75:22; 77:14; 78:24; 91:5; 93:15; 106:18; 131:22; 158:6, 11 exam 13:18, 22 examination 4:3, 6; 35:4, 9; 52:4; 60:19; 85:8; 156:4; 163:1; 166:8 examinations 34:15, 16, 17 examined 4:5; 58:13 except 5:22; 15:6; 155:10; 163:21 exceptions 58:8 excision 93:10, 16; 94:13 excluded 95:2 excluding 43:5 exclusively 89:9 Exhibit 11:2; 12:4; 166:11; 168:16 existed 113:20 existence 26:5 exists 152:16 expect 28:12; 102:23; 103:1; 113:3; 127:12, 18; 133:19 expectancy 129:6, 13; 167:14 expectation 66:22 expected 133:21 expenses 28:14; 29:19 experience 46:21; 51:12; 88:7, 23; 128:20 experienced 133:19 expert 5:12; 9:7; 24:22; 25:3, 4; 29:8, 15, 24; 66:24; 112:5; 119:23; 166:24; 167:9 explain 33:24; 109:16 explained 80:17; 97:7; 164:9 explaining 97:24 explanation 98:5 explicit 36:18 explore 101:14 expressed 111:13 expresses 74:22	expressing 165:4 extended 147:24 extensive 35:15; 71:5 extent 68:22 extremely 128:5, 8; 144:4 eyepiece 21:11	F	F.R.C.P 4:2 face 116:7 facilities 18:3 facility 17:23; 108:20 fact 35:22; 40:12, 21; 47:6; 52:24; 69:18; 77:8; 91:23; 92:1, 23; 100:5; 106:19; 117:2; 127:21; 133:6, 7; 134:1; 136:18; 145:5, 9; 147:12; 151:6, 10, 12; 153:11; 163:6 facts 10:6; 56:18; 79:7; 136:4; 137:3; 161:2, 22; 162:17; 164:14 factual 42:4; 72:16; 101:13; 163:3 faculty 15:8; 16:18; 18:9, 9, 14 failing 165:11, 20 failure 36:14; 73:11 fair 5:3; 6:11, 12; 65:20; 72:6; 81:1; 88:8, 9; 89:1; 91:8; 95:5, 6; 102:4; 103:15, 16; 105:14; 113:2, 4; 116:5; 122:13, 14; 123:5, 6, 12; 130:10; 132:24; 133:1, 3, 14; 138:17, 18; 145:15; 164:1; 165:7 fairness 134:9 fall 161:7 familiar 83:19; 96:12; 153:20 family 144:15, 17; 145:10 far 31:14; 35:19; 38:24; 44:9; 51:1; 60:4; 128:18 Father 37:4; 38:24; 40:7; 56:10; 78:8; 93:12; 95:11, 13, 18, 22; 96:18; 97:3; 98:10, 15, 24; 99:13, 16; 100:13, 24; 103:22; 104:7, 14; 115:11, 12; 116:1, 16, 20, 23; 117:9, 20; 118:19; 119:7; 120:24; 121:13, 16; 122:5; 123:10, 16; 124:4; 125:3, 15, 18; 126:12; 127:7, 12, 17; 128:2, 14; 129:17, 24; 130:14, 17, 21; 131:8; 132:21; 133:20; 134:9; 135:5, 22; 136:6, 18; 137:6; 138:2, 23; 141:21, 24; 142:24; 143:10; 144:5, 19, 23; 145:8; 147:12; 148:3; 151:2; 153:7; 157:23 father's 136:12	fault 71:11; 117:17 favor 37:1; 166:13 fear 95:22; 97:3 features 65:9; 107:6; 141:12, 15 February 24:4, 19; 25:15; 26:12 fee 28:5, 9, 13 feel 22:19; 88:13; 89:3; 120:3, 8; 161:18 feels 31:4; 51:15 fellows 17:1, 15; 22:3; 29:13 fellowship 13:9; 14:7, 8, 11, 16, 21; 17:4, 12; 29:18; 85:21 felt 98:3, 4 few 4:12; 45:2; 111:5; 147:4; 156:2; 166:10 Fiber-optic 20:15, 19; 21:9 field 86:22 fifteen 100:3 fifty 18:8 figure 108:3 file 22:23; 23:4; 27:9; 146:5; 154:15; 167:20, 21 final 25:23; 38:21; 45:8, 21; 49:10 finalized 26:19 find 40:20; 54:11; 71:11; 111:23; 132:16; 147:3, 4, 6, 7 finding 144:14; 151:5 findings 35:7 finds 81:8 fine 25:6; 73:18 fingerlike 149:19 fingers 149:19, 21 firm 49:8 first 4:4; 12:15; 13:23; 21:23; 22:21; 30:3; 36:14; 37:15; 54:1; 57:1; 59:8; 63:4; 67:7, 23; 69:5, 22; 74:8; 75:9; 82:18; 91:9; 99:18; 119:2, 4, 10, 14, 16; 120:17; 127:23; 145:2, 4; 152:1, 2, 10; 156:8, 14, 18; 159:6 Firstly 104:5 fistula 121:14, 15, 17, 19; 122:2, 6, 12; 126:19, 22; 127:2, 13 fit 15:15 five 5:9, 10, 19; 6:24; 7:4; 10:5; 12:20; 14:15, 16; 69:23; 100:1, 2; 116:3; 129:23; 142:20; 150:18 flat 61:10 flavored 50:17 flew 10:3 flex 13:21 flexure 30:15; 32:3; 34:19; 57:11; 61:9; 65:11; 90:23; 93:14; 95:14;	02:3; 106:24; 107:2; 40:8; 148:12; 152:11; 57:10 lushes 50:9 ly 9:24 older 166:12, 13; 168:15 ollow 138:13; 159:21 ollow-up 112:16; 142:14; 161:5 ollowing 35:4; 39:24; 103:81:13; 82:23; 162:8 ollows 4:5 orget 91:19 orgot 27:16 orm 96:13; 102:16; 104:8 ormed 96:2 orty 6:7, 9, 13; 18:20 orward 106:16; 112:11; 135:14 ound 54:15; 55:20; 57:21; 116:23; 139:2, 18; 162:2 our 5:9, 10; 6:24; 7:4, 24; 10:5; 22:16; 51:8 ourteen 126:2 frame 158:24 Frederick 24:22, 23 free 58:8 frequently 24:2; 38:5 front 29:24; 121:21 full 37:3; 69:5 fully 110:20 fund 29:6, 7, 10 fundamentals 12:11 funds 29:15 furnish 115:2, 4 further 12:17; 55:20; 93:5; 97:21; 129:12; 140:6; 141:2; 148:5; 150:22; 165:3; 166:8 future 97:4; 127:7, 13, 18; 130:2; 148:6; 151:15; 153:8	36:11, 22 gastrointestinal 17:24; 18:24 Gastroscopy 19:4 gathered 136:1 gave 11:4; 82:13; 113:22; 158:11 general 14:12; 39:1, 10, 11; 41:4, 14; 42:12, 21, 24; 43:1, 13, 16; 44:12, 16; 45:9, 21, 23; 46:14, 24; 48:9, 21; 52:23; 54:20; 57:20; 58:14, 21; 59:17; 62:24; 65:20; 66:6; 74:4; 76:20; 77:3; 80:4; 88:24; 89:9; 130:4; 135:4 generate 159:18, 18 genteel 99:5 gentleman 65:7; 78:14, 15, 19; 114:2; 160:16; 168:1 gets 77:23 GI 18:9 given 5:8; 20:21; 50:2; 82:12; 90:8; 98:5; 111:8, 19; 113:6; 117:20; 118:14; 120:14; 131:16; 132:13; 135:12; 136:5, 22; 137:7; 138:2, 8, 12; 145:9; 162:17; 163:4, 14 gives 149:21 giving 118:15; 135:20; 167:12 goes 29:6, 18; 81:6; 141:21 good 54:3; 79:15; 117:18; 162:14, 15 Gottesman 4:4, 13; 24:11; 30:20; 31:24; 32:17; 33:9, 13; 34:11; 36:6; 39:16, 23; 40:22; 42:6; 44:4; 60:8; 61:20; 62:23, 24; 64:1; 66:17; 68:5; 69:7, 19; 77:2, 8, 14, 18; 78:11, 16, 20; 79:17; 80:3; 81:4, 6, 12; 82:13, 19, 21; 83:23, 24; 84:12; 88:15; 90:2, 10; 92:16, 19; 94:9; 98:9; 99:12; 100:1; 106:3; 108:21, 23; 135:8; 139:11; 145:6; 148:11; 152:10; 153:13; 154:6; 156:7, 8, 10; 157:14; 158:12; 159:1, 9, 12; 160:3, 9, 13, 15, 17; 161:4, 13, 23; 162:5, 10, 12, 18 Gottesman's 30:4, 10; 60:3, 22; 61:15; 65:16; 66:24; 69:21; 70:13; 71:11; 83:9; 148:18; 149:3; 150:3 Gouge 108:11; 109:4, 5, 17, 20, 23; 110:2, 9, 19; 111:8, 8, 19; 112:1; 113:1, 13, 22; 114:1, 17; 117:24; 118:4 Gouge's 115:9 grade 152:19
---	--	----------	--	--	---	---

<p>granuloma 141:14, 19 great 18:4; 101:17; 129:9 greater 54:10; 55:6, 9; 58:7; 152:7; 153:2 gross 67:14; 71:13 ground 4:17 group 18:6 growth 47:8 guarantee 95:13, 15 guess 23:22; 85:3; 142:3; 154:16 guest 74:6 guy 65:13</p>	<p>hernia 118:21; 120:1; 131:15, 15; 132:8 herself 65:21 higher 16:7; 60:17; 62:8; 95:24; 96:4; 144:24 highly 128:10 Hill 24:9 Hillcrest 24:6; 34:14; 83:15 himself 65:21 hindered 129:1 HIRSHMAN 7:10; 10:11, 21; 11:3, 6, 24; 22:21; 23:14, 23; 24:13; 25:2, 10; 26:14, 19, 24; 36:8; 39:18; 40:8, 11, 17; 54:24; 56:17; 58:3; 67:21; 70:12; 72:4, 13; 73:24; 80:19; 83:16; 84:22; 85:5; 92:1, 14; 96:5, 20; 97:10; 100:18; 101:5, 9, 15; 102:6, 10; 109:11, 14, 19; 111:2; 112:15; 113:12, 24; 114:5, 10, 12, 18; 115:4; 118:3; 128:10; 131:10; 132:3; 133:6; 134:12, 15; 136:8, 23; 137:2; 146:13, 17; 148:20; 151:17; 155:21; 165:5; 166:19; 167:2, 18; 168:6, 10, 12 histopathology 90:4, 6 history 34:7, 9; 63:24; 144:11, 16; 145:10 HMO 18:10 hold 83:10; 85:2; 146:17 home 81:7; 82:9 hope 9:5; 65:23; 121:5 Hopefully 84:13 hospital 5:18; 6:17; 7:2; 9:5, 8; 16:17; 17:13, 22; 24:6, 7, 9, 10; 25:22; 26:9; 29:11; 34:15; 38:17; 45:1; 55:16; 80:1, 1; 81:7, 15, 20, 24; 82:6, 19, 24; 83:15; 84:24; 85:3; 120:12; 160:6; 161:7; 162:16; 163:5, 8, 13, 15, 16, 23; 164:11, 13, 15, 22; 165:10, 17 hour 27:2, 4; 28:2; 29:1; 114:22; 167:19 hours 27:2, 19, 22 housecleaning 166:10 huge 21:6 hundred 16:19; 94:17 hurry 92:8; 158:23 hyperplastic 108:9; 157:8 hypothetical 42:1, 2; 56:3; 58:11; 74:15; 82:12; 111:3, 7, 8; 112:24; 113:9; 116:5; 136:23; 137:4; 139:8; 158:12 hypothetically 53:19; 59:22; 77:24; 134:23</p>	<p>I dea 6:14; 16:13; 19:24; 21:7; 23:17, 23; 53:22; 128:24; 164:24 deal 21:17 deas 47:18 dentification 12:4; 168:16 dentified 112:4 identify 11:7 ileocecal 134:1 ileorectal 126:9 leum 122:19 ileus 118:20 Il 121:2, 3; 126:16; 161:9 image 21:5, 13, 17, 19 imagine 24:19 immediate 52:22 Immediately 35:4; 38:14 impact 79:7 implies 102:11; 150:22 imply 38:22 importance 35:24 important 41:20; 42:3; 62:3, 11, 14; 135:16; 152:9 impossible 73:11; 155:19 impression 70:23, 24; 78:10; 156:13 inaccurate 99:3, 4; 114:13 inadequate 32:1, 15 inappropriate 33:2; 104:17; 130:24; 131:1, 6 incapacitated 128:19 incapacitating 128:23 incidence 132:19 incision 131:19, 21 incisional 120:1; 131:15; 132:3, 7 include 117:21 included 118:8 includes 114:17 including 26:9; 116:24 increase 144:17; 151:6, 7, 14; 153:7 increased 130:1, 3; 144:12; 145:1; 148:5; 150:9; 153:10 increases 54:10; 93:17; 122:19 indeed 64:10; 99:2; 100:14, 24 independent 25:7; 163:13 indicate 40:21; 42:5; 164:23 indicated 102:7; 104:6 indicates 77:13 indicating 26:10 indication 39:14; 65:13;</p>	<p>105:12; 109:13 indications 109:12 individual 84:16; 95:22; 133:2 infection 118:20; 131:14; 132:7, 19, 23; 133:10, 11 infections 133:16 inflamed 93:13 inflammation 62:12, 15, 18 inflammatory 35:22; 63:16, 20, 21; 64:2; 65:5, 7, 10, 13, 18; 93:22; 94:19, 23; 102:4; 103:18; 104:21; 105:14, 17; 107:21; 108:10; 110:15; 117:4; 137:23; 141:11, 13, 15; 142:9; 157:17, 19; 158:2 inflation 51:23 influenced 140:9 inform 162:10 information 7:9; 269; 38:19; 55:23; 58:6; 79:13; 93:5; 97:8; 98:7; 99:16; 102:15, 20; 103:4, 17, 19; 115:7; 120:14; 122:8; 127:14; 128:13; 135:9, 12; 137:7; 140:6 informed 110:20; 136:5; 154:2 initial 26:16; 31:6; 75:19 initially 13:20; 34:12; 45:19; 139:17 initiated 161:20 injured 7:16 injuries 119:18; 125:15; 126:12; 132:4 injury 7:18 inpatient 19:23; 89:9 inspection 46:19 instances 48:10 instead 46:7; 149:6 institution 15:11; 49:1; 79:14; 102:23 instructions 50:2 instruments 20:19; 21:4, 10 interest 14:19 interested 29:14 interject 76:23 intermittent 34:6 internal 14:2 internist 83:17 internship 13:6, 8, 13 interpret 74:24; 98:17 interpretable 94:10 interpretation 62:3; 63:19; 93:3, 4; 150:10 interpreted 157:10, 13 interruption 80:21 interval 147:23 intervals 148:1 interviewed 125:23; 128:17</p>	<p>into 15:15; 29:18; 45:15; 104:22; 118:4; 125:14; 141:1 introduced 4:12 invariably 63:23 investigate 34:12 investigated 126:4; 127:9 investigations 128:6 involve 10:6; 64:8; 139:24; 163:23; 164:2 involved 5:20; 8:22; 10:5; 19:15; 28:9; 49:18; 86:12; 107:9; 159:19; 165:9, 15 involvement 9:4; 22:2; 166:5 involves 18:4; 163:24 involving 164:7 Ireland 7:23; 8:6; 9:22 Irish 10:3 ischemic 47:19 issue 7:7; 31:17; 64:5; 109:11; 115:13; 119:22; 140:18 issues 45:14; 159:24; 164:11 items 119:1 itself 14:16; 108:4; 163:5, 8, 24</p> <p>J January 146:10, 14 job 50:21; 95:16; 98:6 joint 45:12 Judging 19:12 judgment 37:9, 11; 84:5; 104:3; 111:1; 115:16; 162:14 July 27:1 June 67:8 junior 81:20 jury 111:11; 115:8; 119:2, 10, 16; 155:17</p> <p>K keep 8:24; 9:1; 25:23; 74:12; 141:3; 147:20; 166:23; 167:1, 4, 8 keeping 31:15; 86:14 Kingdom 14:18; 86:13 knew 68:24; 96:10; 106:2; 141:18 Knock 80:9 knowing 68:16; 79:10; 92:19, 20; 155:6 knowledge 39:22; 44:3, 6, 7; 54:17, 18; 86:4, 7; 96:1; 110:17; 161:10 known 19:4, 9; 39:10; 104:11; 118:18; 123:22 knows 79:11; 98:16</p>
---	--	---	---	--

<p>L</p> <p>L 4:2, 4 lack 154:11, 14 Lake 24:8; 120:12 laparotomies 124:11 laparotomy 43:16, 20 large 67:15; 71:13; 72:15, 23; 93:16; 94:12; 95:1; 97:15 larger 57:18; 61:16; 95:7; 100:3; 152:14 last 20:1, 21; 22:10, 16; 43:5; 63:5; 67:19, 21; 74:7; 79:13; 80:24; 112:6; 113:22; 114:22; 127:21; 129:9; 162:24 late 55:18 later 11:18; 48:24; 134:8; 147:7 Latin 149:19 lawsuits 87:13 leakage 132:18 learning 17:1 learns 82:20 least 16:15; 34:5; 49:6; 54:20; 55:8; 103:11 leave 42:20 lecturer 14:19 led 32:24; 34:11, 21; 157:22 left 4:13; 69:24; 126:18 legal 5:11, 13, 24; 6:14; 7:24; 10:5, 17; 87:9; 166:24; 167:9 Leicester 14:21; 15:3 length 12:18 lesion 30:14; 32:3; 33:22, 23; 34:2, 19, 22, 24; 35:21, 22; 36:3, 15, 20; 56:9; 57:9; 60:11; 63:19; 64:23, 24; 75:11; 90:18, 22; 92:20; 93:1, 5, 9, 11, 22, 22; 94:5, 8, 12, 20; 97:17, 20; 102:3; 106:2, 23; 107:1, 10, 16; 108:4; 138:6; 139:16, 20, 22; 140:1; 141:4; 146:24; 147:3, 4, 6; 148:11, 14; 149:20, 24; 150:5, 12; 151:3, 10; 152:11; 157:5, 9, 11, 22, 22; 158:3 lesions 36:4; 57:15; 61:11; 99:1, 21; 100:7; 101:19, 22; 147:16; 148:13, 19; 149:11, 12; 157:2 Leslie 4:10 less 55:14; 56:2; 95:8; 133:23, 24; 147:22; 160:12 lesser 118:8 letter 23:1, 3, 14, 20; 24:14, 24; 27:1; 40:17; 146:5</p>	<p>letters 40:12 level 37:20; 149:4; 151:7 levels 86:23 license 13:21 licensed 85:10, 14, 24 life 129:6, 13; 144:10, 11; 167:14 Lightly 51:2 likelihood 129:15 likely 56:22; 57:19; 95:8; 127:24; 128:8; 131:9 limitation 129:2 limitations 125:4, 11, 15 limited 88:23 limiting 90:12 tine 63:5 list 8:24; 11:17; 19:2; 40:10, 11; 166:23; 167:1, 8 lists 22:17 literature 25:10; 132:16 liters 51:8 little 11:20; 12:12; 39:24; 60:10; 62:13; 73:14; 98:19; 100:3; 128:22; 141:13; 152:23 live 28:6; 97:12; 146:4 local 113:18 location 21:21 London 55:17 long 14:14; 20:3; 35:9; 72:10; 89:20; 139:15; 140:2 longer 25:18; 26:4; 76:8; 106:14; 147:23, 24 look 37:1; 54:23; 55:19; 63:4; 71:19; 77:9; 78:18; 111:11; 116:8; 132:16; 148:20; 149:20 looked 46:22; 92:4; 97:1 looking 12:5; 57:7; 108:2 looks 22:24; 150:8 loose 128:21 lot 47:21; 55:15; 72:7; 149:14; 166:1 lower 95:24 lump 149:6 lumpy 149:8</p>	<p>102:24; 103:1; 151:1, 3 malignant 35:22; 46:12; 60:17; 157:11; 165:22 malpractice 5:20; 29:21 manage 51:10; 121:8; 160:7 management 63:6, 7; 64:14, 16; 76:7 many 5:7, 19; 6:2; 7:4; 12:13; 18:4, 6; 19:5, 24; 24:2; 43:3, 21; 52:18; 60:6; 86:21; 87:6; 95:3; 98:11, 17; 107:6; 111:13, 22; 113:19; 118:9; 125:20; 126:4; 128:18; 134:6; 157:5 March 23:3, 15 mark 11:1, 24; 166:11, 16 Mark's 55:16 marked 12:3; 168:15 mass 46:23; 47:8 Massachusetts 8:13; 13:21 Masses 48:14 mater 108:23 materials 24:3, 20, 21; 39:15; 165:2; 167:6 matter 40:12; 103:11; 111:1; 114:5; 115:15; 150:21 matters 24:2 may 9:4; 12:12; 32:1, 14; 36:23; 38:10, 20; 41:7; 44:23; 45:17, 19; 46:9; 54:18; 59:4; 60:11; 61:6; 62:3, 12; 64:2, 7, 8; 68:23; 75:3; 84:4; 90:12; 91:24; 92:23; 98:19; 99:11; 105:14; 109:24; 131:21; 136:18; 140:1, 2; 158:1; 161:7, 20; 164:2, 11, 13; 165:4; 168:8 maybe 68:11; 74:23; 80:6; 84:9; 87:3; 141:8; 162:16 mean 5:15; 22:5; 25:2; 36:17; 37:8; 38:14, 21; 40:9; 41:5; 46:7; 53:10; 61:22; 62:12; 63:8; 64:17; 75:16, 23; 79:12; 80:3; 81:19; 83:12; 88:9; 90:14; 93:16; 103:24; 109:8; 111:4; 123:2; 125:6; 133:4; 146:14, 23; 149:4; 154:18, 22; 159:24; 165:13 means 36:19, 19; 74:23; 108:9; 149:9, 12, 18 meant 148:18 mechanics 21:4 medical 5:11, 13, 20, 24; 6:14; 7:24; 10:5, 17; 12:14, 17, 19; 14:4; 22:6, 7; 25:7, 9; 29:20; 32:16; 33:6, 13; 40:20; 41:8; 91:14; 99:15; 108:16; 111:1; 112:21; 115:16; 119:10, 20;</p>	<p>122:22; 123:15; 125:19; 128:17; 139:24; 141:5, 6; 142:5, 10; 147:15; 154:19; 160:20; 163:13; 166:24; 167:9, 13 medicine 14:2, 13, 19; 84:5; 85:11, 14; 86:1; 87:10, 17 meet 44:24; 49:2, 6, 12; 103:7 meetings 11:16 memory 23:17 mention 32:19; 47:4; 73:20 mentioned 5:5; 18:16; 22:2; 28:7; 31:16, 17; 32:23; 33:17; 40:16; 43:21; 45:1; 59:4; 61:13; 63:23; 65:5; 66:23; 73:13; 139:12; 140:12; 141:19, 20; 145:3; 148:23 mesh 119:24 met 125:18 metachronous 147:8, 10, 16 methods 48:5 Michael 24:11 microscope 61:24 mid-1970s 22:1 mid-1980s 20:16; 87:3 middle 80:13 might 9:13; 14:22; 27:12; 34:23; 39:6; 48:2; 52:6; 57:23; 71:9; 78:5; 106:9; 111:24; 113:16, 18; 118:9; 120:1; 134:5; 139:23, 24; 141:4; 145:14; 146:6 miles 88:20 millimeter 108:6; 150:13 millimeters 100:2, 2, 2, 3; 129:21, 23, 23; 150:18 million 20:11 mind 31:15; 70:13; 86:14; 103:8; 104:20; 149:16; 156:11 minds 45:17 minute 146:17 misery 52:15 misleading 60:10 misquote 106:6 mistaken 83:17 misunderstood 13:3 mixed 152:5 moment 75:20; 92:11 moments 4:12 money 29:3, 4, 5 monitor 90:18 monitors 21:20 Montana 8:16, 18; 9:9 month 23:21 monthly 16:12 months 27:17; 147:7 More 6:4, 5, 7; 11:20; 20:8; 21:11, 14, 20; 24:20;</p>	<p>27:6; 37:22; 54:6; 55:19, 24; 57:15, 19; 71:4; 95:6; 112:17; 152:6; 164:2, 12 morning 82:18; 162:8, 8 most 20:18; 28:8; 45:18; 50:21; 51:9, 18; 64:10; 75:17; 126:19; 131:9; 145:4; 152:9, 16 mostly 75:9; 88:6 mouth 33:19 move 87:6 moved 88:11 movements 128:21 much 12:11; 15:6; 19:15; 21:5; 27:8; 53:2; 55:17; 71:4; 72:15; 86:9, 12; 87:4, 14; 94:3; 102:22 multilobulated 60:5; 61:10; 148:12; 149:9 multiple 104:23; 105:2; 153:11, 12 must 23:19; 52:16, 18; 113:15 myself 4:12, 23; 76:6</p> <hr/> <p>N</p> <p>name 4:8, 11; 10:12; 23:24; 29:11; 49:16; 67:5; 71:7; 120:11 namely 34:19 names 7:13; 8:21 National 15:10; 87:24 nature 45:12, 13, 14; 68:24; 117:1; 128:14; 133:14 nearly 88:19 necessarily 75:2 necessary 18:3; 39:6; 68:14; 69:14 need 30:19, 22; 32:15; 33:5; 47:6; 93:19, 23; 139:7; 140:23, 24; 166:20 needed 123:19; 135:21; 136:5 needs 21:12 neoplasia 150:23 neoplasm 91:1, 8, 21; 94:1; 165:22 neoplastic 63:21; 97:17; 139:18 new 21:8; 112:6 next 21:2; 35:18; 41:21, 23; 53:10; 71:8; 84:1; 97:11; 139:19 nine 129:21; 150:13, 19 nobody 51:8; 68:3; 106:2 nodes 48:11, 13, 13 nods 4:24 None 13:20; 65:8; 165:19 nor 35:21; 71:12; 113:12 normal 96:4; 100:6; 108:10; 157:7 northeast 10:9</p>
---	---	---	--	--

<p>note 62:11; 72:13; 156:9 notes 25:21; 26:1; 114:21 nothing 65:16; 77:12; 146:3, 14; 161:20; 166:14 notice 26:21 noticed 146:4 November 35:3; 91:4, 7, 10, 12, 13, 16; 92:3, 9; 95:11; 96:22; 97:1; 101:1; 103:6; 112:9; 116:17, 24; 130:22; 134:14; 135:23; 139:2; 156:10 nowhere 154:4 nuclei 62:1 number 5:19; 18:21; 52:5; 87:19; 120:21; 149:7; 150:18 numbers 55:11 NYU 108:16, 20; 111:17; 112:4</p>	<p>often 21:16; 25:21; 38:19; 44:22; 45:6, 11, 17; 49:4; 14:50:21; 58:11; 127:9; 138:22; 152:24 Ohio 10:9; 88:16; 89:4 old 53:18 once 25:22; 30:16; 68:23; 75:14; 78:12, 21; 79:1; 81:13; 106:14; 109:2; 141:1 One 4:18; 5:22; 7:6; 8:6, 6, 12, 12, 12, 16; 9:9; 11:20; 12:1, 13, 13; 13:10; 17:6; 18:12, 14; 21:12, 14, 14, 15, 20, 21; 28:12; 33:18; 34:5, 18; 40:12; 41:4, 15; 43:12, 17, 22; 47:23; 48:8; 49:13; 50:21; 52:22; 53:22; 54:1, 2, 3, 4, 9, 15, 15; 55:6, 20; 56:15; 58:6, 11; 60:1; 85:17; 87:21; 93:2; 94:19; 95:16; 97:11, 22; 100:5; 103:12; 105:24; 110:11; 111:9; 112:17; 113:5, 18; 115:17; 118:9; 119:22; 123:4; 124:21, 23; 129:15, 21, 21; 133:15; 143:6, 7, 7, 23; 145:4; 147:3, 6, 8; 149:6; 153:5, 6; 154:12, 15, 19, 23; 156:19; 157:7, 22; 158:9; 167:11 one-year 13:13 ones 50:5; 100:5; 113:7 ongoing 8:20; 9:3 only 17:15; 20:10; 24:21; 25:15; 26:16, 20; 30:12; 31:22; 47:14; 48:2; 87:21; 90:13; 100:4; 105:5; 116:4, 8; 118:10, 13; 124:23; 126:7; 135:19; 144:14; 146:7; 158:4; 160:18 onwards 89:8 open 43:16 operate 36:1; 41:18; 78:3; 163:14 operated 38:14; 47:21; 66:6 operating 66:19; 87:22; 163:21; 164:4 operation 35:18; 53:11; 117:21; 119:14; 121:3, 6; 124:15, 18; 127:23; 128:9; 138:14 operations 126:17; 132:15 operative 65:17; 124:10; 156:9 operator 21:10 opine 72:9; 74:3; 111:10; 118:14 opined 110:19; 112:8 opines 111:9 opinion 32:15; 33:5, 12; 37:8; 59:14, 15; 63:4; 69:6, 14; 70:14, 22; 75:22;</p>	<p>76:12, 13, 19, 20; 77:5; 78:5; 79:1; 89:18; 95:21; 96:3, 8, 14; 105:18; 109:4, 6, 8, 10; 110:8; 111:15, 24; 113:22; 119:18; 120:4; 122:21; 123:1, 14; 124:3, 16; 126:23; 127:5, 19, 20; 128:1; 129:5; 131:24; 132:11; 135:21; 136:16; 141:22; 142:4; 147:14; 153:23; 154:5; 155:3; 156:10; 158:15; 164:15, 18, 21; 165:6; 167:12 opinions 89:13, 16; 114:7; 115:8; 120:9; 122:11; 127:11, 17; 165:3, 7 opportunity 11:11; 71:18, 23; 78:8 opposed 12:10; 109:14; 132:13; 133:18 opposite 37:11 Optical 21:10 option 90:9; 103:22; 104:14, 18; 109:2; 110:5, 17, 20, 21; 113:16; 118:10, 14, 15; 131:7; 137:13; 138:1, 9 options 38:22, 23; 63:9; 90:12, 13; 112:18; 113:3, 6, 10, 19; 115:10, 22, 23; 116:8, 11, 13, 15, 18; 117:10, 13, 15, 19, 21; 118:9, 16; 135:18, 20, 21; 136:5; 139:21 oral 102:16 order 13:20; 136:6 organ 145:14; 165:13 organizations 86:9 original 40:19; 120:6; 128:9; 129:11 originally 61:4 others 8:3; 18:23; 93:2; 116:9; 119:5 otherwise 30:8; 79:2 out 20:9; 23:1; 26:7; 31:5; 36:20; 46:15; 49:21; 63:20; 68:13; 72:8; 81:8; 92:4; 93:22; 101:13; 102:4; 105:9; 108:3; 117:3; 136:21; 137:10; 138:6; 152:18; 157:4, 7; 161:12; 163:4; 165:22 outcome 134:5 outpatient 18:19; 89:10 outside 7:14; 75:18; 84:15; 110:8; 130:16, 19 over 9:24; 10:3; 18:1; 28:14; 49:24; 53:15; 102:16, 20; 103:4; 140:1; 151:21; 153:17; 154:8 own 25:18; 29:23; 52:4; 126:1; 138:14</p>	<p>P p.m 168:18 page 4:20; 37:3; 67:7, 23; 69:4, 5; 71:9; 72:15; 74:8 pager 36:7 paid 28:14 pain 52:14 painful 51:21 pancreas 19:10 pancreatitis 123:21; 124:5 paragraph 37:4; 63:4; 67:19, 21; 71:8; 72:15; 74:7 paraphrase 89:23 part 16:2; 27:7; 34:7; 86:9 partial 64:20, 22; 104:1 participant 161:6 particular 22:19; 32:2; 38:11; 72:5; 98:4; 151:10 particularly 19:22; 28:7; 49:13; 55:16; 76:11; 82:9; 86:21; 98:18, 19; 128:21 parties 49:11 partly 39:5; 88:9; 93:7 Parts 24:11; 107:13; 157:2 pass 13:23; 75:23; 166:17, 21 past 83:20 pathologic 137:22 pathological 61:23; 150:1, 9 pathologist 92:4; 102:20; 103:4, 15; 108:7; 149:24; 150:14 pathologists 62:6, 8 pathology 35:9, 20; 38:2; 39:2; 44:17; 45:13; 46:2; 47:1; 48:10; 56:7, 21; 58:2; 59:5; 60:7; 63:1; 65:12, 21; 66:19; 68:24; 72:21; 77:4, 9; 78:18; 95:12; 97:18; 98:1; 102:2, 16; 103:9, 11; 104:10; 105:13; 106:1, 14; 107:6, 10, 15, 17, 23; 108:3, 4; 109:3; 110:3, 4, 11; 112:8; 115:11; 116:17; 130:16, 22; 135:12; 137:24; 152:3, 23; 155:4; 158:8, 18; 159:10, 13, 16; 160:13, 14; 162:6 pathways 12:13 patient 7:13, 15; 9:10, 15; 30:16; 31:15, 18, 23; 32:6, 11; 33:22; 34:4; 35:8, 11; 37:15, 17, 22; 38:1, 10, 11, 12, 14, 15; 39:7, 10; 41:10; 44:16, 22, 24, 24; 47:10; 48:1, 18; 49:1, 4, 7; 50:2; 51:14; 52:8, 12; 53:1, 14, 18, 21; 56:4, 12; 58:1, 20; 59:3, 4, 9; 62:23; 64:21; 66:5, 9, 20; 69:7, 14, 24;</p>	<p>70:21; 71:1, 12; 74:20; 75:21, 24; 76:13, 16; 77:2, 10, 15, 23; 78:2, 6; 79:2, 9, 10, 23; 81:13, 15, 18; 82:5, 14, 20, 23; 83:4, 9, 22; 84:16; 89:6; 90:3, 8, 8; 95:23; 97:16, 19, 23; 98:3; 101:18; 103:6, 19, 21; 104:12, 23; 105:13, 16, 19; 106:7; 109:2; 110:5, 5, 12, 14, 20; 112:10, 11, 14, 19; 113:6; 116:7; 120:16; 133:2; 134:3; 135:3; 137:16; 138:8; 139:7, 13; 143:14; 148:2; 153:18; 154:8; 155:5; 156:11; 158:13; 159:1, 10; 161:6, 8, 19; 162:9, 11; 164:4 patient's 33:1; 45:13; 76:7; 96:16; 135:1; 138:13; 161:16 patients 15:16, 22; 18:1, 16, 20; 39:1; 41:5, 16; 42:16; 46:1; 47:19, 21; 49:18; 51:3, 9, 18; 52:6, 16; 58:14; 67:14; 81:21; 82:8; 87:20; 98:17; 99:9, 9; 100:10; 126:19; 128:20; 134:6; 143:4; 147:18; 152:16 Pause 145:16; 146:19 people 20:11, 20; 96:10; 159:19 per 27:2 perceive 148:17 percent 6:19; 15:23; 16:19; 19:17, 19; 54:21; 55:8; 94:17, 18; 123:16; 132:22, 24 percentage 6:15, 16, 22; 15:20; 54:16; 94:7; 147:17 perfectly 59:19 perforation 7:18; 143:21 perform 17:23; 18:23; 19:6; 20:14; 25:6; 31:2; 36:22; 39:12; 41:4, 15; 42:13, 23; 43:24; 44:4, 8; 47:20; 48:21; 54:12; 56:13; 84:5 performed 32:5, 11; 34:13, 14; 35:2, 18; 37:6; 42:8; 43:1; 55:17; 89:20; 122:17, 24; 146:22 performing 19:16; 20:16; 21:24; 65:22; 88:2 Perhaps 30:5; 79:15, 17; 115:2; 119:22; 142:10 period 27:18; 84:17; 136:10; 140:2; 160:12 periods 27:20 permanency 126:23; 127:6 permanent 13:21 permanently 13:5 persistent 126:10 person 21:12, 14, 15; 47:6; 59:13; 77:19;</p>
--	---	--	---	---

129:14, 17
personally 29:14; 125:23
personnel 163:24;
 164:15, 22
Peter 4:11
phobia 96:3, 5, 7
phobic 96:14
phone 23:2, 8, 13;
 102:17, 21; 103:4
photographs 94:8;
 149:1
phrase 32:14; 41:17
physician 5:18; 9:5, 12;
 15:9; 25:12; 36:5; 60:7;
 75:19, 24; 76:4; 77:23;
 79:21; 82:4; 108:24;
 114:15; 138:3, 9; 153:15
physicians 16:6; 17:23;
 18:6, 8, 10, 13; 24:17;
 86:5, 17, 18; 157:13;
 160:5; 163:24; 164:13
pick 72:8
picture 148:23
piece 21:13; 93:20
place 32:10; 35:12;
 37:15, 21; 49:2; 51:24;
 52:3; 53:12; 80:8; 82:10;
 85:24; 97:19; 98:21;
 101:6, 6; 124:18; 125:17;
 152:10
plaintiff 7:5, 19; 8:12;
 9:10, 15
plaintiff's 112:4
plaintiffs 6:15; 10:19
plan 146:10
planned 39:17; 40:23;
 78:13
plans 145:24
play 135:2; 136:14
played 136:21
pleasant 51:12; 99:22
please 4:9, 22; 19:3; 23:6;
 36:9; 73:19; 145:19; 165:4
plus 18:21
point 20:9; 23:16; 30:13;
 37:9; 45:7; 78:24; 91:5;
 92:6; 103:3, 22; 104:15;
 145:18, 21; 151:11, 13;
 158:23
policies 163:7; 164:13
polyp 30:15; 35:23; 46:9,
 12, 23; 53:22, 24; 54:9, 11,
 14, 21; 56:7, 20, 23; 57:14,
 23; 58:6; 59:5; 60:1, 15;
 61:1, 11, 16; 62:19; 63:11;
 64:6; 65:10; 67:15; 68:2, 6,
 14, 19; 71:14; 72:23;
 73:15; 74:9, 18; 75:5;
 95:13; 97:15; 104:21;
 108:6, 6; 110:15; 113:17;
 117:2; 129:15, 16; 130:11;
 140:7; 141:11; 142:9;
 146:21, 21; 149:5; 150:13;
 152:18; 157:8
polypectomy 67:16;
 94:15

polyps 34:18; 35:1; 46:3,
 5, 7, 8, 14; 48:11, 14; 54:4,
 6; 55:4, 11, 20, 23; 56:2, 6,
 15; 57:8, 18, 22; 58:5, 17,
 22; 63:11; 64:8; 69:23;
 92:21; 96:23, 24; 99:24;
 100:13, 18; 104:23; 105:2,
 3, 4, 6, 17, 17; 116:24;
 117:2; 129:18, 24; 130:2,
 6; 138:20; 139:10, 11, 14;
 140:4; 141:14; 142:12, 14;
 143:12, 13; 144:15; 145:6,
 11; 147:1, 13, 18, 19;
 148:4, 6; 151:8; 153:4;
 157:4, 7
population 20:11; 130:4
portion 93:13; 94:6
pose 158:22
posed 112:24
position 15:8; 79:18;
 83:10; 84:13; 101:12;
 155:9, 14; 160:10; 164:18
positions 84:11
possibility 34:22; 64:2;
 95:4
possible 21:13; 62:20;
 64:22; 80:7; 121:10;
 122:18; 130:13; 157:11,
 14
Possibly 6:6; 47:7; 143:8
post 121:17
postoperative 118:21
potential 60:18; 96:3, 17;
 97:4; 144:2; 148:6; 152:7,
 14; 153:3
practice 15:4, 14; 16:13,
 20; 19:1, 15; 25:19; 29:8;
 45:11; 67:13; 82:7; 85:11,
 14, 24; 86:11; 88:3; 100:9;
 143:5; 154:19, 22
practiced 8:4
practicing 15:2; 87:7;
 88:19
practitioners 163:14
precancer 98:11, 13
precancerous 34:23;
 95:14; 99:2, 14, 21;
 100:14; 101:2, 3, 19, 22
preceding 23:2
precisely 92:6
preclinical 22:15
predict 129:12
Predominantly 6:18;
 15:14
premalignant 35:21;
 64:6; 65:10; 67:15; 68:2, 6,
 14, 19; 71:14; 72:23;
 73:15; 74:9, 18; 75:5;
 95:13; 97:15; 104:21;
 108:6, 6; 110:15; 113:17;
 117:2; 129:15, 16; 130:11;
 140:7; 141:11; 142:9;
 146:21, 21; 149:5; 150:13;
 152:18; 157:8
preoperation 35:14
prep 53:9
preparation 49:23, 24;
 50:3, 18; 52:2; 53:15;
 144:3
preparations 50:15
prepared 89:16
prepped 53:1
prerogative 74:5

presence 34:17; 40:3;
 62:12; 150:22
present 35:6; 36:4;
 60:12; 95:9; 101:19, 23;
 150:24
presentation 64:1
presentations 22:18
presented 34:5
presumably 84:23; 90
 153:2; 161:14
presume 55:2; 160:5
pretty 12:11; 36:18;
 50:20; 53:2; 121:3
previous 58:10; 100:8;
 164:6
previously 28:8; 135:17;
 158:20
primary 22:9; 60:6;
 79:21; 124:15
principal 27:24; 143:20,
 22
principally 16:18; 17:17;
 62:1; 125:20; 163:20
Printed 102:6, 8; 110:1
prior 23:16; 27:23; 32:11;
 49:18; 50:5; 64:1; 65:8, 22;
 66:11; 85:13; 86:13; 87:6;
 135:22
private 81:23; 82:6, 7;
 88:2
privileges 5:18; 9:6;
 85:19; 163:14
probability 33:7; 122:4,
 23; 123:15; 132:1; 133:13;
 145:7; 147:15
probably 6:8; 18:20;
 19:17; 20:8; 26:2; 28:4;
 32:20; 76:10; 84:18;
 87:11; 97:16; 122:5;
 130:13; 131:15; 150:8;
 152:8; 166:1
problem 121:9; 126:20;
 128:23; 146:5; 162:16
problems 127:6; 133:12
procedure 7:16; 19:18;
 31:3, 12; 48:4; 50:4; 71:6;
 82:9; 98:20; 109:14;
 115:13; 118:8; 143:18;
 147:3; 164:7
procedures 18:17, 21,
 24; 19:22; 31:5; 42:17;
 43:11, 14; 85:23; 137:9;
 143:16, 24; 163:7
proceed 35:13
proceeded 92:8
proceeding 109:12
PROCEEDINGS 4:1
process 27:7
produce 25:17, 20;
 26:17; 27:6
produced 25:23
profession 129:1
professional 15:21;
 86:9; 89:7
profuse 126:1

program 17:4, 11, 12;
 29:18; 108:16; 111:16, 17;
 112:3
progressed 151:12
progression 152:15
propensity 153:7
proper 135:7, 24
proportion 94:12
prosecuting 87:14
protrusions 149:20
prove 123:20; 124:7
provide 29:8; 31:9; 36:14
provided 24:20; 25:9;
 135:9
provides 10:18; 17:23
providing 18:2; 32:2, 24;
 33:18, 21; 34:1; 75:10
provisional 85:19
proximate 126:13
proximately 122:16;
 124:5
psychiatric 96:15
publications 11:15;
 22:17
published 143:23
pulled 23:1
pulmonary 17:24
purely 139:23
purpose 49:15
purposes 29:13; 118:11
pursued 55:24; 115:24
put 33:18; 49:4; 84:10,
 13; 111:2; 137:4

Q

qualified 89:3; 119:23;
 120:4, 8
qualify 56:24
quality 21:16
questioned 164:8
quickly 11:11
quite 20:19; 34:11; 37:11;
 55:15; 67:12; 111:24;
 140:19; 152:22
quote 61:8
quoted 69:23

R

raised 94:22; 105:24;
 149:4
raising 64:1
range 50:5
rare 130:13; 144:4
rate 27:4; 132:18, 19
rates 132:17
rather 64:14; 147:22
rational 135:10
reached 151:11
read 24:3; 30:2; 60:21;
 63:12, 13; 66:23; 67:11;

69:16; 70:12; 71:23;
 72:12; 73:23; 78:8; 80:16;
 102:12; 109:6; 125:24;
 150:3; 167:19, 20, 21, 22;
 168:13
reading 61:14; 74:12;
 96:2; 168:12
real 96:18; 97:4
realistic 116:2, 5
really 16:19; 49:11;
 57:14; 63:18; 107:18;
 111:6; 150:21; 157:22
reason 37:23; 44:21, 22;
 49:11; 53:6, 16; 54:3; 59:6;
 68:4; 73:21; 141:4; 161:12
reasonable 32:16; 33:6,
 12; 43:10; 44:10; 58:1;
 63:9; 66:21; 77:2, 5, 7;
 79:4; 122:22; 123:15;
 142:5; 147:14; 158:14;
 162:2; 167:13
reasonably 51:10; 94:20
reasons 48:9; 52:5, 22;
 73:11
recall 7:11; 10:10; 23:19;
 39:21; 40:15; 48:1; 51:1;
 60:4, 13, 24; 61:3, 14, 18;
 63:22; 69:22; 92:16; 96:9;
 104:7; 128:18; 157:1
receive 18:22; 23:8;
 102:20
received 51:2
recent 20:18; 147:21
recently 20:20
Recess 36:11; 80:12;
 145:22
reciting 114:1
recognize 87:1, 8;
 153:19
recollection 23:7; 112:7;
 114:20; 115:9; 124:13
recommend 95:18;
 131:6
reconcile 161:16
record 4:8; 11:8; 77:13,
 16; 80:19; 96:6; 128:17;
 154:10; 160:20; 168:8, 11
recorded 34:17
records 9:1; 24:6, 8, 10;
 26:9; 31:16; 32:9; 34:4;
 39:15; 40:20; 42:5; 90:21;
 98:8; 121:21, 23; 125:19;
 154:4
RECROSS 163:1
rectal 34:5, 10
rectum 55:20
REDIRECT 156:4; 166:8
reduces 139:12; 145:5
refer 48:9; 58:1; 59:4, 8,
 12; 62:23; 66:9; 67:7, 14;
 69:14; 77:2; 78:2
reference 24:14; 82:4
referral 10:18; 30:17;
 31:19; 44:23; 46:24;
 52:23; 71:12, 17; 74:22;
 75:14, 22; 78:12, 21; 81:5,

14;82:14;83:5;161:24 referrals 18:22 referred 37:4; 38:1; 39:1, 9; 44:15; 46:1; 58:14, 20; 66:5; 69:7; 82:5; 158:12; 159:1 referring 43:14; 50:3; 59:18; 61:1; 75:1, 1; 77:22; 82:16, 17; 88:2 refers 23:15 regard 34:3; 95:23; 108:24 regarding 89:14, 22; 96:8, 17; 127:12; 135:1, 12, 14; 136:13; 146:21; 154:6 regardless 95:3; 128:3 registered 10:17 regular 154:18 regularly 76:15; 160:6 Rehabilitation 24:9 reiterating 73:23 relate 22:19 related 122:17, 23; 124:6, 14 relates 127:13 relatively 127:23; 133:20; 139:10 relevance 106:21 relevant 48:3; 74:19; 113:20 reliable 168:2 rely 66:1, 18; 77:8; 158:17 relying 69:19 remain 6:21; 127:10 remainder 142:11 remained 101:21 remaining 74:17 remember 8:18, 21; 61:18; 99:24; 108:5; 155:11; 156:19 remembering 51:18 remote 21:21 removable 68:3; 73:9 removal 64:14, 19, 20, 22; 69:1; 123:8; 145:5 remove 46:14; 59:6, 7; 61:1, 16; 68:2, 14, 16, 19; 73:3; 93:20; 94:17, 18; 97:15; 100:12 removed 35:2; 47:8; 58:12; 64:10, 24; 67:16; 68:5; 72:23; 73:7, 9, 15, 21; 74:9; 94:13; 97:18; 99:1, 21; 100:1, 4, 8, 11; 101:19; 117:1; 123:11; 129:24; 130:7; 134:2; 137:18, 20; 139:11; 145:11; 148:4; 150:12; 151:4, 14, 16; 153:6; 157:3; 166:14 removes 79:20 removing 113:17 render 120:4, 8; 164:15, 18	rendering 122:11; 124:3; 127:11, 17 repair 119:24; 121:12; 132:8 repeat 52:13; 90:17; 93:8, 9; 94:3; 95:19; 112:20; 135:15; 136:19; 137:8; 138:2, 4, 4, 22; 140:9, 21; 145:8; 154:13 repeated 140:1 report 24:4; 25:15; 26:11, 15, 19; 27:6; 29:24; 30:2; 35:9, 20; 37:1; 60:3; 61:4, 8, 63:3; 65:17; 66:24; 67:8, 22; 69:4, 23, 23; 70:20, 23; 71:9, 19; 72:8, 12; 73:5, 21; 74:4; 78:18; 91:11, 16; 102:2; 103:13, 14; 105:13; 107:18, 23; 108:3; 110:13; 112:9; 115:11; 116:17; 135:12; 141:19; 148:10, 19, 21; 149:10; 150:5; 160:14 reported 74:16 reporter 4:23; 145:17; 168:8 reports 25:3, 4, 22; 38:2; 44:17; 162:6 represents 139:22 reproduce 149:1 reproduced 94:9 request 26:17; 37:14 requested 31:3; 36:22; 111:21 require 42:11; 68:15; 69:1; 73:7; 140:1, 2; 141:2; 158:3 required 7:17; 13:13, 15; 18:21; 22:16; 36:23; 37:20; 45:7; 48:4; 50:1; 73:22; 88:5, 14; 90:24; 93:6; 97:21; 123:8; 140:17, 21; 142:16; 156:12 requires 41:3; 45:3; 66:14 requiring 126:17 research 15:15; 25:7, 10 resect 57:24; 93:10, 23 resectable 90:23 resected 65:1; 97:1; 107:24; 153:5 resection 35:15; 36:23; 43:22; 53:10; 91:1; 93:24; 104:6; 113:18; 122:19; 141:20; 157:18 residency 13:9, 16; 17:11; 108:16; 111:16; 112:3 resident 82:7 residents 16:7 resolve 121:5 respect 49:20; 109:6; 120:3; 132:22; 147:1; 152:20 response 82:1	responsibilities 15:24; 16:5, 24; 22:4 responsibility 16:22; 22:9; 30:16; 31:2, 8, 18; 33:22; 36:5; 75:12, 13, 19; 76:7, 16; 77:19, 22; 78:22; 79:2, 21; 82:8; 83:6, 22; 159:15, 20 responsible 18:2; 161:14, 15 rest 63:12 restrain 118:3, 5 result 7:16; 125:4, 16; 126:13; 159:10 resultant 125:5 results 40:2; 65:22; 77:3; 90:4, 6; 91:6; 92:10, 18; 95:12; 103:12; 104:10; 109:3; 112:8; 130:15; 133:19; 155:4, 8, 13, 18; 159:14; 162:7 retain 29:15 retrospect 91:3; 121:7; 158:4, 6, 7 revealed 157:2; 160:18 Reverend 24:8; 40:2; 50:23; 53:17 review 23:11; 26:18; 27:2, 7; 29:3; 40:7; 124:10; 165:2 reviewed 6:3, 14; 10:14; 39:15; 40:10; 68:11 reviewing 5:23; 25:7, 13; 26:24; 28:1 reviews 11:9; 23:9; 27:14; 61:7; 67:24; 74:14 revoked 9:6 revolve 163:18 ridiculous 114:10, 13 right 10:11; 14:1; 15:1; 22:14; 29:23; 32:13; 36:13, 17; 39:5; 40:18; 46:13; 47:4; 48:2, 8, 12; 52:17; 63:7; 66:6, 18; 70:1; 71:1, 13, 18; 74:12; 79:6; 81:10; 102:1, 8, 14; 104:2; 109:21; 114:15, 18, 21; 115:14; 116:14; 130:18; 131:3, 17; 132:13; 133:18; 134:2, 6, 16, 21; 142:7; 158:16, 17; 161:22; 167:20, 22, 23 risk 54:6, 10, 13, 16, 21, 22; 110:16; 130:1, 5; 134:22; 139:13; 143:18, 20, 22, 22; 144:12, 14, 17, 24; 145:1, 5; 147:19, 22; 148:5; 150:9; 151:7, 15; 153:7 risks 42:16; 43:11, 20, 20, 23; 44:11; 138:16, 19; 143:16, 19; 144:1, 2, 5 role 135:2 room 21:21; 163:22; 164:5 rough 25:17, 20 Roughly 5:7; 56:4, 13	rule 97:11 rules 4:18; 28:11 runaway 39:19 running 18:2	sentence 63:12; 67:10, 19; 69:5; 74:5, 5; 81:1 sentences 72:7 separate 68:23; 149:12 sequence 12:12; 31:10; 68:11; 161:21 series 55:10 serve 166:24 served 167:9 service 10:18; 15:10; 19:23; 83:16; 88:1 sessile 67:15; 72:23; 108:6 set 11:6; 109:9 setting 22:6, 13, 15 seven 18:11 several 22:17; 48:24 severe 61:21; 126:20; 150:14; 151:11, 12, 22 severely 128:19, 22 severity 152:19 shall 81:10 shame 148:24 short 145:19; 158:24 shortly 33:2; 35:8 shouldn't 38:21 show 34:4; 103:1 showed 35:20; 102:24; 157:17, 19 showing 74:17 shown 142:15; 147:21; 160:21 shows 79:14; 94:19 sided 71:14 sigmoid 55:21 sigmoidoscopy 19:7; 31:6; 34:12; 54:12 sign 79:11; 104:7; 168:14 significance 150:15 signing 168:12 similar 10:6; 62:7; 86:12, 15, 23; 131:21 similarities 86:21 simply 153:10 single 54:11; 93:20 sit 166:1 site 124:13 sitting 21:22; 111:4 situation 21:6; 47:22; 48:2; 57:21; 59:13; 78:23; 79:24; 84:8; 87:5; 88:12; 99:13; 101:1, 13, 22; 113:19; 116:6; 120:24; 126:24; 127:1; 137:15; 139:1; 153:15, 24; 154:5; 155:2; 158:22; 161:19; 163:9, 12 situations 45:2; 48:7; 68:18; 75:17 six 12:18; 18:9, 12, 14; 27:19, 22; 34:17; 69:24; 105:4, 6, 17; 108:5; 129:22; 157:2 size 34:20; 54:1, 11, 15;
--	---	--	--	--

55:23; 56:16; 57:8, 12;
58:7; 68:22; 140:7, 13, 17,
22; 149:15; 152:8, 8, 8, 12
Slezak 24:22
slightly 74:23; 77:21
small 54:5; 55:23; 99:24;
100:5; 120:7, 17, 22;
121:12; 123:22; 124:8, 12,
16; 126:14; 139:10;
143:17; 149:21
smaller 50:19; 54:4; 56:1;
149:14
snare 67:16
socialized 87:17, 20, 22;
88:1
society 10:18
sole 64:17
solely 69:20; 70:22
solution 50:16; 51:9
solutions 50:20
somebody 75:21; 83:12;
111:5; 137:19
somehow 96:14; 148:13
someone 45:18; 109:4;
146:18
something 37:21; 41:9;
46:8; 50:7; 51:2; 56:11;
71:4; 73:8; 80:14; 84:9;
99:5; 106:5; 108:8;
129:23; 137:17; 140:19;
143:23; 159:21; 165:21
sometime 82:15
sometimes 21:14; 28:9,
12:60; 18; 147:6, 7;
149:22; 152:5, 17
Somewhere 6:9; 54:22;
57:9; 137:4
soon 54:9; 121:3
sorry 14:22; 15:12;
21:23; 24:16, 24; 27:15,
16; 40:15; 43:8; 84:12;
107:2; 116:3; 154:13
sort 36:1; 50:4
sought 76:14; 161:24
sound 106:9
sounded 70:3
sounds 36:7; 70:20;
82:10; 106:11
source 79:13
sources 152:4
space 26:8
speak 77:24
specialty 19:13
specialties 76:1
specialty 14:5
specific 74:1; 114:19
specifically 18:22;
43:11; 59:23; 148:2
specify 131:12
specimen 157:18
spectrum 133:12; 142:2,
8
spend 16:18
spent 13:10; 19:18; 27:8,

23
split 21:13
spoke 137:7
spontaneously 130:10
staff 81:19, 21; 82:6;
91:14
stage 59:9; 130:23;
150:23, 24; 151:3; 153:1
stages 151:20; 152:17
standard 32:23; 41:2, 7,
13; 42:10; 43:9; 59:12;
62:22; 64:18, 21; 65:3;
66:13; 67:13; 68:15; 73:6;
75:7; 78:20; 79:4; 81:12;
84:3; 86:4, 14; 87:2, 9;
88:5, 14; 89:4, 14; 100:9,
15; 102:19; 103:8, 21;
104:13, 19; 105:19;
106:15; 109:1; 110:6, 8;
111:9; 112:13; 115:17;
116:1; 117:20; 118:16, 24;
130:16, 19; 143:5; 148:7;
159:7; 161:8; 162:12, 19
standards 30:20, 23;
32:17; 33:10, 14; 82:22;
86:10, 16, 18; 99:15;
101:4; 119:10, 21; 164:16
standing 146:3, 15
start 20:23; 21:23; 139:4,
5
started 20:16; 117:12
state 4:8; 8:15; 37:7; 82:3;
85:11, 14; 86:1
stated 33:11, 20; 35:16;
40:1; 58:10; 73:8; 101:18;
125:12; 154:9
statement 68:1; 69:9, 17;
70:24; 71:15, 17; 72:5, 11,
22; 73:4, 10; 74:9, 13, 16;
78:9; 90:20; 91:18; 99:3, 6,
8; 100:23; 107:23; 115:20;
126:1; 133:3; 152:1;
156:9; 162:24
statements 72:2; 74:2,
15, 21
States 7:20; 8:1, 8, 11;
9:15, 19; 12:10; 13:4, 7,
12, 19; 14:5, 9, 23; 85:11,
15; 86:1, 5, 17; 87:6; 88:7,
12; 155:15
step 30:6, 7; 139:19
Stephen 24:8
steroids 141:8
still 8:20; 10:2; 20:20;
26:5; 44:24; 54:7; 55:15;
57:15; 76:6; 82:21; 83:10,
24; 84:2; 91:7, 18; 101:21;
115:24; 117:2, 4; 123:7;
126:3; 134:21; 161:5, 15;
162:11
stop 32:13; 73:24; 75:20;
80:10; 121:23; 125:19
stopped 40:14
store 26:8
stretching 51:24
strictly 74:19; 113:20
studied 54:8

studies 54:19
stuff 163:8
subject 80:23
subjects 80:23
subsequent 31:7, 12;
72:20; 95:17; 118:20;
119:18, 19; 124:4; 126:4;
128:7; 131:15; 132:6, 8;
134:3; 144:6, 8; 151:8;
165:2
subsequently 32:5;
35:20; 36:20; 61:19;
66:10; 119:13; 123:17, 19;
139:18; 142:15; 145:10;
147:19; 157:16
substantiated 63:17;
126:7
subtotal 35:16; 104:2;
11024; 115:15; 116:14;
117:11, 22; 118:10, 13;
126:8; 130:15; 131:10, 11;
132:13; 133:18; 134:17,
20
successfully 139:11;
145:6
sued 29:20
suffered 63:24; 119:19;
125:5, 22; 126:12, 14;
131:13; 132:9
suffers 126:3
sufficient 31:11; 54:23
suggest 90:22; 145:9
suggested 65:17; 126:6;
147:21
suggesting 39:18;
107:7; 110:21; 137:16, 21
suggestion 105:13
suggestive 107:11
suggests 69:15; 144:11
suits 87:14
summarizes 30:18
superficial 141:16
support 29:13; 40:21
suppose 55:3; 134:18;
153:12
Sure 11:23; 24:1; 32:3;
33:1; 36:10; 40:8, 18;
46:17; 47:17; 48:23;
49:23; 51:14; 59:9, 21;
77:6, 19; 80:11; 91:7;
93:21; 94:5; 96:21; 98:15;
106:21; 111:21; 125:9;
135:18; 165:8; 167:11
surgeon 37:16; 38:2, 11,
13; 39:10, 11, 19; 41:4, 15,
18; 42:13, 21; 43:13;
44:12, 16, 23; 45:10, 21,
24; 46:24; 48:9; 49:2, 5,
13; 52:23; 58:1, 15, 21;
59:13, 17; 60:5; 62:24;
65:20; 66:1, 6; 71:12, 17;
75:2; 76:20; 77:3; 78:2;
80:4; 82:16, 17; 89:4;
105:21; 106:8, 13, 15, 20;
108:18; 109:1; 111:10;
112:13; 115:16, 24;
116:16; 120:10; 159:17;

163:21
surgeon's 49:16
surgeons 39:2; 46:2;
89:9; 111:23; 121:4
surgeries 115:18; 120:7,
9; 126:4
surgery 7:17; 32:11;
35:14, 14; 36:1; 37:5, 10,
16, 17; 39:6, 12, 17; 40:4,
24; 41:4, 15; 42:7, 13, 23,
24; 43:1, 4, 5, 15, 16, 19;
44:1, 5, 13; 45:9, 17, 22;
47:6, 7, 11; 52:24; 53:4;
59:19; 64:8; 65:1, 22; 66:4,
11; 67:14; 69:8, 15, 20;
70:4, 16, 21; 72:20; 73:22;
74:22; 75:1; 76:9, 21;
77:10, 15, 20; 78:14, 16,
19; 81:8; 82:21; 88:24;
89:6, 13, 17, 19, 22; 90:3,
9; 92:8, 12, 17; 103:7, 20;
104:1, 15, 18; 105:19;
106:7, 13, 16; 108:16;
111:17; 112:5, 11, 14;
113:5; 115:10; 117:10;
119:2, 4, 11, 17; 120:6, 16,
17, 20; 121:12, 18; 122:3,
4, 17, 24; 123:17; 124:6,
22, 24; 125:1, 5, 16;
126:13; 128:4, 7; 129:11;
133:10; 134:11, 12, 13, 24;
135:1, 2, 6, 13, 15, 23;
136:2, 7, 13, 15, 20;
137:11, 13; 138:5, 10;
139:3, 24; 141:21; 144:9,
20; 155:5; 156:12; 158:3,
19, 22; 159:11; 160:16;
162:9, 11; 164:9
surgical 30:17; 31:12;
32:7; 33:1; 35:5, 13; 36:22;
37:22; 42:16; 44:11;
59:15; 64:19; 69:13;
88:23; 103:22; 104:3;
109:2; 110:5, 17, 21;
113:16; 120:23; 132:16;
158:16
surgically 32:5
surprisingly 51:9
surrounding 149:5
surveillance 63:5; 64:12,
13; 90:16; 138:16, 20;
140:2, 3, 14, 17, 19;
147:20
suspect 108:17, 19
suspicion 36:19; 58:16
suspicious 44:21; 46:4,
6, 23; 48:11, 22; 58:22;
64:23, 23; 113:17
switch 21:1
sworn 4:5
symptoms 34:5; 125:20
Synchronous 54:24;
55:2; 146:23; 147:5
system 12:9; 15:7; 41:8;
50:9; 87:13, 21, 22; 88:1

T

taboo 49:8
talk 26:14; 47:15; 59:23;
168:9
talked 48:8; 75:9; 98:16;
146:5; 153:13
talking 36:13; 47:13;
52:23; 53:11; 55:1; 59:21;
95:10; 99:24; 100:7, 18;
111:4; 113:7; 137:14;
151:23
taste 50:13, 16
tasteless 50:20
tastes 50:11, 12
taught 22:8, 11
teach 19:6; 22:12
teaching 15:24; 16:4, 24;
21:6; 22:4
team 16:6
technical 89:19
technique 89:19; 94:14
techniques 19:11; 44:11;
57:5
technological 21:2
technology 21:8
telephone 23:15, 18
television 21:20
telling 70:19; 79:19;
82:11; 83:12; 99:10;
106:1; 136:8; 137:11;
155:17; 160:23
tells 149:24
ten 6:1; 20:24; 27:16
tendency 62:9
term 14:17; 61:23; 62:7;
64:16; 91:19; 140:18;
150:1
termed 15:9
terminology 87:9, 12
terms 74:4; 81:13; 87:9;
148:15; 150:9; 153:20;
159:7
terrible 161:18
testified 4:5; 9:14, 17;
109:18, 20, 24; 110:3;
111:5, 21
testifies 155:7, 12
testify 9:24; 10:3; 28:5;
146:4
testifying 5:12; 29:16
testimony 24:22; 25:1, 2;
28:20; 29:9; 88:4; 111:18;
112:7; 114:4, 6, 6, 16, 17,
17, 19, 24; 115:9; 119:23;
138:7
themselves 119:1;
151:15
therapeutic 19:5, 8, 11
therapy 64:7
therefore 41:19; 83:5, 14;
93:5; 110:16; 126:7;
160:20

<p>They're 15:8; 52:6; 54:5; 58:12, 12; 79:11; 97:20; 98:18; 100:10; 129:15; 132:15; 137:19; 148:16; 152:5; 153:1; 160:1</p> <p>they've 20:21; 53:4; 97:23</p> <p>thin 149:20</p> <p>thinking 70:11; 150:8</p> <p>third 55:4; 56:8; 146:21</p> <p>thirteen 120:16; 126:2; 127:22; 128:21; 129:9; 134:7</p> <p>thirty 6:5, 9, 13</p> <p>Thomas 24:23; 66:24; 67:3; 69:4; 71:9, 19; 72:12; 74:22; 108:11; 112:1</p> <p>though 43:18; 45:19; 73:13; 88:19; 89:12; 112:16; 161:20</p> <p>thought 46:23; 57:23; 58:22; 73:16; 118:7; 130:12; 137:23; 139:17; 164:3</p> <p>thousand 148:24</p> <p>thousands 52:18; 143:2, 4</p> <p>three 7:24; 8:7; 12:17; 17:7, 8; 27:2; 33:20; 50:14; 115:18; 118:6; 142:17, 22; 154:12, 15; 167:19</p> <p>three-hour 27:17</p> <p>throughout 6:22; 34:18; 89:7</p> <p>throw 26:7</p> <p>Thursday 81:7; 82:20; 83:1</p> <p>times 5:7; 33:20; 39:9; 51:21; 60:6; 87:6; 98:12; 111:13; 118:7; 126:2; 128:18; 157:5</p> <p>timing 32:19; 37:19; 120:20</p> <p>tissue 62:5; 93:13, 20; 94:4, 19, 23, 23; 100:6; 107:24; 108:8; 149:5, 6; 157:7, 20; 159:18</p> <p>Toby 40:14; 101:12; 114:8; 166:17, 21</p> <p>today 4:14; 22:2; 27:23; 28:1; 32:21; 54:8; 55:15, 19, 24; 71:21, 22; 86:24; 87:3; 92:5; 125:6; 140:5; 141:24; 145:12; 156:17</p> <p>together 160:6, 8</p> <p>told 14:22; 23:7; 24:2; 42:10; 57:13; 66:3; 69:2; 73:6; 77:12, 13; 78:14; 79:12; 88:22; 98:10; 99:1, 13, 20; 100:24; 101:21; 108:15; 110:11, 15; 112:2; 130:14; 135:18; 137:17, 21; 159:3; 160:1; 161:1</p> <p>tolerate 51:10</p> <p>tomorrow 78:3</p> <p>took 13:21; 32:10; 34:8; 35:12; 70:10; 83:5; 85:24;</p>	<p>94:9; 98:21; 101:6; 103:6; 112:6; 120:15; 124:18; 125:17; 155:5; 162:9</p> <p>top 69:5</p> <p>topic 17:14</p> <p>total 27:23; 105:17</p> <p>totally 36:2; 137:14</p> <p>towards 62:9; 150:24; 151:3; 152:15</p> <p>tract 19:10; 123:7</p> <p>traditional 49:23</p> <p>train 18:23</p> <p>trainee 16:6; 17:1</p> <p>trainees 16:7</p> <p>training 13:9; 16:8; 17:2, 3, 10; 43:2; 88:24</p> <p>transcript 110:1; 168:2</p> <p>transferred 76:3; 83:22</p> <p>transferring 84:4</p> <p>transpired 84:1</p> <p>travel 28:14, 17; 38:16</p> <p>traveling 29:19; 87:5</p> <p>treat 139:14</p> <p>treated 87:20; 96:13; 120:22; 121:4</p> <p>treating 33:23; 48:6; 116:21</p> <p>treatment 30:4, 10; 31:9, 13, 20; 32:7; 33:1; 45:18; 59:10; 63:9, 15; 64:17; 77:24; 93:24; 94:1; 112:21; 116:19; 139:21, 23; 141:3, 5, 6; 142:10; 161:19</p> <p>treatments 96:11; 119:12</p> <p>trial 9:22; 101:13; 115:3; 122:12, 21; 125:14; 142:6; 143:9; 146:1; 155:7, 13; 163:5; 165:4; 167:14</p> <p>tried 148:9</p> <p>true 68:1; 74:19; 78:17; 110:7; 119:4; 123:9; 134:11; 158:1; 160:24; 161:2, 2; 162:13; 163:4</p> <p>trust 76:15</p> <p>try 13:23</p> <p>trying 38:22; 85:2; 151:17</p> <p>tubular 60:18; 152:2, 5, 13, 20</p> <p>tumor 97:17</p> <p>tumors 60:16, 17</p> <p>turn 46:15; 101:13; 116:4; 163:4</p> <p>turned 63:20; 68:13; 93:22; 102:4; 105:9; 157:4, 7; 165:21</p> <p>TV 21:15</p> <p>twelve 128:20</p> <p>twelve-hour 16:15</p> <p>twenty 6:4; 20:5</p> <p>twenty-two 20:5</p> <p>twice 53:3</p>	<p>two 4:17; 8:7, 9, 11; 10:1; 13:1; 18:19; 32:22; 33:16; 34:5; 47:11; 48:1; 49:11; 55:3; 56:5, 6, 8, 15, 19, 22; 57:1, 10, 21, 22; 58:5; 60:2; 61:11; 74:21, 23; 76:1; 86:15, 23; 87:14; 90:13; 92:20; 100:4, 7, 20; 101:16; 103:12; 105:1, 3, 3, 5, 9, 16; 110:10; 116:4; 117:2; 124:2, 11; 126:17; 129:18; 139:7, 10, 10; 140:8; 144:14; 145:11; 146:24; 147:13; 148:3, 24; 150:2; 152:4; 153:3, 12; 156:7, 19; 157:4; 160:5; 163:24; 164:12</p> <p>type 13:18; 18:17; 20:13; 43:4, 15, 19; 50:18; 63:11; 121:19; 128:2</p> <p>typed 91:12, 16</p> <p>types 25:20; 43:22, 23; 44:1, 4; 146:24; 153:3</p>	<p>103:2</p> <p>unlikely 128:5, 11</p> <p>unpleasant 52:2</p> <p>unreasonable 45:20, 23; 62:22; 63:2</p> <p>unrelated 56:18</p> <p>unsafe 59:7; 73:16</p> <p>unusual 77:21</p> <p>up 11:15, 20; 18:20; 34:17; 76:7; 82:23; 110:1; 125:19; 126:2; 145:12; 156:11; 159:21; 167:18, 20</p> <p>up-to-date 11:17</p> <p>updated 166:20</p> <p>upon 9:7; 23:11; 47:20; 69:19; 76:8; 86:3; 104:3; 132:11</p> <p>urgency 37:20; 45:3; 125:21</p> <p>urgently 37:22</p> <p>use 18:8; 20:20, 22; 33:4; 49:14; 50:15, 21; 51:23; 94:14; 116:16; 119:24; 168:13</p> <p>used 14:18; 20:19; 28:23, 24; 29:12; 30:21; 32:14; 61:19, 23; 62:6, 7, 8; 91:20; 98:11; 140:19; 146:22; 147:22; 150:1; 152:19</p> <p>uses 87:12</p> <p>using 20:23</p> <p>usual 25:19; 27:4</p> <p>usually 25:23; 38:9, 15; 45:1; 66:7; 68:22; 76:2; 79:11; 149:14; 152:20; 158:9</p>	<p>visual 21:7</p> <p>visually 162:2</p> <p>voice 78:4</p> <p>volume 50:19</p> <p>voluminous 25:21</p> <p>VOUDOURIS 4:7, 12; 11:5; 12:2; 36:10, 12; 67:23; 80:11, 15; 124:21; 125:8; 138:24; 156:2, 5; 162:21; 163:3; 166:9; 167:17</p>
W				
<p>Wait 40:5, 5, 5; 48:22; 59:7; 97:18; 163:11</p> <p>waits 158:9</p> <p>waive 167:23</p> <p>Walick 24:8; 37:4; 38:24; 40:2; 50:23; 53:18; 56:10; 93:12; 95:11, 13, 18; 97:3; 98:10, 16, 24; 99:13, 16; 100:13, 24; 103:22; 104:7, 14; 115:11, 13; 116:1, 16; 117:9, 20; 121:1, 13, 16; 122:5; 123:16; 125:16, 18; 126:12; 127:7, 12, 17; 128:2, 15; 129:17, 24; 130:15, 18, 21; 131:9; 132:21; 133:20; 134:9; 135:22; 136:6; 138:23; 141:21, 24; 142:24; 143:10; 144:5, 23; 145:8; 148:3; 151:2; 167:14</p> <p>Walick's 40:7; 56:5; 78:9; 95:22; 96:18; 116:20, 23; 118:19; 119:8; 123:10; 124:4; 125:4; 135:5; 147:12; 153:7; 157:24</p> <p>warranted 76:11; 119:3, 5, 11, 17</p> <p>watch 21:15</p> <p>way 20:22; 21:5; 30:8; 32:5; 60:9; 79:10; 83:18; 84:2, 5, 11; 94:10; 95:14; 97:22, 24; 98:24; 99:5, 7, 22; 101:18; 111:9, 10; 121:8; 129:2; 143:13; 146:3, 15; 148:11, 17; 154:19; 155:6</p> <p>ways 30:19; 74:23; 87:19; 98:18; 103:13; 116:3; 120:21; 157:12</p> <p>Wednesday 81:5; 82:15, 24; 83:23</p> <p>week 16:9; 18:19, 20; 19:18; 112:6; 113:23</p> <p>weekends 16:16</p> <p>weekly 16:12; 18:15</p> <p>weeks 147:7</p> <p>weight 138:8, 12</p> <p>well-defined 86:22</p> <p>What's 16:9; 49:16; 53:6; 55:4; 59:2, 20; 129:15; 156:18, 22; 158:23</p> <p>Whereupon 168:17</p>				
U				
<p>U.K 12:14; 86:19; 87:1, 8, 17</p> <p>U.S 8:9</p> <p>ultimate 134:5</p> <p>unaware 88:11</p> <p>unbeknownst 160:15</p> <p>unchanged 127:23</p> <p>uncomfortable 51:21</p> <p>uncommon 151:5</p> <p>under 29:10; 61:24; 63:4; 83:4, 9; 109:9; 112:11; 117:8; 130:18; 137:12; 138:11, 14; 147:20</p> <p>undergo 52:3, 7; 53:14; 70:1, 21; 71:1, 3, 6; 137:8</p> <p>undergone 52:1; 96:11; 133:17; 143:1, 10; 145:8</p> <p>undergraduates 22:8</p> <p>understood 5:3; 73:13</p> <p>undertake 97:21</p> <p>undertaken 36:2</p> <p>underwent 47:10, 11; 52:12; 71:4; 134:13, 20; 144:20</p> <p>unfair 63:14; 113:14</p> <p>unfamiliar 52:3</p> <p>unfortunate 82:3; 94:8; 160:11</p> <p>Unfortunately 77:17</p> <p>unit 17:24; 18:2</p> <p>United 7:20; 8:1, 7, 11; 9:15, 19; 12:10; 13:4, 12, 19; 14:5, 9, 18, 23; 85:11, 15; 86:1, 5, 13, 17; 87:5; 88:7, 12</p> <p>universities 13:1</p> <p>university 12:15, 16; 14:20; 15:3</p> <p>unless 58:4; 75:18, 24;</p>				
V				
<p>valuable 145:4</p> <p>valve 134:1</p> <p>various 117:9, 13, 15, 19</p> <p>vary 34:8</p> <p>verbal 103:14</p> <p>verbally 4:23</p> <p>versus 153:16</p> <p>video 20:22, 23; 21:18; 28:20</p> <p>view 21:11, 12; 30:13; 75:3; 84:15; 111:13</p> <p>viewed 10:8</p> <p>villous 137:24</p> <p>villus 56:7, 20; 57:11, 23; 58:6; 60:3, 5, 8, 11, 14, 16, 17; 61:2, 5, 12, 17, 19; 97:2; 137:24; 148:14; 149:17, 18, 22, 24; 150:6, 8; 151:13, 18, 21; 152:5, 6, 13, 22, 24; 157:15</p> <p>visibly 44:17</p> <p>visit 82:24</p> <p>visits 142:16</p>				

who's 44:12; 85:6; 95:10
whole 12:18; 64:4
whose 9:6
wish 19:2; 76:1; 90:17;
138:7; 139:9; 148:20
wishes 45:13; 135:1, 5,
13; 136:12
within 21:20; 23:21; 43:9;
47: 11; 48:1; 64:18, 20;
65:2; 67:12; 79:13; 86:5,
21; 92:21; 102:19; 105:2,
18; 106:15; 109:1; 110:6;
115:15; 116:1, 15; 117:20;
118:16; 120:16; 147:4;
160:12
without 44:16; 46:2;
56:20; 63:15; 82:4; 93:10,
10; 107:12; 123:4; 143:21;
161:10
witness 4:3; 7:8; 9:7;
11:9; 23:9; 24:16; 25:4;
27:13, 14; 36:7, 9; 40:15;
55:2; 61:7; 67:24; 74:14;
80:10, 13; 83:18; 114:23;
128:12; 136:11; 148:22;
168:4
Women's 16:17; 18:9
won 7:19
word 30:22; 33:4; 61:5,
12, 19; 62:6; 96:5; 98:11;
146:23
worded 69:10
wording 71:16
words 30:15; 33:19; 35:8,
15; 48:7; 62:9; 64:19; 70:2;
147:2, 9; 148:18, 24;
149:7; 150:24
work 15:13, 20; 16:3, 9,
15, 18; 19:23; 29:9; 49:13;
55:17; 76:15; 81:6; 111:23
worked 86:8; 89:8; 160:5
working 10:2; 15:9;
167:4
works 18:10; 41:8
worried 106:2; 152:10
worth 148:23
wound 118:20; 131:14;
132:7, 19, 23; 133:9, 11,
16
write 40:13
written 50:2; 103:13;
165:1
wrong 109:24; 156:7
wrote 40:6; 106:s

X

X 155:17, 21

Y

Y 155:17, 22
year 13:10; 14:23; 17:6,
9; 18:1; 20:1, 4, 7; 85:17;
86:5; 145:2

years 6:1; 12:17, 18, 21;
14:15, 16; 17:7, 8; 20:5,
24; 22:16; 43:3; 49:24;
53:18; 86:8; 127:22;
129:10; 134:7; 142:17, 20,
22; 147:7
York 112:7
yours 109:9

Z

Z 155:17, 22
zero 132:23