STATE OF OHIO,
SS:
COUNTY OF CUYAHOGA.)

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IN THE COURT OF COMMON PLEAS

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ANTHONY WOZNIAK, et al.,
Plaintiffs,
vs.
ENT SERVICES, INC., et al.,
Defendants.

Case No. 82754

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Transcript of the deposition of DALE COWAN, M.D. called as a Witness by the Plaintiffs, pursuant to the Ohio Rules of Civil Procedure, taken before ne Suzanne Vadnal, a Registered Professional Reporter and Notary Public within and for the State of Ohio, pursuant to notice of counsel, at the offices of Dr. Dale Cowan, 12300 McCracken Road, Garfield Heights, Ohio, on Thursday, the 20th day of February, 1986, commencing at 11:40 o'clock a.m.

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APPEARANCES:

On **behalf** of the Plaintiffs:

Jeffries & **Monteleone** Co., L.P.A.:

J. **Michael** Monteleone, **Esq.**

On behalf of **the** Defendants:

Reminger & Reminger Co., L.P.A.:

Roy A. Hulme, **Esq.**

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DALE COWAN, M.D.,

called as a Witness by the Plaintiffs, pursuant to the Ohio Rules of Civil Procedure, was by me first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION

BY MR. MONTELEONE:

Q Doctor, let's have your full name, please.

A Dale Cowan.

Q My name is Mike Monteleone. We've not met before today but I'm going to be asking you some questions about your background, about the opinions you have in this case and about some other things that involve my client, Tony Wozniak. If you are not sure of my questions at any time, please let me know and I'll be glad to rephrase them. Fair enough?

A Good enough.

Q I understand that your hourly fee is $250 per hour.

A For the deposition.

Q For the deposition, and that's my responsibility to pay you for that. It's about 11:35 right now, 11:40. Send the bill to this address and I'll see that it's taken care of for the deposition

time, okay?

A Thank you,

Q I understand that you are both a doctor and lawyer.

A Correct,

Q I presume that you got your medical degree before you got your law degree?

A Yes.

Q When did you get your law degree?

A 1981.

Q Here in town?

A Yes.

Q From what university?

A Case Western Reserve.

Q Do you practice law at all, Dr. Cowan?

A Yes, I do.

Q You are associated with the firm of?

A Burke, Haber & Berick.

Q I presume you derive some kind of salary from that?

A Yes, I do, although the relationship is ending at the end of this month. I'm going to be going on my own.

Q Is that right?

A Yes.

Q Starting your own law practice?
A I'm not certain I would dignify it with the term law practice. I'm starting consulting, private consulting in the health care area.
Q What kind of work do you anticipate doing in that area?
A Consulting with physicians and medical staffs with respect to their medical staff issues, the credentialing issues, contract matters.
Q You are still going to maintain your practice as an oncologist, I take it?
A Yes, that's my major activity.
Q Right now as far as your professional time is concerned, what part of it is dedicated to the practice of medicine?
A Easily 75, 80 percent.
Q And the other 20 percent would be --
A Is my other activities, in terms of actual hours spent.
Q That would include such things as what, your law practice, things like that?
A Yes.
Q If you had to place a dividing line on it, you'd say that 75 to 80 percent of your time, professional time, is spent in the practice of medicine?

A That's correct.

Q The remaining time is either in legal consulting or medical consulting or your law practice.

A That's correct. All the legal work I do is health care related in nonliability areas.

Q When you say nonliability, you are talking about things like HMO's, PPO's?

A No. Nonliability. As a lawyer I don't do any malpractice or products liability or any litigation or anything of that. It has all been creating alternative health-care delivery systems and working with medical staffs to work with them on their bylaws or in matters that affect, again, privileging and credentialing matters of physicians on hospital medical staffs. In other words, I try to maintain a very clean break between my medical practice and what I do outside of my medical practice.

Q At Burke, Haber's office, you do have an office down there, though.

A Yes.

Q You are on the letterhead listed somehow?

A Of counsel.

Q Of counsel. Speaking about litigation, I know you don't actively practice that, but I presume

that you've given depositions before?

A Yes.

Q You consult in medical malpractice cases?

A As a medical expert.

Q As a mφδ♭cal expert ⊙kay. ×aωe yoω eωer c⊙n-sulted for the Reminger office before?

A Yes.

Q Approximately how many occasions?

A Maybe half a dozen previous occasions, maybe eight.

Q I'm sorry?

A Maybe eight. I don't know.

Q Have each of these cases been on behalf of a doctor or hospital who is sued for medical malpractice?

A Yes.

Q Are you working on any cases for them right now besides this one?

A One other case at the moment.

Q Do you remember the lawyer's name involved in that case?

A Which lawyer? You mean from the firm of Reminger?

Q Yes, sir.

A Yes. Do you want the name?

Q Please.

A Gary Goldwasser.

Q Have you consulted in any medical malpractice cases in which you have testified on behalf of a Plaintiff who was suing a doctor or hospital for medical malpractice?

A Yes, I have.

Q How many other such instances?

A I've only been in court once and that was the time that I was serving as an expert, if you will, on behalf of Plaintiff. My recollection is that I have served as a Plaintiff's expert on one or two other occasions but those cases never came to trial.

Q Did you in the case in which you testified render the opinion that the Defendant had departed from acceptable standards of medical care?

A Yes.

Q Do you remember the Plaintiff's attorney whom you were involved with in that case?

A Plaintiff's attorney? No, I don't. The case was about eight years ago.

Q Do you remember the name of the case?

A I'm sure I could find it out. I don't recall offhand the patient- The Plaintiff was a patient of mine and I can't recall the name right

now.

Q In terms of consulting for either Plaintiffs or Defendants in medical malpractice cases, what percentage of them seemed to be for Defendants?

A I would say probably two-thirds to three-fourths are of Defendants.

Q Outside of the one occasion that you just told us about, have you ever testified either in deposition or in court that a doctor or hospital has departed from acceptable standards of medica3 care in the treatment of a plaintiff?

A I have been deposed on one or maybe two other occasions.

Q In which you gave that opinion?

A In which I gave that opinion, but I've only been to court once.

Q Did you enjoy that, by the way?

A I hated it.

Q I take *it* you're not planning on being a trial lawyer then.

A Correct.

Q Tell me, if you would, please, how much time have you spent on this case so far, Dr. Cowan, in reviewing materials and talking with either

hours?

A I would estimate probably, all told, probably about five.

Q About five hours? Do you remember when it was that you first got involved in this case?

A I couldn't tell you without referring to my correspondence that I don't have here. All I have here is my own letter to Mr. Hulme which is dated January 20, so I probably got involved in December of 1985.

MR. HULME: Don't guess, Doctor.

Q Do you know whether you initially were contacted by Mr. Hulme or was it Mr. Buck?

A Mr. Buck.

Q Did that result from a phone call of some kind or just a letter summarizing the events in this case?

A I couldn't be specific in my response. Normally I am called on the phone, would I be willing to serve as an expert in the particular case, and the facts are generally outlined, and if I think it's something that's within my field of competencies, yes, rather than just get a letter

cold. I don't know if that was done specifically in this case or not.

Q You must have a file on this case, I take it.

A Yes.

Q Is that the whole file right there?

A No. Some of these earlier letters are not there in this packet.

Q Anything else that's excluded from the packet there that you are holding there in your hand?

A No. This is just the letters,

Q When you say letters that would be excluded, those would be what?

A Letters requesting my services from Mr. Buck and subsequently from Mr. Hulme.

Q Those are the only letters that are excluded then.

A That's correct,

Q The report that you wrote on January 20 of 1986, is that the one and only report you've written in this case?

A That's correct.

Q Were there any rough drafts that preceded this?

A No rough drafts of the record. Only my handwritten notes as I went through the materials, when I extract what I consider to be the pertinent

information.

Q May I see what you have there, please, as far as your file is concerned?

A Sure.

Q Doctor, what I found in your file was your report dated January 20, 1986.

A Right.

Q The deposition of the Plaintiff, Anthony Wozniak, correct?

A Correct.

Q The office records of Br. Keith Smith, as well as his bills and some pathology reports for a mucocele on the lip, which was a couple years before this particular cervical node became enlarged, and some records I see here from Kaiser Hospitals, okay? And the Complaint that was filed in this case by myself. I recognize all of those things. Did you review any records from the Cleveland Clinic?

A Everything I reviewed. is here,

Q Is that it?

A So the answer *to* your question is no.

Q Have you spoken with anyone at the Cleveland Clinic about this man's condition?

A No.

Q Do you know Dr. Smith personally?

A No.

Q I presume you've never been on the staffs of any hospitals together.

A Not that I'm aware of. I don't know what staffs he's on.

Q Have you spoken to him about this case?

A To whom, please?

Q Dr. Smith.

A No.

Q You have not, all right.

Since I don't have your CV here, let me ask you a few questions about your backqround, You are board certified?

A Do you want her to bring it in?

Q Doctor, the 17 page CV which you just handed me, I presume that this is up to date?

A *Yes.*

MR. HULME: Let me interrupt here for a second. In this packet of materials you looked through, there are, in fact, Cleveland Clinic Foundation records.

MR. MONTELEONE: There is a short discharge summary, Roy.

MR. HULME: Well, I mean you didn't even mention the Cleveland Clinic.

MR. MONTELEONE: I didn't see it. I've got no problem with that. What's the date on that one?

MR. HULME: Admission 10-3-83. There is an admission 1-26-84, There is a letter from Dr. Smith dated November 30 in the file, too, to Beth Sebaugh.

MR. MONTELEONE: Who is that?

MR. HULME: From Bob Buck's office, Another one from the Clinic 54-28-83.

MR. MONTELEONE: What he's got there are the discharge summaries then from the Cleveland Clinic?

MR. HULME: Yes.

MR. MONTELEONE: That would be it.

MR. HULME: That's what it looks like.

Q Doctor, just to clear this up and we can move along then, do you have any independent memory of reviewing the entire Cleveland Clinic chart on this man?

A I have no independent memory of doing so, no.

Q Do you know whether you did or not?

A I think I reviewed materials that are here, that have been enumerated here.

Q Which do not include the complete chart.

A That's right.

Q In the list of articles that *you* have published dealing with your specialty of oncology, have you written anything at all about Hodgkin's disease?

A No.

Q I presume because Hodqkin's disease is, in fact, a form of cancer, that you consider yourself expert in that area.

A I guess I would be considered expert in the cancer area, yes. The reason I didn't Publish it was I happened not to be carrying out independent investigation specifically pertaining to Hodqkin's disease. But having said that, some *of* my most recent medical publications did include tissue from patients with Hodgkin's disease and other lymphomas. It was not, however, a research that was specifically focusing on Hodgkin's disease as a clinical entity. I have participated in clinical trials of treatment of Hodgkin's disease. I arc listed as a contributor

to the study but not as one of the co-authors of the paper and so it does not appear on that CV.

Q I wanted to know whether or not you had, in fact, written anything at all about Hodgkin's disease.

A I have not written specifically on Hodgkin's disease.

Q But incidental to other clinical trials in which you've been involved, you've examined tissue in which the entity known as Hodgkin's disease was, in fact, one of the factors,

A That is correct.

Q Are you a pathologist also, Doctor?

A No, sir.

Q I notice there are a good many lectures which you've given, Dr. Cowan. Have you lectured at all in the field of dealing with Hodgkin's disease?

A *Yes.*

Q Are they listed in this CV?

A No.

Q They are not.

A Many of them, if not most of them, are medical education conferences that I lectured men who were undergoing rounds at one or another insti-

tution, or teaching exercises for medical students or fellows and residents, and I wasn't listing all those.

Q I take it in your profession that occurs rather frequently.

A That's correct,

Q Because you've been associated with teaching hospitals in the past, and I don't know, is Marymount a teaching hospital?

A No.

Q But you have had residents and interns who have studied under you or followed you in your treatment of cancer?

A That's right.

Q Including Hodgkin's disease?

A That's correct,

Q Would you just give us, if you can, a quick definition of what Hodgkin's disease is?

A Yes. It's a malignant neoplasm that arises primarily in lymph tissue, or at least from lymph tissue. The precise cell that undergoes the neoplastic transformation I think is still a matter of some dispute, although most individuals consider it to be the lymphocyte. There are still some who feel there is evidence that

it might be in the histiocytic cell line or reticulocytic cell line. So, I would say there is still a lack of precise information as to what the specific cell is from which the disorder arises, but it is a neoplastic disorder and it commonly arises in lymph nodes, which is where the majority of the lymph cell or lymph tissue is located. It rarely will arise in other organs that are not primarily lymph organs, such as the lung.

There is some dispute still in the literature as to whether it is of unifocal or multifocal origin. That is to say, does it arise in a single location and spread from that location to other locations as is characteristic of most solid tumors, or is there simultaneous neoplastic transformation arising in multiple sites?

Q Which of those particular schools do you adhere to or believe in?

A I don't say I adhere to one or the other.

Q Which is more persuasive in your own professional judgment?

A I think it's more persuasive to conceive of it as generally arising in a single location and then spreading from there to other locations, but

there certainly are data which would support an alternative point of view.

Q Hodgkin's disease is, in fact, a form of cancer,

A That's correct,

Q It is, in fact, a treatable and in some instances curable form of cancer?

A That's correct,

Q Hodgkin's disease, if left untreated and undiagnosed, will result in premature death of the patient?

A That's correct.

Q As I understand it, in order to made a definitive diagnosis of Hodgkin's disease, you have to submit the tissue to a pathological review: is that true?

A Yes, that's correct.

Q So that a doctor in attempting to arrive at a diagnosis of Hodgkin's disease would first have to remove some sort of tissue from the patient, the suspected tissue, give it to a pathologist who would look at it under a microscope and say, "Yes, it is Hodgkin's, No, it is not. It may be something else."

A That's correct.

Q Certainly Hodgkin's disease is not something the

patient himself can ever diagnose.

A Patients do not walk into the office saying, "Doctor, I have Hodgkin's disease."

Q They have got to rely upon the doctor for that, don't they?

A That's correct.

Q What are the signs and symptoms of Hodgkin's disease?

A They are variable. They may range from appearance of a nontender lump someplace, commonly in the neck or in the supraclavicular area, in other words, above the collar bone or under the arm. Sometimes in the groin area, although that is rather more difficult to evaluate. Other symptoms may be the appearance of chills, sweats, night sweats, loss of appetite, weight loss. occasionally some itching.

Q Pruritus?

A Pruritus. Then if the focus of the site of origin happens to be in a particular organ, there may be symptoms that are referable to a particular organ. For example, if it arises in the lung, there may be cough ox chest pain, If it arises ox if it's present in the abdomen, there may be some abdominal complaints of one kind or another.

so, it's variable.

Q Is low grade fever one of the symptoms or signs of --

A Low grade fever, is another one, yes.

Q How about a general feeling of --

A Malaise, lassitude, easy fatigability, exercise intolerance.

Q Each of these that you have enumerated may, in fact, be indicative of Hodgkin's disease?

A That's correct.

Q They need not all occur, of course, in a particular patient to say this is Hodgkin's, this is not. Some of them may have one or two symptoms. Some may have all.

A That is correct. They are also not specifically diagnostic of Hodgkin's disease. They are nonspecific, what are termed constitutional symptoms that may arise in a variety of disease states, both neoplastic and nonneoplastic, but they are certainly seen in patients with Hodgkin's disease,

Q To make sure I understand you, you used the term neoplastic to include what the laymen would think of as cancerous?

A That's correct.

Q When Tony Wozniak was seeing Dr. Keith Smith during March, April and May of 1983, did Tony Wozniak have signs or symptoms indicative of Hodgkin's disease?

A If I may refer to my notes, please,

Q Absolutely, at any time. At any time you feel you need to do that.

A What I don't see is my letter. Here we go, okay,

In answer to your question, when he first presented to Dr. Smith, he presented with a complaint that is one of those that I mentioned before, and that is, an enlarged node or mass on the right side of the neck. So, yes, that is a complaint that is one of those that is associated with Hodgkin's disease or can be associated with Hodgkin's disease.

Q So that we can agree then that while he was seeing Dr. Smith during March, April and May of 1983, Tony Wozniak did have signs or symptoms of Hodgkin's disease.

MR. HULME: So far he's mentioned one, Do you want to take the S of€ signs?

A I think to be more precise and to be, fair with it, it would be better to say that he had signs

and symptoms that were consistent with a number of disorders, one of which is Hodgkin's disease,

Q Do you believe that the May 28, 1983 visit to Dr. Smith in which there is a notation there of dermatitis, an itching, that, in fact, is also, I think you mentioned earlier, one of the signs or symptoms of Hodgkin's disease?

A I don't know if I can make a statement one way or the other about that. Generally the itching with Hodgkin's disease is a generalized pruritis, a generalized itching, rather than a localized type of thing, and there commonly is no observable cutaneous manifestation that one observes. I don't have enough information from the record to make a judgment one way or the other to answer in a responsive manner to your question.

Q Can we agree that the earlier that the doctor makes the diagnosis and begins the treatment, the better the chances for a long term survival, of a patient in Hodgkin's disease?

A As a general rule that would be true for all neoplasms.

Q Can we agree then that the delay in the diagnosis and treatment of Hodgkin's disease can, in fact,

be harmful to the patient?

A Delay of diagnosis can be harmful, depending upon the duration of the delay and the nature of the disorder.

Q From reading your report I got the impression that one first in dealing with Hodgkin's disease must stage the disease, and the staqe of the disease, in fact, tells the doctor in a sense what modes of treatment are to be used,

A That's essentially correct.

Q If there is a delay in diagnosis, the treatment may, in fact, have to be more radical than if the diagnosis is made earlier on,

A I'm not certain what you mean by the term radical.

Q Let's take a Stage 1 patient, all right?

A All right.

Q Do all Stage 1 patients, Hodgkin's disease, that is, undergo splenectomy?

A Well, now you're talking about diagnosis, not treatment.

Q I thought the question was -- maybe I didn't make --

A You don't know whether they are Stage 1 until you've done the splenectomy.

Q Is that correct?

A That's correct.

Q In other words, all Hodgkin's patients must undergo spfenectomy?

A I didn't say that,

Q All right.

A In order to determine the stage, there is an orderly sequence of diagnostic studies that are undertaken, depending upon the site of initial presentation, and included among those is a surgical procedure termed exploratory laparotomy with splenectomy, lymph node biopsy and liver biopsy. However, that surgical procedure may not be undertaken in cases where evidence based on less invasive diagnostic studies provides enough evidence to the physician to select the appropriate modality of therapy.

Q If I understand you correctly, what you are saying is that there are lesser tests, so to speak, which may obviate the need to do a splenectomy or an exploratory laparotomy?

A That's correct.

Q Let us take, for instance, a patient who presents with one enlarged swollen cervical node? all. right? That patient comes in to you, Doctor, with a history that he's got a lump on the right

side of his neck for about three months, okay? What would you do in that situation, Dr. Cowan?

A That would depend part on the age of the patient, but let's assume an individual of this patient's age, a person in their 30's. Obviously I'd take a history to find out what, if any, symptoms are associated with this. I would undertake also then a complete physical examination to find out if there are not only other enlarged lymph nodes but any signs of disease of any kind elsewhere.

Q Okay.

A Depending on the results of those studies, I might recommend any of several things.

Q Such as?

A They could range from do nothing and let's reassess it in two weeks or three weeks, to requesting that the patient obtain a chest x-ray or a blood count, to recommending a course of antibiotic therapy if there were symptoms and signs that suggested the possibility of infectious nature for this lymph node enlargement.

So, how one would approach it would obviously be dependent very much on the information

one generates at the time of the initial visit.

Q In such a patient, when you felt the node in the neck area, would you record the size of the node?

A Yes.

Q That would be important; would it not?

A Yes, it is.

Q Would you take the vitals on the patient, for instance, a temperature, pulse rate?

A We routinely obtain the vital signs and the weight and height and basic information about the patient.

Q Tell me, Dr. Cowan, in your judgment, sir, how long would you wait if that node that we're discussing, that enlarged node, did not decrease in size or go away before you did a biopsy?

A This would depend in part on the size of the node, If it's a one centimeter node I might be willing to give it four weeks or so, If one comes in with a mass three, four or five centimeters, I would probably want to proceed reasonably promptly for a biopsy, depending on how long the patient indicated the node had been there, In some instances I've been known to recommend right away that the individual have a biopsy obtained. So, a lot of it depends on the history and on the

specific findings.

Q Let's assume that the node that we're talking about, the single enlarged node, goes four or five weeks and is still swollen, still enlarged. The patient's been on antibiotic therapy and it's not gone away at that point. What is the medically acceptable standard of care for a doctor under those circumstances?

A At that point it would be appropriate to refer the patient for a biopsy or if the person is capable of doing the biopsy himself, doing the biopsy.

Q A biopsy, as I understand it, can be done in the office?

A Depends on the size of the lymph node,

Q Would you agree, Doctor, that during the time that Dr. Smith was seeing this gentleman, I'm not only talking about the first time he saw him in March, but during March, during April and during May of 1983, would you agree that Dr. Smith departed from acceptable standards of medical care in his treatment of this man?

A The problem I have in responding to that is that I don't have adequate documentation from the record as to what the observations were, I have

general statements that indicate, for example, between March 5 and March 19 that the lymph node was reported to be decreased. I don't know what the original size of the node was when first seen on March 5. It's not stated in the record. I don't know how much of a decrease there was that was observed on March 19.

March 26 it's again stated there was no change. There is again no comment on April 9 or on May 28 as to what the size is. So, whether or not the physician departed from standard medical practice is something that for me would require a little more information than I'm provided here from the record.

Q Well, what additional information, Dr. Cowan, would you as an oncologist like to see?

A The information I would like to know is what was the size of the lymph node when first observed and what was the size of the lymph node on subsequent observations.

Q Let me tell you, sir, that Dr. Smith's deposition has been taken and I presume from your answers that you've not had a chance to read it.

A That's correct.

Q Let me tell you that Dr. Smith says that when he

saw him on March 5 the lymph node was a centimeter or less; that when he saw him on March 19 he took the history of the patient to say that there had been a decrease in size but he doesn't remember exactly the size. He believes it was about the same size, about a centimeter, okay? That when he saw him on March 26 it was about the same size, a centimeter; that when he saw him on April 9 he believes it was about the same size, a centimeter, But that when he saw him on May 28 of 1983 he did not even examine the man's node on the right side, okay? This is sworn testimony from Dr. Smith,

MR. HULME: You want him to assume that that's what he said.

Q That's right, or I can show you the deposition where he said each of these things, Doctor. But I want you to make those assumptions. This is what Dr. Smith has testified to and now I would like to ask whether you have a sufficient amount of information to give me an answer to the question or whether Dr. Smith complied with acceptable standards of medical care in his treatment and evaluation of this man?

A Well, working back, I would say that on May 28

my answer would have to be no: that over an interval of two and a half months there should be some further assessment done of the node, namely, a biopsy. Over the period of one month between March 5 and April 9, it's arguable, I think if that was done during that interval it was not a departure from standard medical practice, but sometime after April 9 one would have normally proceeded with a further investigation of the lymph node.

Q So that if I understand you correctly then, sometime after April 9, 1983 Dr. Smith in his care and evaluation and treatment of this man did, in fact, depart from acceptable standards of medical care,

MR. HULME: Based on the information you have given him. With that qualification I have no objection to the question.

A Yes.

Q Is that true?

A Yes.

Q This departure from the standard of care which you just referred to resulted in a delayed diagnosis of this man's Hodgkin's disease,

did it not, Doctor?

A There was a delay in the diagnosis of Hodgkin's disease. If I may go back for a minute, I am assuming that there were no other physical findings observed or no other complaints on the part of the patient that provided a reasonable judgment on the part of the examining physician that there was inflammatory basis for this lymph node. In other words, no sore throat, no sign of any lesion in the mouth and no obvious abscess in the jaw, around the teeth, that could have accounted for a swollen node. That the node itself was nontender and there was no expression of discomfort or pain or tenderness on the part of the patient with respect to this,

Lymph nodes can be present for a long time for a lot of reasons. When we're talking about whether or not it's a departure of standard medical practice not to proceed with a biopsy in a lymph node that has been around for a while, we're really restricting that judgment to situations where there is no evidence of infectious, inflammatory basis for the lymph node.

Q You have the complete office chart of Dr. Smith, don't you, Doctor?

A Yes.

Q Do you see any evidence --

A There is nothing in the record that suggests that. You were asking me a hypothetical question in a sense and I was wanting to respond in a full and complete manner to you.

Q I appreciate your doing that but so that we are clear then is there any evidence in any of Dr. Smith's complete office records, which you have, which changes your opinion that he departed from acceptable standards of medical care following April 9, 1983?

A Based on the information I have here, no. Now I interrupted your train of thought and I apologize.

Q Assuming that Tony Wozniak was your patient on March 5, 1983, March 13, March 26, April 9 and May 28, 1983, tell us, Doctor, what would you have done at that May 28, 1983 visit in terms of evaluating and treating the man?

MR. HULME: Based on the information he has or do you want him to assume something?

MR. MONTELEONE: Based upon what he has, Dr. Smith's records. He's the only doctor who was seeing him at that time.

A On the May 28 visit?

Q Yes, sir.

A I would have again taken a history with respect to any symptoms referable to this or any generalized symptoms and examined it and examined other lymph node bearing areas.

Q You certainly would have done an excisional biopsy at that May 28, 1983 visit, wouldn't you?

A I would have requested one be done. I don't personally biopsy, but yes.

Q You certainly would have at least examined the area that had been swollen for over two months.

A Yes.

Q No question that that departs from acceptable standards of medical care not to do that.

A That's correct.

Q I think you referenced this in your report but so I am clear, when you talk about stagin or stages of Hodgkin's disease, we're talking about 1, 2, 3, 4, and I believe they can be either 1A or 1B, 2A or 2B; is that true?

A That's correct.

Q I've done a little bit of reading on this, not very much at all certainly. How do you define Stage 1 Hodgkin's disease?

A Stage 1 Hodqkin's disease is that disease which is confined to a single lymph node,

Q A or B simply means whether they have constitutional symptoms or not,

A That's correct, A is lack of symptoms, B is symptomatic.

Q Symptomatic would include what kinds of things,

A It would include fever, chills, sweats, weight loss, malaise, lassitude, anorexia.

Q Stage 2 then would include what?

A Involvement with two or more noncontiquous lymph nodes or lymph node areas on one or the other side of the diaphragm.

Q Then Stage 3, I presume, involves --

A Lymph node involvement above and below *the* diaphragm.

Q And Stage 4?

A For that purpose the spleen is considered as a lymph node,

Q Thank you. Is that considered above or below the diaphragm?

A The spleen is below the diaphragm. Stage 4 is involvement of visceral organs, lung, liver, bone marrow.

Q Do you have an opinion, Doctor, whether Mr. Wozniak had Hodgkin's disease in March of 1983?

A No, I don't,

Q Do you have an opinion whether or not he had Hodgkin's disease in April of 1983?

A I don't have an opinion on that.

Q Do you have an opinion whether or not he had Hodgkin's disease in May of 1983?

A Based on the record, I don't,

Q What is it that you'd like to know in order to help you formulate that opinion?

A Into May I would like to know, of course, what the physical examination showed and whether there was enlargement of the node at that time. I know that you've just told me or have made reference to the deposition of Dr. Smith in which he apparently asserted that to his recollection there was -- no, he said he didn't examine,

Q He didn't even examine the right side of the neck.

A What I would need to know is whether it was there and, of course, what the size was. If I knew, for example, in September it was a five by five

centimeter node.

Q Right.

A It would be important to know was it that size in May or not. A one centimeter node in March or April may or may not have been Hodgkin's disease and there is no way to know for certain, I can't say within reasonable medical probability there was Hodgkin's disease there in March or April based on all the information I have and what you have just told me about the size.

Q What is your professional hunch?

MR. HULMC: Objection.

A Even if I were to do that, he obviously developed Hodgkin's disease somewhere along the line. The question is at what point? Was it there in March or April? I don't know about March. Possibly, yes, in March. April, more likely. May, probably more likely.

Q That he had Hodqkin's disease at that time.

A Right.

Q This is May of 1983.

A Yes, the same year,

Q I suppose the information you'd like to have you don't have because the biopsy wasn't done at that time.

A That's right, and I'm not trying to be coy about it. I think that we've seen situations in patients who have had documented Hodgkin's disease whom we've treated who have developed lymph nodes, and because of the history of Hodgkin's disease we have biopsied them and they haven't contained Hodgkin's disease.

So, just because there is a lymph node that subsequently is biopsied and proved to have Hodgkin's disease which is substantially greater size dgesn't necessarily mean that the disease was present and diagnosable pathologically some months earlier, One has to be very cautious about this, On the one hand, we don't want to misdiagnose and not be appropriately aggressive in pursuing diagnostic studies. On the other hand, it's inappropriate to make assumptions because very often our assumptions are incorrect.

It's a matter of judgment so it's very difficult to say and it's not a matter of being coy. It's a matter of not being judgmental on the basis of inadequate data.

Q The inadequate data, of course, is because Dr. Smith didn't include that information in his records: isn't that true?

A In part, yes.

Q Is it true that in Hodgkin's disease a swollen or an enlarged node can sometimes remain that size for a very long period of time and then all of a sudden grow?

A You are like my patients. What's a very long period of time?

Q You know what I'm getting at, don't you?

A No.

Q You don't, all right. Is it true that a node, a swollen node can remain swollen, be Hodgkin's disease and remain just that same size for let's say five, six, seven, eight months?

A Here again, the question is was it Hodgkin's disease all along or at what point along the line did the Hodgkin's disease appear, Patients will come in and say, "I have had this lymph node fox a long time and last week it suddenly got big," and you biopsy it and. lo and behold, it's Hodgkin's disease. Was it there all that time? I don't know, It may or may not have been.

Q I think you've answered my question. Since you don't have an opinion as to whether or not this man had Hodgkin's disease in March of 1983, I presume you have no opinion as to what stage it

was either.

A That's correct.

Q You don't know whether it was Stage 1, Stage 2 or Stage 3.

A There is certainly no evidence, no information from the record that would enable me to make that judgment.

Q Certainly one of the people who could have made that information available to you and to all of us would have been Dr. Smith, true?

A Well, Dr. Smith or another examining physician at the time, *yes*.

Q Do you have any opinion in this *case* as to the origin of the Hodgkin's disease in this man?

A Do you mean from what site it arose?

Q *Yes*.

A Or what the cause was of Hodgkin's disease?

Q No, I don't want to ask about the cause of Hodgkin's disease.

A Thank you, because I don't know what the cause of Hodgkin's disease is.

Q I don't think anyone does, do they?

A Nor does anybody else.

Q If *you* don't know, Dr. Cowan, nobody knows.

A No, I wouldn't say that. I appreciate the

compliment.

As to the site of origin, I don't think that one can be 100 percent certain. Obviously the fact that he had the cervical lymph node, it is reasonable to presume that it arose in that area,

Q When you say cervical, we're talking about the neck area,

A Yes.

Q Do you think it is more likely that if this man, in fact, had Hodgkin's disease in March of 1983 that is was Stage 1 as opposed to Stage 3?

A That would be a matter of speculation and I can't say that certainly within the standard of reasonable medical probability. It's conceivable that he could have had abdominal lymph node? involvement or even splenic involvement back in March.

He subsequently had spleen and celiac lymph node, It's conceivable he could have the celiac node involvement back in March, too, and it wouldn't have caused any symptoms, so I don't think one can say in all honesty what it was.

Q You don't know whether it was Stage 1, Stage 2 or

Stage 3 back in March of 1983,

A Or Stage anything.

Q Well, we know it wasn't Stage 4. We know that, don't we?

A Right, I'm saying we don't. We don't know, If one assumes he had Hodgkin's disease in March, if one is making that as an assumption, I don't think that one can state what the stage was. I can't state what the *stage* was,

a Tell us, please, what symptoms or signs Tony Wozniak had in March, April or May of 1983 that suggested to you that he had Stage 3 Hodgkin's disease.

A Based again on the information that was available to me, the records that I reviewed, there was no information that suggested there was Staqe 3 disease present.

Q In fact, the only information that's available, Doctor, suggested he had Stage 1 disease, doesn't it?

A Based an the information again, if he had any disease at all at that time, the information available indicated only involvement on the right side of the neck, Stage 1 disease.

Q Is it a fair statement to say that undiagnosed

Stage 1 Hodgkin's and untreated Stage 1 Hodgkin's will progress to Stage 2, to Stage 3 and ultimately to Stage 4? Is that a fair statement?

A That's a fair statement.

Q Doctor, in this particular case, would you agree that it is at least conceivable that Tony Wozniak had Stage 1 Hodgkin's in March of 1983, which, left untreated and undiagnosed, progressed to Stage 3 in September of 1983?

A It's certainly conceivable.

Q I have seen a number of studies on this topic but I'd like to know what your feeling is about it, if I can. In terms of the long-term survival, a prognosis oncologists are concerned with, you look at a five year period and a ten year period. Which are you comfortable with, Doctor, in terms of making any kind of statistical prediction?

A With Hodgkin's disease, if they survive five years, the likelihood of a relapse after that is very remote. Not unheard of but very remote. So, if you look at the survival curves now, they are flat after five years.

Q Five years from date of diagnosis?

A Yes. The treatment only takes a few months,

Q So, what in your opinion then is the five year survival rate for Stage 1 Hodgkin's disease patients?

A Stage 1?

? Yes.

A 100 p'ercent, 99, 100 percent. It's very high. It's extraordinarily high,

Q Which is a tribute, of course, to you oncologists,

A Well, radiation oncologists, As much as medical oncologists would like to take credit for that, our colleagues in radiation therapy are responsible.

Q What in your opinion is the ten year survival rate for Stage 1 Hodgkin's patients?

A The same,

Q 99, 100 percent?

A 99.

Q Let's talk about Stage 3 for a moment, if we can. What is the five year survival rate of a Stage 3 Hodgkin's patient?

A Depending on the studies that one looks at, it's going to be between 85 and 90 percent.

Q Less than the Stage 1 patients.

A Yes.

Q Now, how about the ten year survival rate?

A It will be the same. There really is very little relapse after that.

Q So, you think that in your judgment anyway, the ten year survival rate for Stage 3 patients with Hodgkin's disease is 85 percent?

MR. HULME: 85 to 90.

Q I'm sorry, is that what you said?

A Yes.

Q 85 to 90 percent?

A Yes, in that range.

Q Now, after ten years, isn't there a considerable drop off?

A Not with Hodgkin's disease, There are a few patients who will relapse late, Every so often we get a patient who will come in whose disease was treated 15 years ago. But in terms of large numbers, the general rule of thumb is that if they go five years without a relapse, chances are they are home free,

Q So, in this particular case then, as far as Tony Wozniak is concerned, you can't give us any idea until after 17988, I presume.

A That's correct, The majority of the relapses occur within the first two to three years.

Q Khat kind of percentages are we talking about?

A For what now, please?

Q For relapse of Stage 3 patients.

a We're talking about 15 percent approximately,

Q Who do relapse within three years?

A That would be the opposite statistics to saying you have an 85 percent or so five year survival. We have to distinguish between relapse and survival, of course. You talk about disease free survival, which is what I'm really referring to when I talk about survival. Relapse, they may relapse but that doesn't mean they are going *to* die. They can be retreated and still be alive.

Q All right.

A So, I suppose you would still say maybe a 15 percent relapse rate durinq that first three years or four years.

Q Do Stage 3 Hodgkin's patients have a higher tendency to relapse than Stage 1 patients?

A Yes.

Q When you use the term relapse, I just want to be clear *as to* what that means to you, Doctor. What does that mean, relapse?

A Relapse means that there is reappearance of

Hodgkin's disease.

Q And to be in remission means there is no evidence right now that the person has any other Hodgkin's disease.

A That's right. Remission, a complete remission implies that there is no evidence by physical examination or laboratory or radiologic examination of any disease.

Q Do you have any opinion on the chances of Tony Wozniak surviving five years?

A Well, I don't know what his response to therapy was. If he had a complete remission as a result of his initial therapy, I would think he has an excellent chance of five years.

Q How about ten years?

A Excellent chance of ten years.

Q Since he would fit into the Stage 3 category, you're talking about what, 85 to 90 percent chance of survival ten years?

A Yes, and he was 3A.

Q Right.

A Which is important.

Q Better than 3B certainly.

A Yes. Patients who are symptom Class A have lesser rates of relapse than patients who are symptom

Class B.

Q Assume for the moment, if you will, that he did have Hodgkin's in March of 1983 and assume further that it was diagnosed at that time. Do you have any opinion on whether or not this man could have been treated without chemotherapy?

A That would depend on what the stage was.

Q Assuming it was Stage 1.

A If it was Stage 1, the treatment of choice would have been radiation therapy to the involved field or extended field or however the radiation therapist wanted to do it.

Q Assume also that he did have Stage 1 in March of 1983 and that it was diagnosed at that time. Do you have any opinion as to whether or not he would have undergone a splenectomy?

A I would have assumed that the determination of his having Stage 1 disease would have been made after he had had a splenectomy. In other words, one would have to know that the spleen was free of disease before placing him in Stage 1, and the only way of finding that out in an individual whose spleen is not enlarged on a CT scan, and even if it is

enlarged on a CT scan, the only way of knowing is to take the spleen out and look at it under the microscope.

Q Once you go in and do the laparotomy you've got to take the spleen out anyway,

A If you want to examine the spleen and find out what's going on you have to remove it to do that. You can't biopsy the spleen,

Q You can't wedge it like they do the liver?

A No.

Q Does the spleen serve a useful purpose in human anatomy?

A Yes.

Q What does it do?

A It has several functions,

Q Just tell me the most important ones,

A I was just going to say I give lectures on this, the function of the spleen, I could go on for an hour, The spleen serves in a sense as a sponge5 It removes effete red cells and platelets from the blood stream, It removes other extraneous particles, debris, if you will, from the blood stream. It filters the blood stream in a sense.

It also, of course, is a major site

A Well, I suppose that Dr. Divita, Vincent Divita is as authoritative as anybody. He is the current Director of the National Cancer Institute and he was one of the investigators on the original protocol that was the combination chemotherapy treatment of patients with advanced Hodgkin's disease that represented a breakthrough in our management of this disease. Obviously the people out at Stanford who have done all the work on

radiation therapy of Hodgkin's disease. There are so many.

Q How about Dr. Henry Kaplan?

A Kaplan, sure. He's one of the Stanford group. I believe.

Q I thought so too.

I don't know if I asked you this or not, but I'm winding down here. Let me make sure I covered this with you. Do you have any opinion at all on what the future holds for Tony Wozniak?

A Yes. Assuming that he was in a complete remission at the completion of his treatment program and by this time assuming that he is still in a complete remission, I would say he has an excellent outlook for a normal existence.

Q Normal life expectancy?

A Normal life expectancy.

Q The basis for that opinion is what exactly?

A Both based on the literature and the results of large studies, studies of large groups of patients, and on my own experiences with patients of a similar age and similar stage of Hodgkin's disease and how they have done,

which has been uniformly excellent.

Q We agree, of course, that a Stage 1 Hodgkin's patient has a much better future outlook than a Stage 3.

A Yes, but even Stage 3, because I personally don't end up treating Stage 1 patients because they get referred for radiation therapy, so everybody I treat is Stage 2, 3 and 4.

Q Which is what, chemotherapy?

A Yes.

Q You are not a surgical oncologist, I take it.

A No.

Q In addition to chemotherapy, and by the way, what effect does this have on the people who are undergoing this kind of treatment, chemotherapy?

A That depends on the individual. There are individuals who have no significant side effects, no time lost from work apart from coming in and getting treated, and don't turn a hair with the treatment. There are other people who do develop symptoms of one kind or another, so there is some variation.

Q The ones who develop symptoms, they talk about

what kind of symptoms, nausea, vomiting?

A Nausea, generalized weakness or tendency to fatigue more easily.

Q Do you know Dr. Jack Berman?

A Yes, I do.

Q Is he a qualified competent medical oncologist?

A I would say so.

Q Have you had a chance to see his report, Doctor?

A I haven't read his report. Was I shown the report or not now? Come to think of it, I think I was shown his report just a little while ago. I didn't really read the whole thing.

Q His report of January 12, 1985, is that the one you saw?

A I don't recall the date of the report I saw.

MR. HULME: I'll tell you when it was. Has he written more than one?

MR. MONTELEONE: No.

MR. HULME: January 12. Do you want him to look at it?

Q Would you, please?

A Sure.

Q I just want to know if there are any points of disagreement that you and Dr. Berman have,

MR. HULME: Do you want him to sit and read the whole thing?

MR. MONTELEONE: Sure. It won't take him that long.

A Well, as I'm going through this, I can't say it's a disagreement. I guess it would be a difference in emphasis. When it says, "the mixed cellular category is a distinctly less favorable pathological type of Hodgkin's disease," that was certainly true before the current era of modern combination chemotherapy for Hodgkin's disease. The life table analyses of treatment would *suggest* that the cell type is not *so* significant as it previously *was.* That's a very fine distinction,

Q How about his statement that a lymph node that does not respond --

A Right, He's saying present for a week or ten days should be removed fur pathological diagnosis, and as I responded earlier to your inquiry regarding this, this depends on the size of the lymph node and on what else is

going on, If I have a patient coming in with a five centimeter lymph node with no sore throat, upper respiratory infection, as far as I'm concerned, ten days would be too long. There is no reason to wait, If you have a person coming in with a one centimeter node and they have had a little bit of a flu like illness or this or that, it's a different situation, So, I think that the time has to be taken in conjunction with what is going on.

Q Certainly. He says a week or ten days. You'd be more comfortable with 30 days?

A In an otherwise asymptomatic individual with a one centimeter node,

Q He was talking about this case as we have been.

A Right, but if this were a five centimeter node then yes, I'd certainly want to know what's going one

Now, the bast sentence in that paragraph, I don't know if you would say I'd take issue with it. I think I know what he's saying. I would have expressed it differently because my opinion is one doesn't

know that one has Stage 1 or Stage 2 disease until one has excluded disease in the spleen and lymph nodes in the abdomen, and if it's not possible to exclude it on the basis of CT scanning of the abdomen and lymphangiography, then one has to go to surgery, and there are cases and I've had cases where there was no evidence of disease below the diaphragm and the CT scan of the abdomen was negative and the lymphangiography was negative, and, of course, we do a bone marrow aspiration biopsy and that was negative, and when we went to do the surgery, lo and behold, the spleen had Hodgkin's disease. So, those cases which on clinical grounds were Stage 1 or 2, on pathologic grounds after the staging laparotomy and splenectomy were Stage 3. So, I could not agree with it as he has expressed it. I think I know what he was trying to say, though.

Q We're talking about his statement, "If the disease is diagnosed sufficiently early in its stage and is a Stage 1 or 2 disease, which means disease above the diaphragm, the possibility of a staging laparotomy,

splenectomy and the morbidity associated with that procedure may be avoided."

A The operative word is may, and that depends on what your findings are of your other diagnostic studies, that I know Jack would do.

Q You essentially don't disagree with this statement. You just would state it in a different way is what you are telling me.

A That's right.

Q Fair enough. Let's go on to the final page then.

A Now, the first complete sentence on page three starting with the words "I think" is obviously a judgment. I think that there is an assumption that the lymph node had it been biopsied in March of 1983 would have shown the presence of Hodgkin's disease, and for the reasons that I've mentioned, I don't know whether that's the case or not. I can't say that I could agree that it would have forestalled hater laparotomy. Again that would have depended on what else was found when they went through the other diagnostic studies.

Q Maybe it would have, Maybe it would not have.

A It might or might not have, okay?

Q How about the final sentence? "There is thus concern that the judgment of allowing a lymph node that did not respond appropriately to antibiotic therapy, to remain present without biopsy, is below the standard of care that would be expected in the ordinary practice of medicine."

A Right there, I think I've already testified that within the time limits that we discussed earlier, that I agreed with that, and that subjecting the patient to a prolonged course of therapy, that I don't know. whether *it* would have prevented unnecessary surgery, I *just* don't know,

Q So, his last sentence then on page three of his January 12, 1985 report, you don't disagree with it. You just don't know,

A That's right. It may or may not be correct, at least the last half of that sentence.

Q I'd like *to* keep doing this for a while but I'm sure you have other things you'd like *to* do.

A I have as much time as you have.

Q I don't have any other questions. You can look at this or you can waive your signature on it, It's whatever your pleasure is.

MR. HULME: I won't waive the signature and I am representing Dr. Smith. That saves your decision,

MR. MONTELEONE: You Will not,

MR. HULME: I will not.

MR. MONTELEONE: Fair enough, Doctor. Thank you very much.

THE WITNESS: Thank you.

(Deposition concluded)

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STATE OF OHIO,)
) SS: CERTIFICATE
COUNTY OF CUYAHOGA.)

I, Suzanne Vadnal, a Registered Professional Reporter and Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named witness, DALE COWAN, M. D., was by me first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by him was by me reduced to stenotypy in the presence of said witness, afterwards transcribed upon a typewriter; and that the foregoing is a true and correct transcript of the testimony so given by him as aforesaid.

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

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

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 28th day of February, 1986.

Suzanne Vadnal

Suzanne Vadnal, RPR, Notary Public
In and for the State of Ohio
My commission expires October 4, 1988.

- - -

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STATE OF OHIO,)
) SS: AFFIDAVIT
COUNTY OF CUYAHOGA.)

SUZANNE VADNAL, being first duly sworn according to law, states as follows:

1. That she is a Registered Professional Reporter and Notary Public within and for the State of Ohio;

2. That the deposition of Dale Cowan, M.D., a witness herein, called by the plaintiffs for cross-examination pursuant to the Ohio Rules of Civil Procedure, was taken before her on February 20, 1986;

3. That when the deposition was transcribed, she notified the witness on or about March 4, 1986 that the deposition was transcribed and was available to be read and signed;

4. That the witness made no attempt to read and sign said deposition during the next seven days.

Further affiant saith naught.

Suzanne Vadnal
Suzanne Vadnal

SWORN TO BEFORE ME and subscribed in my presence this 21st day of March, 1986.

Marian E. Spehar
Marian E. Spehar, Notary Public
In and for the State of Ohio

My commission expires July 25, 1989.