IN THE COMMON PLEAS COURT OF LAWRENCE COUNTY, OHIO

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TERRI NOEL, et al.,

Plaintiffs, :

vs. : case NO. PI-98-401

RODOLFO CANOS, et al., :

Defendants. :

- - -

Videotaped Deposition of STEPHEN J. DEVOE, M.D., a witness called by the defendants under the applicable Ohio Rules of Civil Procedure, taken before Denise L. Shoemaker, a notary public in and for the State of Ohio, pursuant to notice and stipulations of counsel hereinafter set forth, at the offices of the deponent, 3555 Olentangy-River Road, Columbus, Ohio, commencing on Thursday, July 8, 1999, at 4:18 p.m.

- - -

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Canned

THURSDAY AFTERNOON SESSION.

July 8, 1999

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STIPULATIONS

It is stipulated by and among counsel for the respective parties that the deposition of Stephen J. DeVoe, M.D., a witness called by the defendants under the applicable Ohio Rules of Civil Procedure, may be taken at this time in stenotypy by the notary: that said deposition may thereafter be transcribed by the notary out of the presence of the witness; that proof of the official charactec and qualification of the notary is waived.

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APPEARANCES:

Amysue Taylor, Esquire
501 south High Street
Columbus. Ohio 43215

on behalf of the Plaintiffs.

Stanley C. Bender, Esquire
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P.O. Box 950
Portsmouth. Ohio 45662

On behalf of the Defendants.

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INDW TO EXEIBITS (Marked Prior)

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Thereupon, Defendant's Exhibit A was marked for the purpose of identification.

Thereupon,

STEPHEN J. DEVOE. M.D.

being by me first duly sworn, as hereinafter certified, deposes and says as follows:

DIRECT EXAMINATION

By Mr. Bender:

Q For the record, this is the deposition of Dr. Stephen DeVoe. It's being taken at Riverside Hospital in Columbus, Ohio. It is July the 8th of 1999, and it's very close to 20 minutes after 4:00.

Doctor, with that, would you tell the ladies and gentlemen of the jury your name and your profession.

A My name is Steve DeVoe, and I'm a physician specializing in obstetrics and gynecology.

Q Doctor, what is obstetrics and gynecology?

A Obstetrics and gynecology is the care of -- the obstetrics part first, I guess, is the care of the pregnant woman, that is, diagnosis and management of pregnancy, deliver a baby -- delivery of babies and postpartum problems and problems that may

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come up during the pregnancy.

Gynecology is the management, diagnosis and treatment of diseases of the reproductive tract in the nonpregnant woman.

Q By the time that a jury hears your testimony in the course of this trial, the phrase "carcinoma in situ" will have been mentioned many tunes, I'm sure. But does your practice encompass the management, diagnosis and treatment of carcinoma or cancer in situ?

A Yes, it does.

Q Would you tell us your education and your training and your experience as a medical doctor in general and as an obstetrician-gynecologist in particular?

A I graduated medical school at Ohio State in 1969. Took a year of surgical internship at the hospital at the University of Pennsylvania in Philadelphia. Then I took a four-year residency at the same institution, '70 to '74. I was in the Navy for two years where I practiced obstetrics and gynecology. Then I came back to Columbus and set up a private practice in OB/GYN at Riverside.

I'm heavily involved with medical education. We train residents to practice obstetrics

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and gynecology who are Riverside residents. I also teach medical students from Ohio State who rotate through Riverside. I'm on the faculty of the Ohio State University College of Medicine.

My private practice consists of about half and half obstetrics and gynecology. Part of the normal function of a gynecologist is annual pap smears or more often than annual. So I spend a good bit of time dealing with the interpretation and management of pap smear problems and treatment of them.

Q You are -- I'm sure this question seems self-evident, but you are board certified?

A Yes, I am.

Q And would you tell the jury what you're board certified in and what it means to become board certified?

A I'm board certified in the special field of obstetrics and gynecology. What it means is that you finish an accredited or approved residency program, which I took at Penn. Then you sit for a written examination at the conclusion of the residency, two- to three-hour exam. Beginning a year later you collect all of your cases, that is, all of your clinical experience for a year, and several months after that 12-month record is completed, you

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sit for an oral exam in our field involving your cases or whatever else they want to ask you.

Q Let me ask you this: You indicated that you are on the staff at Ohio State University?

A Yes, I am.

Q In the course of that, do you have the experience of instructing and training other doctors?

A Yes, I do. For years I was a faculty member of the high-risk OB clinic there, that is, the high-risk pregnancy clinic. We also have medical students who are not quite doctors yet but also residents who are physicians who are being trained in obstetrics and gynecology at Riverside, and I'm heavily involved with their education in the management of their residency program.

Q Of course we're talking about carcinoma or cancer in situ in this case. Is that a topic that in the course of your teaching and training of other physicians and medical students that you have had occasion to lecture on?

A *Yes*, I have several times talked to medical students and residents about management and diagnosis of this problem.

Q Let me ask you this: In the course of your profession, have you had occasion to be asked by

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lawyers to appear in courts or in depositions like this and express your opinions as to the quality of care that physicians may have given to patients?
A Yes, I have over the years. I have been asked a number of times to do that.
Q You charge for that time, I assume, since it takes away from your practice?
A I do charge for it, yes.
Q I think I have asked you on one other occasion, have I not, to do that?
A Yes, you have, I think one other case.
Q And has Ms. Taylor, who is representing the plaintiffs in this case, has she asked you to do that in the past'?
A I think I've dealt with her, she told me earlier, at least two cases, and several informal meetings where cases are reviewed at her request.
Q Do you have any bias to one side or the other in this case, doctor, or any of the cases where you're asked to review the facts?
A I really don't. We're asked -- my understanding of our role here is to function as a technically supposedly expert person who explains technical matters to the court and not function as an advocate.

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Q Have you had situations in the past where you were asked to review cases such as this and you have expressed opinions adverse to the doctors involved?
A Yes, I have.
Q In fact, have you had at Least one situation where you have testified against a medical doctor before the state medical board on behalf of patients?
A Yes, I have. I've done that.
Q At my request did you review the medical records of Mrs. Noel and the depositions of Mr. and Mrs. Noel and both Drs. Canos and Dr. Essig in this case?
A Yes, I did.
Q And let me ask you some opinions here and then we're going to get into the specifics of the case.
Based upon your review of these records and documents and your education and your training and your experience, in your opinion, did Dr. Canos and Dr. Canos in recommending to Mrs. Noel a hysterectomy in February of 1996 meet appropriate medical standards of care?
A It is my opinion that they did meet the appropriate relevant medical standards of care.
Q Let me say that in legal terms that we have to do as lawyers. Do you have an opinion as to whether or not both Drs. Canos in their treatment and management of Mrs. Noel acted as physicians of ordinary skill, care and diligence would have done under similar circumstances, not only in recommending this hysterectomy, but in managing her case in general?
A I do have an opinion.
Q And what is your opinion?
A My opinion is that they did meet the relevant medical standards in the management of her case recommending that surgery, carrying out the surgery and rendering the care they gave her.
Q Let me ask you to tell the jury after your review of these records and these depositions what you think the pertinent facts are in trying to evaluate this situation.
A The pertinent facts are that at a very young age, I believe about 21, Mrs. Noel developed a severely abnormal pap smear and underwent a cone biopsy. A cone biopsy is a procedure in which a cone-shaped piece of tissue is removed from the cervix in order to diagnose why somebody has an abnonnal pap

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smear. Perhaps I might make a little drawing to help with that.
Q If you would, please, have you marked or have I had marked and you provided to me for marking a diagram of the cervix before this deposition?
A Yes.
Q And we have one of those someplace marked as Exhibit A. Do you have that in front of you?
A I think it's here somewhere.
Q There should be one the court reporter marked.
A It's right there. You want me to write on that one?
Q Sure. They're all the same, are they not?
A Yes, they are. They're copies from a textbook.
Basically what a cone biopsy is -- well, first for some orientation. The top picture is what the doctor sees looking at a cervix during an examination. The cervix is the mouth of the womb. The bottom picture shows what it might look like in the patient if you could look into the abdomen. The

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uterus is up here like this, the cervix sticks down into the vagina. We put an instrument into the vagina and take a look at the cervix and *see* this circular picture.

A cone biopsy then, an incision is made basically where this line is around the cervix, and I'll make it brighter or bigger. Sort of circular piece of tissue is removed from the cervix. In the other direction it looks like this. The bottom picture is the uterus looking at it from the front as if looking at the palm of my hand, the uterus *or* cervix is at the bottom and the top of the uterus is my fingertips, and you take out a cone-shaped piece of tissue to get the surface area of the cervix where the abnonnal pap smear cells are coming from. The purpose of this is to diagnose what's wrong with the patient's cervix or what's wrong with the pap smear is to find out what the problem is.

Q Let me back up for just a little bit. I notice that you have some notes here that you've taken in the course of reviewing this.

A I have some notes.

Q Feel free to use any whenever you want.

A Thank you.

Q Mrs. Noel presented to Drs. Canos in November of '94 and there was something about her that they wanted to do a cervical conization for.

A There was an abnormal pap smear.

Q Now, we've heard the phrase "pap smear" a lot. Can you tell us what that is?

A That's a-good question. A pap smear is named after a man who described the process. But basically it involves scraping some cells off the cervix, putting them onto a slide usually, some stains to fix the cells so they don't deteriorate. Then they're evaluated under the microscope by an expert, pathologist or cytologist, to see if they're normal or not. This is something every woman should do at least every year.

Q Are pap smears -- well, a pap smear is designed to show the presence of abnormal cells; is that correct?

A That's correct.

Q If a pap smear does not show abnormal cells, does that mean definitely that there are no abnormal cells there?

A No, it does not mean that. Unfortunately, like most medical tests, pap smears have a false-negative rate. In fact, even when a patient has invasive cervical cancer, 5 percent of the time the pap smears will be normal. This is the reason behind getting them every year, to cut down the chance of someone having a false-negative pap smear every year and having it being missed.

Q I've heard pap smears described this way and you tell me if I'm mischaracterizing this. I have heard **pap** smears described not as something that is necessarily diagnostic of any condition but is something that is useful --

MS. TAYLOR: Objection.

Q I haven't finish the question yet.

-- something that is useful'as a screening device. Would you agree or disagree with that characterization?

MS. TAYLOR: Objection; leading the witness.

A I would agree with that characterization. That's definitely true. Pap smears are screening tests and simply when they work, identify the patients who need further evaluation or treatment.

Q Now, when this young lady presented in November of '94 and had this cervical conization and you told us that she had an abnonnal pap smear, is a cone biopsy in your mind an acceptable way for the Drs. Canos in this case to follow-up on that abnormal **pap** smear?

A Yes, it is. Her pap smear was severely abnormal, and the severity of it warranted a conization biopsy to identify why it was abnormal, exactly what the abnormality was.

Q How do you do a cone biopsy? I know you started to explain that to us and I interrupted you. But explain how that is done.

A This kind of cone biopsy, which I also do, is done in the operating room. In this particular case a laser beam was used, which is basically a light beam of stimulated, in this case, carbon dioxide instrument of high energy that will cut through tissue, and it's used to excise or remove a cone-shaped piece of tissue. If I turn this upside down, this looks like an ice cream cone at the top. That's the piece of tissue that would be excised.

The operator goes around in a circle of the cervix and then angles the beam toward the middle of the cervix and takes out a cone-shaped piece of tissue to remove the area where the pap smears are coming from and where the abnormalities are arising so it can be studied further under the microscope.

Q Now, when a doctor takes out this

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patient's tissue with a cone biopsy, what is then done with that tissue?
A That tissue is then fixed so it doesn't deteriorate and studied by a pathologist. It's sliced into sections, and they make a diagnosis based on what the section showed under the microscope.
Q Now, what is a pathologist?
A A pathologist is an M.D. usually or an osteopathic physician who is trained in the special field of pathology. And one of the areas of that is anatomic pathology, and they look at tissue samples, blood samples under the microscope or by other technologies to make diagnoses.
Q Now, once a pathologist examines tissues such as in this case, does a pathologist typically make a written report that is then given back to the attending physician to be used in the further treatment of the patient?
A Yes, they do. That's exactly how it works.
Q And was that done in this case. and do you have a copy of that pathology report that you might look at?
A I do.
Q Why don't you take a minute to get that

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and I want to ask you some questions about it.
A I have it. I have a copy of it anyway.
Q By this point in this trial, this pathology report has been identified into evidence and I want to read a section of this to you and have you explain it to us, please. With reference to the microscopic examination, this pathology report said, "sections reveal a circumferential carcinoma in situ occupying the area of the transitional zone." Let's digest that much first. Can you explain that to the jury? And if you need to use your drawing, please feel free to do so.
A I can. The transition zone or transformation zone is where *two* different cell types meet. The skin-like cells or squamous cells align the surface of the cervix, the lining of the vagina and the skin on the outside. The columnar cells or mucous reducing cells line the canal on up into the uterine cavity. Where they meet is the transition zone or transfonnation zone. That's where new cells grow, that's where abnormalities develop, including cancers, and that's the area you're interested in removing when you do a cone so you can see it under the microscope.
Q I'm interested in particular in the word "circumferential." What does that mean in this

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case, if you know?
A Circumference, of course, is the distance around a circle. And what that means to me is the pathologist's description of how extensive the carcinoma in situ is. To me it means it's all over the specimen, all around the specimen in a circular manner.
In other words, in this drawing I made earlier, this is the surface of the cervix and the circumferential carcinoma in situ goes all the way around the cervix. He described it as the face of a clock. He said that also at the section between 12:00 and 3:00, which would be this quadrant on the patient's left, it appeared that the carcinoma in situ went through the edges of the specimen, which means some of the disease was left behind.
Q Okay. Now, let me stop you there. Hold that up, if you will.
When you describe or the pathologist describes this carcinoma as being circumferential in the cervix, does that mean that it's just localized in one spot or does that mean it goes all the way around this clock?
A It means it goes all the way around the face of the clock, if you will. And it also by

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description here involves the whole surface. To think in another dimension, from the surface of the cervix on into the lining of the surface or basement membrane, the whole surface, the whole thickness is involved from the surface down as well as all over on the surface. So it's very extensive.
Q All right. Now, we have heard the phrase many, many times at this point in the trial "carcinoma in situ." Can you tell us what that is?
A In a technical term, that technical definition means cancer cells. They're malignant cells. They're limited to the surface of the cervix. They've not broken through the basement membrane, which is a lining that can be identified under the microscope as the bottom part of the surface lining. It's a malignancy limited to the surface of the cervix. It's not invasive at that point.
Q Correct me if I'm wrong, what you're telling us is and what the pathology folks are telling us here is that this lady has a cancer that has not yet invaded the out -- farther than the outside cells of her cervix but it has done it pretty much over the entire cervix?
MS. TAYLOR: Objection.
A That's exactly right.

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MS. TAYLOR Objection; move to strike. Leading the witness. Testifying for the witness.
By Mr. Bender:
Q Now, doctor, is this something that's going to have to be treated?
A Absolutely.
Q Let's assume for a minute that a carcinoma in situ is not treated or that it is treated in a substandard fashion, and by substandard fashion I mean you don't get it all, and it is allowed to invade into the body. Does that happen from time to time?
A Yes, it does.
Q And can you tell the jury what happens if you allow this carcinoma to escape'?
A Well, if it escapes and goes through the cervix, it then becomes an invasive cancer with the potential to become a fatal disease. If it's diagnosed at that late stage, the patient has a chance of dying from it and has to have a radical hysterectomy and/or radiation and still has a chance of dying down the road from recurrent or persistent cancer.
Q *You* were telling us earlier when Ms. Taylor was asking you some questions about the number

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of people who may die each year from this sort of thing. Do you remember that?
A There are about 5,000 deaths a year in the Unites Stated from cancer of the cervix.
Q Is it prudent for any gynecologist who is faced with carcinoma in situ to do everything that he or she can to ensure that this does not escape?
A Yes, it is, of course.
Q Now, when you -- when one does a cone biopsy, which is what was done in this case, is it always possible to ensure when one does that cone biopsy that you get all of this bad tissue? They call that a lesion, then don't they?
A Yeah, it's a lesion. Just means something abnormal.
Q Is it always possible to ensure that you get all of the bad tissue?
A It's not possible to ensure that because the process is going on microscopically, and we don't have a microscope where you can see in the operating room how extensive the disease is. So you take an approximation of the cervix trying to get this transfonnation zone or transition zone completely removed and then you send it to a pathologist to see what the result is and how extensive the disease is.

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Q Now, in this case, in this pathology report, was the pathologist able to guarantee or ensure Drs. Canos that all of the bad tissue, all the lesion was removed?
A No. In fact, there was a specific comment that a source of concern.
Q Would you read that comment into the record, please?
A Yes. This is at the conclusion of the report that you started reading a few minutes ago. This is only a problem -- back up. In the 12:00 to 3:00 quadrant where the carcinoma in situ appears to extend through one of the margins.
Q Now, what does extending through one of the margins mean here medically?
A It means that some of the disease was left behind. Some of the microscopic cancer cells were left behind in the cervix inadvertently by Dr. Canos during the cone.
Q Is that malpractice or is that just something that happens in conizations?
A It's one of the limits of the procedure. It happens in conizations. And again, as I said a few minutes ago, this is a microscopic process and one can't tell how extensive it is in the

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operating room.
Q Can you hold Exhibit A up and show to the jury where this 12:00 to 3:00 area might be?
A I'll make another mark on this thing. Again, we're looking at the cervix and considering it as if it were the face of a clock. This is the picture the doctor sees doing a cone or even for that matter taking a pap smear. And then pathologist will divide this cervix into quadrants and make some sections of each quadrant. So now he's got four pieces, at least for his description he has maybe one piece, but he's going to describe it in four parts, A, B, C, and D or 12 to 3, 3 to 6, 6 to 9.
The 12 to 3 segment would be on her left toward the front of her body, toward her abdominal wall. In that I2 to 3 segment the pathologist said the carcinoma in situ goes through the margins. "Appears to extend through one of the margins" is a quote.
Q We talked a little bit about what a carcinoma in situ is. Can you tell us how these cancerous lesions or microscopic cancerous lesions develop, what they are typically associated with?
A In almost all cases, microscopic cancer or invasive cancer are due to infection with a virus

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that changes the cells behavior and causes them to become abnormal. In some types -- in some cases depending on how aggressive or how destructive the virus is the patient may develop a severe precancerous condition such as this as the first sign that there's anything wrong. Those patients have a considerable **risk** of developing invasive cancer in the near time after that.

Q Now, there has been some testimony in this case by the time we get to your testimony that these cancerous lesion develop at a slow, predictable pace over a number of years. Do you believe that to be true?

A We used to believe that was the case. We think now that it's true for a minority of cervical cancers. Actually there are a lot of reasons to support this. One of them is there seems to be two peak ages for cancer to be diagnosed. One is around 52 and the other is much younger than that. And it appears that because of that, that the progression theory applies to a minority of the patients but a majority of patients who develop cervical cancer develop it rapidly after acquiring this virus that damages their cells in their cervix and the lead time can be as short as two years from the first abnormal

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pap smear to the development of invasive cancer.

Q Do you have some percentages as to in how many cases this condition can develop to invasive cancer within two years?

A I do. The pathology coinmunity has grouped together several severe premalignant changes including carcinoma in situ and this is for technical reasons. They can't always agree among themselves which is which, so they grouped several together and call them high-grade squamous intraepithelial lesions and the generally accepted fact is that of the patients who have high-grade lesions, about 33 percent will develop invasive cancer if untreated.

Q Now, obviously this pathology report back in November of 1994 was referred back to Portia and Rudy Canos, those are the husband and wife.

A Yes.

Q Can you tell from the records what recommendations at that point they gave to Mrs. Noel?

A They recommended that she consider having a hysterectomy as curative treatment for her carcinoma in situ because of the positive margin or the question of the disease extending through the margin. They also suggested that she talk it over with her husband and her mother and give it some

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thought.

Q That is in '96. I'm back in '94 yet.

A Oh, I'm sorry.

Q Before she became pregnant. What was the recommendation from the records in November of '94 once the cone biopsy was reported back?

A They discussed with her the need for further treatment or at least close follow-up, and I think that was what was done. And she got pregnant while all this consideration was going on two or three months later.

Q Now, can you explain to the jury the different options of a hysterectomy as opposed to referral to a gynecologist for close follow-up?

A Well, those are the options. One would be close follow-up by a gynecologist. There are several ways of doing that, but they always involve frequent pap smears. Because of this danger of cervical cancer, I do something called a colposcopy. It's where you look at the cervix under a magnifying system along with a pap smear.

Another option is always hysterectomy while the disease is a preinvasive cancer rather than running a risk that it might develop into an invasive cancer. That's a total legitimate option. Close

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follow-up is another option.

Q Is a hysterectomy a definitive way of treating it'?

A Yes, it is. It's a way of removing the cervix in this transformation zone and almost always leads to a cure and the end of the process for the patient.

Q Now, in this earlier situation in November of '94, she elected at that point to be followed by a gynecologist. Did you find that to be appropriate, too?

A Yes.

Q Does your review of the record show that in fact she was referred to a gynecologist by Drs. Canos?

A Right. 1think she saw Dr. Pettit in February of '95 where she did have an abnonnal pap smear. It was low-grade SIL at this time. And then she subsequently delivered and had a pap smear after that that was normal.

Q That was something I was going to ask you about. Once we have the cone biopsy pathology report that shows that there is part of this bad tissue, this lesion extending through the margin, in subsequent pap smears, whether they be abnormal or

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normal, really tell you for sure whether or not this cancer was completely removed?
A They do not. Pap smears do have a false-negative rate. As I said I think a few minutes ago, about 5 percent of the cases where actually the patient has a life-threatening invasive cancer, the pap smear will be negative through a failure to process. Pap smears are like most medical tests, they're not a hundred percent effective in diagnosing or recognizing, I should say, a given condition. So that someone can have normal pap smears and still have persistent disease buried in the surface of the cervix.
Q Is there any way that you know of, doctor, to ultimately, definitively remove the chance of this young lady having either a continuation of the existing cancer or a recurrence of new cancer in her cervix other than finally having a hysterectomy'?
A That's the most definitive way of doing it. Obviously it's a final step in terms of having babies. That is the most definitive way of doing it.
Q Let me ask you this: If you have had a carcinoma in situ or if you have one, just the fact that you have it or have had it, does that in any way statistically increase your likelihood that you're

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going to have it again?
A Yes, it does. The reasons why people get these things aren't well worked out. But whatever influences they are, once we know from a statistic -- a series of statistical studies once you've had a carcinoma in situ-or an abnormal pap of any kind, you're more likely to have a subsequent problem. It's considered persistent disease or disease that wasn't removed that happened within two years but occurs after two years down the road it's new disease, new problem, starting from scratch over again.
Q You said this was viral related?
A It appears to be, in almost all cases.
Q Can you tell anything in this case about the how virulent or aggressive the virus is in this lady's case?
A Not with certainty. Except the fact that she goes from minor abnormalities and normal pap smears to a severely precancerous pap smear. That suggested to me that she has one of the types which are number 16 or 18 of the HPV that are associated with a rapid development of malignancy. The progression theory does not apply to her.
Q Is it unusual to have somebody as young as she is have something like this?

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A Yes, it is. Fairly unusual.
Q Okay. From your review of the records, did she in fact follow the advice of the Drs. Canos and go to a gynecologist for close follow-up?
A Yes, she did.
Q And did she in fact become pregnant, whether intentionally or inadvertently, and have a healthy baby?
A Yes, she did.
Q From your review of the records, did she come back then approximately one year later to the Drs. Canos'?
A Yes, she did.
Q And did she at that point ask them for their opinion or recommendation as to ultimately the final treatment for the problem she had **had with the carcinoma in situ?
A Yes, she did.
Q Obviously we know by now that their recommendation to her was a hysterectomy.
A That's right.
Q And do you have any quarrel or problem with that recommendation to her at that point?
A No, I don't.
Q Have you had situations, doctor, where

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you have recommended hysterectomies to patients who have carcinoma in situs?
A Yes, I have.
Q Have you had patients come to you and ask for a hysterectomy after having learned they have had a carcinoma in situ.
A Yes, I have. That's not infrequent.
Q Is that true even though that patient may have had some normal pap smears before the hysterectomy?
A Yes.
Q And why would that be?
A Well, you have to take into consideration the fact that we know there is a recurrence rate for carcinoma in situ and in some of those cases it's extensive, where the edges of the cone biopsy showed disease right up to the edge of the specimen and presumably off into the remaining cervix, the patients, I make them aware of that. They want something done definitively and they choose the hysterectomy.
Q Can you tell from the records as to whether or not she made an excellent recovery from the hysterectomy itself?
A Yes, she had an uneventful

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postoperative course.
Q Doctor, let me ask you this: If this young lady had not had this hysterectomy and this cancer had escaped the margins or she had developed a new carcinoma in situ because her increased risk and it became invasive, in other words, it got away from the doctors and from her, can you explain to the jury how that would progress and what could have happened to her and the kinds of treatments that she would had to have undergone? What if What if . . .
A Once a cancer of the cervix becomes invasive and escapes through that basement membrane I was describing earlier, it requires invasive and/or radical treatment in an attempt to cure it. For young people, the situation is usually a radical hysterectomy, which is an extensive operation removing the cervix and uterus and the tissues around the cervix in order to get the cancer invaded off the cervix.
If it's advanced too far to be treated surgically, and there are stages for invasive cancer, stage 1, 2, 3, 4, if it is past 1B, they have to be treated with radiation. And there is -- each of these stages has a percentage chance of dying within five years depending on how aggressive the cancer is and

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how indignant it appears under the microscope. There are degrees-of malignancy. And if it's very aggressive and very extensive, the chances of dying are considerable, depending on the stage. They get worse with each successive stage.
Q In this case and -- well, let me ask you this: Was removal of the cervix through the hysterectomy, did that eliminate that situation for this young lady?
A It eliminates their chance of having invasive cancer. It appears to, and it's highly unlikely that she is cured from this problem. It could develop in the upper vagina. She should continue to have pap smears annually. But more likely -- much more likely than not she's cured.
Q Let me ask you this: The pathology report where the doctor looks at the tissue and so forth, the cervix after it was removed did not show any carcinoma in situ or cancer; is that correct?
A That's correct, it did not.
Q Is there any way for anyone to have known before the hysterectomy that in fact there was no cancer currently present at that time?
A Not really. All they had was the cone biopsy report from the fall of '94 that showed the

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disease went through the margins of the specimen and suspicion therefore that there was residual carcinoma in situ.
Q Even if there was not found to have been in retrospect after the hysterectomy was performed any cancer at that point, does that mean cancer would not have recurred again because of her susceptibility due to the virus?
A It does not mean that she's going to be cancer free for a lifetime. It also doesn't mean these she's cancer free at that time. Pathology is not a perfect science either, just like our pap smears. And once in a blue moon a cancer will be so small that it's not detectable even with an appropriate thorough exam of the cervix and uterus specimen, the cancer will recur later.
Q Something else I wanted to ask you about that I have read about this disease is its relationship or its seemed occurrence with people who smoke. Can you comment on that for us'?
A That is what's called an epidemiological observation. That is, people sit down and study large groups of patients and see what happens to them. And in several studies, enough so that it's accepted as a fact, the risk of precancerous

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changes is about five or six times higher in smokers compared to nonsmokers. The reasons aren't understood. but obviously the smoking does something to the membrane or surface of the cervix.
Q You have had a chance by now to review the deposition of Dr. Essig, I believe.
A Yes.
Q And this is somebody who is known to you.
A Yes.
Q It may surprise you to know that not all lawyers agree on everything. Do all doctors necessarily agree on everything?
A No, they don't. And I'm sure that Dr. Essig, like I, will allow that there is more than one way to skin a cat.
Q In reviewing Dr. Essig's deposition testimony. his testimony under oath, were there things, comments that he made that perhaps you disagreed with?
A There were some.
Q Would you share those with us, please?
A Well, one is, the most important one I think that bears on this case is a comment that there's the progressive -- that these conditions

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progress slowly over a period of years before they become invasive. I would point out that Mrs. Noel or Noel has an advanced precancerous stage of this disease when it's first diagnosed. She's not beginning at an early stage. The next progression for her is invasive cancer.

Now, the progression theory, which came out in the sixties and has really been shelved for a majority of patients with precancerous cervical disease, it does affect some people. There are certain cervical cancers which develop over a number of years. We recognize now through more recent studies that a majority of cervical cancers develop in people much quicker and earlier and don't go from mild dysplasia to moderate to severe or in situ and then to cancer. They jump right in with a severe precancerous finding, and then shortly after that invasive cancer.

This is how a young person like this who's 21 years old gets an advanced precancerous disease in such a short time. She jumped way into the process, not through the progression stage. It's people like her that led to this conviction that the progression theory no longer applies to most patients with advanced cervical precancer changes.

Q Anything else that leaps out at you in

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Dr. Essig's deposition?

A That's the strongest comment he made. He described the carcinoma in situ as benign neoplasia. I don't know. I think that may have been at the spot where he thought it would take some of the sting out when you're talking about it. This lady had cancer cells on the surface of her cervix, and while cancer of the cervix, cancer in situ doesn't always become invasive instantly, it is a legitimate threat. And I would quibble with the grammar of the terms benign neoplasia. That's two words meaning the opposite, and I don't know how you can use them together.

Q Is there anything benign or harmless about cancer?

A No, of course not. That's really the major disagreements I have with Dr. Essig is the idea that this is a progression and that this lady is most likely going to have a long time before she's at risk for cervical cancer. She's already got the most advanced precancerous change you can have. She's obviously one of the people who, if she is not treated, is this 33 percent risk of developing invasive cancer.

Q Let me ask you about two other things

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and then I think we're done. Let me ask you to assume, and I imagine that you've seen this from your review of the records in any event, that when in 1996, in March of 1996, February, I guess, Rudy and Portia recommended to Mrs. Noel that in their opinion the hysterectomy was something she should consider.

Let me ask you to assume that she was advised by them to think about it, consult with her mother, consult with her husband, consult with any family members that she wanted, and in fact she did do those things. And that she has testified at this point in this trial that she understood that she could have consulted with any other physicians that she wanted to but she chose not to in this instance because she trusted Rudy and Portia's judgment because they had given her good treatment in the past. And further assume that she took two weeks to think about this before she finally elected to have the hysterectomy.

Assuming those things to be true, do you think that's, in your mind, adequate advice for them to give her and an adequate time for her to reflect on this before she elected to do it?

A Yes, I do. I think the advice was satisfactory. She was given the options. She knows

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she can do the follow-up. She had done that for a year. So knows that she has potential for invasive cancer. She chose to have a hysterectomy. And she knows that she had the opportunity, in fact, it was pointed out to her to talk to her husband and her mother and anyone whom she chose. She also knew she could get a second opinion from other doctors. I think she testified to that in the earlier deposition. She was adequately informed and made this choice.

Q And finally let me ask you about something not necessarily related just to gynecologists but medicine in general. Often, I would assume every day, you, as a physician, are placed in a position where you have to present options or make recommendations to your patients.

A That's true.

Q Is there always an easy answer or is there always an obvious answer or do sometimes you have to make recommendations or present options to patients where there are risks and downsides no matter which choice one makes?

A Yes, there are. In medicine most of us refer to those as tradeoffs. You take a certain pathway, with it come some risks or possible complications. For example, a pathway of having the

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surgery runs the risk of a surgical complication, hemorrhage, an injury to the ureter or bladder, but the risk of not having a surgery in this case comes out of getting invasive cancer and dying from the disease.

It's a series of tradeoffs, risks versus benefits, and the patient in the last analysis gets to analyze and choose among the options available to her. Mother nature doesn't always give us great choices.

Q Doctor, thank you very much. Are there any aspects of this case, any medical things that you think that are of significance that you would like to or comment on that perhaps I haven't asked you about?

MS. TAYLOR Objection; overbroad.

A I don't think so. I think I want to stress that Mrs. Noel should be cured of this disease and she should do well and she should have close follow-up. She does have some very small risk of recurrent for new disease.

Q Doctor in the course of the last half hour or so, I've asked you for your medical opinion on various things. Are the opinions that you've given us to a reasonable degree of medical certainty and probability?

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A Yes, they are.

Q And this question I'm sure seems self-evidence. But you do spend 50 percent of your time or more of your professional time in the active clinical practice of medicine or teaching?

A Yes, I do.

Q Probably it's a much higher percentage. What percentage is it?

A I guess 95 percent. As asked earlier, I have a few administrative responsibilities, but all my professional time is patient care or teaching basically, reading, preparation to take care of people.

Q Actually there's a couple other things I saw on your C.V. Have you actually written and published articles and chapters in textbooks?

A I have a handful. That really hasn't been my focus through my career, but I've written a number of articles, small number of articles and two or three book chapters.

Q Doctor, thank you very much for your time. Ms. Taylor will have some questions for you.

- - -

Recess taken.

- - -

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CROSS-EXAMINATION

By Ms. Taylor:

Q Hello, doctor.

A Hello, Ms. Taylor.

Q It's good to see you. We are familiar with each other, aren't we?

A Indeed.

Q In fact, last time I saw you was about two years ago when you discharged me from the hospital.

A I remember, with a new baby.

Q Yes. Your partner delivered me.

A That's right.

Q Last time, though, we were involved before Kip's birth two years ago is when I was a defense lawyer, wasn't it?

A That's right.

Q And that was many years ago when I was doing defense medical malpractice; correct?

A It's been some years. I don't remember how long.

Q And at that time when I had you as an expert you were a defense expert then, weren't you?

A In that particular case, yes.

Q And we know from your earlier

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deposition that was right before this video deposition you testified that you do about 12 to 18 depositions a year?

A Yes.

Q And you could only recall one case in which you've been a plaintiff's expert witness?

A No. I was asked how often I had been in court as a plaintiff's expert witness. I have testified on a number of plaintiff's cases and have some ongoing review, a handful of them now. The question was how many times have I been in court.

Q You've only been one time in court best you recall for a plaintiff's case?

A That's one. And one was canceled at the last minute, and there's one scheduled next month. So I look at cases on behalf of patients, too.

Q But the primary -- the majority of the cases that you do review are for physicians, defense cases; correct?

A That's correct.

Q Physicians and hospitals?

A That's correct.

Q And your charges for reviewing the cases are what, $400 an hour now?

A No, that's not right. I charge $360 an

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hour for the review. It takes time in the evening and weekends, and I charge $400 an hour for testimony.
Q So today when I did your discovery deposition that would have been S400 an hour for that:'
A That's correct.
Q And only about 5 percent of your depositions -- excuse me, 5 percent of your reviews have been on behalf of plaintiffs; correct?
A That was my estimate, yes.
Q 95 percent for the defense?
A Right. I don't get asked a lot by plaintiff's attorneys, quite honesty.
Q And you've testified how many times in trials, sir'?
A Well, I guessed 12 earlier, and I think that's a guess over 16 or 17 years of doing this.
Q You're not a pathologist, are you?
A No.
Q You're not a cytologist?
A No.
Q You do not consider yourself an expert in the diagnosis and treatment of invasive cervical cancer, do you?
A I do consider myself a diagnosis expert. Diagnosis -- excuse me, an expert in

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diagnosis. I would not consider myself an expert in treatment.
Q And, in fact, the patients that do have invasive cervical cancer you refer to other physicians in this office building?
A That's correct.
Q You have been practicing medicine for how long?
A 1976 in private practice. I was in the navy for two years before that practicing. So I've been out of training about 25 years.
Q And over those 25 years, you've had maybe a dozen cases of young women in their early twenties on whom hysterectomies were done after a con biopsy with negative pap smears?
A Yes. I estimated. You asked for a guess, and that was my best estimate.
Q You haven't done any of those within the last year, have you?
A No.
Q In fact -- first of all, am I correct, doctor, that you have no criticism or reason to doubt the accuracy of the pathology reports in this case?
A That's correct.
Q And we have no reason -- there's no

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reason to believe that the pathologist missed cancer on Terri's cervix or her uterus?
A We have no reason to believe that, that's true.
Q And we know based upon that that at the time the hysterectomy was done on Terri, she did not have cancer on the tissue; correct?
A That couldn't be known until after the hysterectomy was done.
Q That wasn't my question. We know now when we look at the -- when the pathologist went through those slides. went through that tissue, that there was no cancer present?
A Right. In hindsight we know that.
Q Now, here you've reviewed all the medical records and the depositions of the parties and Dr. Essig; right?
A That's right.
Q Now, have you reviewed any transcript or heard any tape of a conversation that was done a couple of weeks after the hysterectomy between Terri and Dr. Canos?
A No. I was unaware of any taped telephone conversations.
Q You were first made aware of that taped

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conversation, I believe it was face-to-face, during your discovery deposition; correct?
A An hour or so ago, yes.
Q And, in fact, I read to you a portion of that; correct?
A You did.
Q Now, going back again -- before we get into that, about that taped conversation that Terri did so her husband could hear what happened.
MR. BENDER: Excuse me just a minute. I want to object to the characterization as to why this girl may have done whatever she did.
Q We'll let the evidence show. By the time we actually get to presenting this testimony -- excuse me, this trial deposition, it will be in evidence as to why this occurred.
But assume for me, first of all, doctor, that this tape recording was done so Terri could tell her husband, explain to her husband what Dr. Canos told her since she was very upset.
A Why wouldn't she have her husband go talk to Dr. Canos?
Q Her husband works. He might not have been able to get off work.
A Or make a phone call.

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Q Idon'tknow.
A Talk to him himself.
Q I don't know, sir.
Have you ever met Dr. Canos?
A No, I haven't.
Q Are you familiar with how easy he is to understand or not understand?
A I'm not.
Q So you don't know if he's somebody that would be easy to understand on the phone or not, do you?
A Well, he's been practicing and getting along, I assume he's easy enough to understand. He has been in this country quite a while.
Q That will be something for the jury to know and for you -- well, you won't have that opportunity to know that.
MR. BENDER: Excuse me. I want to WD object to the commentary. Ask it be stricken.
By Ms. Taylor:
Q Now, in this case. doctor, after reviewing the records. if Terri had been your patient and she had gone on and had the cone biopsy performed had two negative pap smears afterwards, am I correct based upon what you told me during your deposition

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before this trial deposition, you would have recommended that she have follow-up with a LEEP cone or a hospital cone, but you would also given her the option of a hysterectomy.
A That's correct.
Q Now, why don't you explain -- would you explain to the jury what is meant by a LEEP cone?
A A LEEP cone is one way of doing a cone biopsy of the cervix. LEEP is what we call an acronym. It's four letters and each of them is the beginning of a word. It stands for loop electrical excision procedure, LEEP. Basically it's a little hot wire connected to an electrical source and you cut through the cervix with the hot wire in the office and do the cone that way with local anesthesia.
Q Now, what is a hospital cone?
A A hospital cone would be one I illustrated. The procedure is done in the hospital operating room with a knife or a laser or a LEEP for that matter with general anesthesia usually.
Q Doctor, why would you have recommended to Terri if she had come to you as a patient that she have a LEEP cone done or a hospital cone done and close follow-up?
A As I said. that's one of the options.

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First off, I think there's a mistake here. Usually the LEEP cone is required for the diagnosis or the hospital cone. So that the alternatives are discussed after you've done the cone and make the diagnosis. The cone you would have to discuss ahead of time and explain why you need it, but the definitive or at least the definite diagnostic step is the cone however we choose to do it. After that, this conversation would take place that you're talking about.
Q And what would you mean by close follow-up for a patient such as Terri?
A My case the way I follow these patients is a pap smear at four months along with a colposcopic exam because pap smears do have such a high false-negative rate. that is, they miss things.
Q What's the false-negative rate for a colposcopic exam?
A Depends on how good the colposcopist is.
Q Well, generally what is your false-negative rate?
A That question sounds real simple. It's not. It depends on false negative for what? False-negative for cancer of the cervix, I hope it's zero. False negative, that is. do I miss a minor

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degree abnormality or call something a little more severe than it turns out to be, I think that probably happens. You're considered to be a pretty good colposcopist if you come within one level on your interpretation by a scope of what you find when you biopsy. So the whole point of this is you take biopsies while you're looking.
You asked me for follow-up on the carcinoma in situ. how that would be. It would be colposcopy and pap smears four months and then six months after that and then six months after that would be one way of following up after the cone biopsy diagnosis of microscopic cancer.
Q Can you have this follow-up when you're pregnant?
A Yes. We don't do biopsies when you're pregnant unless you're very suspicion of invasive disease.
Q So if Terri would have gotten pregnant again, there would not have been a problem with managing or following up closely on her potential to have invasive cervical cancer?
A She could have been followed during pregnancy, yes.
Q Now, doctor, when you're talking about

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this cone biopsy that was done on Tem, which was in Defendant's Exhibit **A,** you identified an area, that 12:00 to 3:00 range, where it was thought there was a break-through of the lesion through the margin of the cone.

A Right.

Q Now, that would be information that Dr. Canos, both Dr. Rudy Canos and Dr. Portia Canos would be aware of that; correct?

A Yes.

Q You would agree with me, wouldn't you, that when Dr. Portia Canos went on to do the second pap smear on Terri after the cone biopsy, that she would have put special emphasis on making sure that she got tissue or scrapings from that area?

A I think if you're talking about the December '94, Dr. Rudy took her back to the OR to get a pap -- got a pap smear and that was abnormal again. He did not do a biopsy because he thought there was too much inflammation and healing, but he did do a pap smear which was interpreted as abnormal again.

Q I'm not talking about that one. After that pap smear Terri went on and had a pap smear by Dr. Laura, correct, that was normal?

A That was early '95, yes.

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Q Correct. She then went on and had a second pap-smear done; correct?

A In early *'96.*

Q Correct.

A Right.

Q And that was normal too, and that was done by Dr. Portia --

A Right.

Q -- Canos.

A Right.

Q And would you agree with me that you would expect Dr. Portia Canos when she did that pap smear to put a special emphasis in making sure that she got scrapings from that 12:00 to 3:00 area?

A I would assume so, yes, sure.

Q And that pap smear was negative; correct?

A Right.

Q Are you aware from reading the deposition of Terri that she says that she was told by Dr. Portia Canos that the pap smear that Dr. Portia had done in February showed cancer; correct?

A She said that she was told that, that's right.

O And if Tem were told that she had

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cervical cancer in February of *'96,* that was wrong?

A Yes. She either misunderstood it or she made a mistake or they told her the wrong thing, yes.

Q Now, doctor, if Terri were told that she had cervical cancer and she based her decision to have the hysterectomy on that false statement that she had cervical cancer, then Terri based her decision upon false information; correct?

A None of us were there. If she was told that that pap smear in February was abnormal and that it showed cancer, then she did base it on false information.

Q Now, Dr. DeVoe, you have also told us that there is a good success rate with treatment of Stage I invasive carcinoma of the cervix; correct?

A In general. Depends on the aggressiveness of the disease and the stage of the lymph nodes.

Q In fact, sir, Stage I cervical cancer without lymph node involvement has a cure rate -- survival rate of 5 years of greater than 95 percent, doesn't it?

A I think I said up to *95* percent. Around 95 percent.

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Q Around *95* percent. So if Terri says that she was told that if she developed invasive carcinoina of the cervix Stage 1 that she would die, a hundred percent chance that she would die in five years, that would be wrong; correct'?

A If it was treated, that would be wrong. Your data might be right for untreated.

Q But for treated invasive carcinoma that would be wrong?

A I think so.

Q And we have no indication that --

MR. BENDER: Do you think you can **turn** your phone off while we get this done?

Q That's exactly what I am doing. *Sorry.* Husband.

We have no -- I'm *sorry,* sir. I've lost my train of thought for a moment.

MR. BENDER: 95 percent.

Q Thank you. We have no indication in this case that Terri was a noncompliant patient?

A That's correct.

Q She was a compliant patient, she followed up, didn't she, with treatments?

A Yes.

Q In fact, she had a pap smear done

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during her pregnancy, and then she followed up with another one time wise just when she was supposed to, three to four months after the other pap smear?
A Right.
Q And if Terri had not had the hysterectomy performed, am I correct you cannot say when to a probability she would have gotten recurrent disease, can you?
A That's correct --
Q You can't --
A -- I can't tell you when.
Q And you can't even say if she would have had recurrent disease to a probability?
A I don't know that for certain that she would have. We never have a crystal ball in medicine. We have to make decisions based on the information at hand.
Q But we're talking about more likely than not. You can't say if she would have had recurrent disease; correct?
A No. But if she does, she's in deep trouble. And the stakes are pretty high for a person that gets recurrent disease.
MS. TAYLOR: Objection; move to strike, nonresponsive.

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By Ms. Taylor:
Q Dr. DeVoe, during your deposition I read to you a portion of a statement that -- of a conversation between Terri and Dr. Canos.
A This is the tape-recorded conversation?
Q Correct.
And assume for me, if you will, that Dr. Canos said to Terri, when you get Stage 1, even if you do a radical and strip, first of all, is that a radical hysterectomy?
A I don't know what the strip means. It may mean radiation plus hysterectomy.
Q We take everything out, tubes, ovaries, all the fat, all the muscle, your survival rate is 50 percent. Even with x-ray and chemotherapy, only 50 out of a hundred survive in two to three years and all of them die in five years. If he told you that, if he told Tem that, that would be incorrect?
A This is first Stage 1 cancer, cervical cancer?
Q Correct.
MR. BENDER: Excuse me just a minute, doctor. Let me object. Number one, I don't think the tape is going to be in evidence. So I think she's asking you questions about something that's not

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a part of the record. You may answer, sir.
A If that statement was made referring to Stage 1 cervical cancer, the statement is not true.
Q And if Terri were told that any delay in having the hysterectomy increased her rate of having -- her risk of having invasive carcinoma, even if she had colposcopies and pap smears, that would be incorrect. too?
A No, that's not true. If you're watching and it develops into invasive cancer, then you got invasive cancer and you got to deal with that. That's the whole point of the follow-up.
Q Well, hopefully during the follow-up you find it pretty evasive again.
A But what are you going to do? You have the same situation you had when you decided to follow-up.
Q Now, doctor, going back to about the colposcopy you were -- excuse me. Going and -- I want to talk to you about this cone biopsy that was done --
A Okay.
Q -- by Dr. Canos. He used a laser on that case.
A That's right.
Q What affect does laser have on the

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tissue surrounding?
A Basically it cuts through the tissue with a heated light beam and can destroy the cells right at the edge of the beam that are left behind.
Q Now, am I correct -- well, strike that.
Doctor, can you explain to me how Terri could have no cancer present, negative pap smears after the cone biopsy if there had been this break-through?
A It could be missed because we talked about the false-negative pap smear, that is, a pap smear that's normal even when there is disease present. The disease could have been destroyed by her body in its healing process.
Q How frequently -- excuse me.
A The laser, the heat from the laser could have destroyed the residual disease.
Q And when you're saying it could be destroyed by her body, am I correct that there's a percentage of these patients that have -- that the tumor just goes away?
A The immune or the inflammatory response is such that in these preinvasive diseases and some of the premalignant dysplasias or abnormal cells the body will simply eradicate them. That can happen

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Q How frequently does that happen?
A Depends on which we're talking about.
Q Let's go with the inflammatory, this preinvasive condition.
A Around 12 percent of the high-grade SIL's, which is the advanced premalignant stuff, will seem to go away under observation, and we think that's the body overwhelming it and eliminating it at least for the time being.
Q Now, what did you mean by the laser going and it can cause the tumor to go away, too?
A The laser cuts through the tissue and heats the tissue, actually makes the water in the cells explode and bums the tissue free of attachments. And for a few fractions of millimeters from that cut surface the cells are destroyed. Which the problem is relying on that you have no way of knowing how far through the margin the abnormal cells are. You have no way of knowing whether the laser is going to get them or did get them.
Q And that's why it's important to do close follow-up after that; correct?
A That's certainly a legitimate option, as is hysterectomy.
Q Another option would be to do the pap

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smears and colposcopies as you would do if it was your patient'?
A Again, that would be an option I would offer the patient, and I would also offer the patient a hysterectomy option.
Q And, of course, doctor, since we know that there was no-cancer found on the pathology report for the uterus and the cervix, if a colposcopy had been done instead of hysterectomy, it probably would have been negative also; correct?
A Probably would have been at least up through March of '96. We have no idea what would happen down the road after that with the cervix and uterus there. Her **risk** of having recurrent or persistent disease doesn't end in March of '96, even if a hysterectomy is skipped.
Q And, doctor, we have no indication in the records that you've reviewed or the depositions that Terri was told that there might be a relationship between smoking and her cervical problem, do we?
A I didn't see that in the records, no.
Q Or in the depositions, correct?
A Right, I agree.
Q And there's no indication in any of the records or the pathology reports that Tem did have

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that virus, is there?
A No. But we know from more sophisticated studies that are not done on a routine hospital basis that HPV is almost always associated with this kind of problem.
Q Now, doctor. what do you think is a reasonable charge for a surgeon such as you to perform a hysterectomy?
A What we charge and what we get are two different things because of managed care.
Q What do you normally charge for a hysterectomy?
A What I charge or the hospital charges?
Q You charge. sir.
A We have a fee charge, and I think ours is around S2,000 for a hysterectomy. We get far less than that unfortunately.
Q And what do you think the hospital charges?
A I have no idea. Depends on how long the patient's in the OR. how long they are in the hospital. how much of the hospital's supplies and equipment and personnel they use.
Q And would a five-day hospitalization be usual for a patient having had a total abdominal

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hysterectomy?
A A little unusual now but not extraordinary. Depends on how well she recovers and how vigorously she pursues her recovery.
Q Doctor, I have no further questions at this time. Thank you.

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REDIRECT EXAMINATION

By Mr. Bender:

Q Doctor, let me ask you couple things, then I'll let you go because we have been at this for some length.
Would you agree with me that one of the issues in this was how anxious was Mrs. Noel to have more children at the time she elected to do the hysterectomy'?
A Yes. That's an issue. The issue of more children is always a question for hysterectomy in someone who's not through menopause.
Q Let me ask you to assume that issue was broached with Mrs. Noel, and that here is what she told Drs. Canos by her own admission. I want to read this verbatim. "They," being Drs. Canos, "they asked us if we wanted more children and we said, not right at the present time we don't. We have a

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four-month-old daughter at home. We're not going to just keep making kids. You know, we wasn't financially stable. We was lucky to have her. You know we just had her. I don't think anyone in their right mind would have a baby whenever they have a four-month-old baby at home, you know, just to keep having children," end quote.

Now, as a reasonably prudent physician who has addressed this issue many times with your own patients, does that sound to you like somebody who wants to have more children at the expense of potentially her own health and well-being?

A No, it does not.

MS. TAYLOR: Objection. sustained

A I think the patient who wants more children probably would answer that question and say, I don't want a baby now but we sure want more or we want another one down the road. I'm speculating.

MS. TAYLOR: Objection.

A But that's what most people in that situation would respond.

MS. TAYLOR: Objection; move to strike.

Q Well let me ask you this, as a reasonably prudent physician, does that sound like

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some patient who clearly understands those risks and benefits and set-offs you were describing to us earlier?

A Right, it does. It sounds like she understands that having her uterus out means she's not going to have more children also.

Q Now, I asked you earlier about some of the things that Dr. Essig and you perhaps disagreed about. Do you recall that?

A Yes.

Q Let me ask you some things that perhaps the two of you agree about. If Dr. Essig testified that in doing this cone biopsy, Dr. Rudy Canos did it in such a fashion that the cervix was left competent so this young lady could have a child if she wanted, would you agree with that?

A Yes, I would.

Q And can you explain to a jury what it means to leave a cervix competent as opposed to, I guess, not competent?

A Real quick. Using this diagram again, looking at the bottom picture. Again, this is the barrel of the vagina coming up along the angle of my pen. This is the cervix down here. If you take a lot of the cervix, the supportive tissue up here, the

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surface plus the connective tissue support, the cervix is not strong enough to hold the weight of pregnancy, and repeated pregnancy loss is a complication of incompetent cervix. And this cone was done in a competent manner so she had a successful pregnancy.

Q So there really is an *art* to doing this cone biopsy, and it appears in this case both Dr. Essig and you agree it was done in a very prudent and workman-like fashion?

A Correct.

Q Now, let's assume that Dr. Essig at this point has testified that when the hysterectomy was done that Dr. Canos left in the ovaries and that Dr. Essig testified that leaving in the ovaries is a very smart thing to do because they continue to get her, meaning Mrs. Noel, estrogen. Would you agree with that statement?

A Absolutely.

Q Can you explain that to the jury?

A Well, the estrogen that people, that women have going through their hormone cycle does all these things for us that we now know, like reducing women's risk of heart disease and some of those other things, is produced internally by the ovaries starting when a young girl starts her periods through the

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change of life. And Mrs. Noel was young enough that her ovarian function probably is going to be good up to 30 more years. So leaving her ovaries in was definitely the right thing to do. She gets the benefit of her own internal hormone production all this the.

Q There was one other comment that he made here that I wanted to ask you about.

A Also said that the cone would have been necessary in this case most likely, and it was indicated to do.

Q The other question I wanted to ask you about that he at this point has testified to, he says that what he would say is that he thinks this young lady is at a greater risk of developing the dysplasia, which I gather is the lesion or the bad tissue?

A Uh-huh.

Q Again because this may all be due to this wart virus which is affiliated with this Human Papillomavirus. Do you agree with him on that?

A I agree with him on that.

Q Can you explain that for us?

A Well, we don't quite understand it, but there are a variety of influences that allow this HPV, which is a more formal term for wart virus, a variety

of influences that allows HPV to change the behavior of the cells in the cervix. Whatever influences the cervix is exposed to including the HPV. the upper vagina is exposed to and the remaining areas on the surface of the cervix are also exposed to it. So down the road there's a chance of her developing recurrent premalignant disease and theoretically cancer of the vagina due to the same influences.

Q And finally, Dr. Essig has told us at this point that he thinks this young lady's chances now of getting cancer are probably, quote, pretty slim now that the cervix is gone, end quote. Would you agree with that'?

A I do agree with that.

Q Doctor, would you like -- I'm sorry. Do you have any other questions?

MR. BENDER No, sir.

MS. TAYLOR Would you like to read and view these depositions, or would you waive those privileges?

THE WITNESS: I would waive those privileges, I guess, for your convenience. Whatever you think I should do.

MR. BENDER: Thank very much. sir.

MS. TAYLOR I move to strike all

the testimony. The doctor's lacking qualifications WD under Ohio law. Thank you.

MR. BENDER: What qualifications is he lacking? We will straighten it up now that we are here.

MS. TAYLOR: Well, I don't think you properly set a foundation for him.

(Signature waived.)

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Thereupon, at 5:45 p.m., Thursday, June 8, 1999, the deposition was concluded.

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CERTLFICATE

STATE OF OHIO :
SS:
COUNTY OF MADISON :

I, Denise L. Shoemaker, RPR. and Notary Public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named Stephen DeVoe, M.D., was by me first duly sworn to testify to the truth. the whole truth, and nothing but the truth in the cause aforesaid; that the deposition then given by him was by me reduced to stenotype in the presence of said witness, afterward transcribed upon a computer; that the foregoing is a true and correct transcript of the deposition so given by him; that the deposition was taken at the time and place in the caption specified and was completed without adjournment; and that I am in no way related to or employed by any attorney or party hereto, or financially interested in the action.

IN WITNESS WHEREOF. I have hereunto set my hand and affixed my seal of office at London, Ohio. on this 8th day of June 1999.

DENISE L SHOEMAKER. RPR
NOTARY PUBLIC-STATE OF OHIO

My **Commission Expires:** January 20. *1999.*

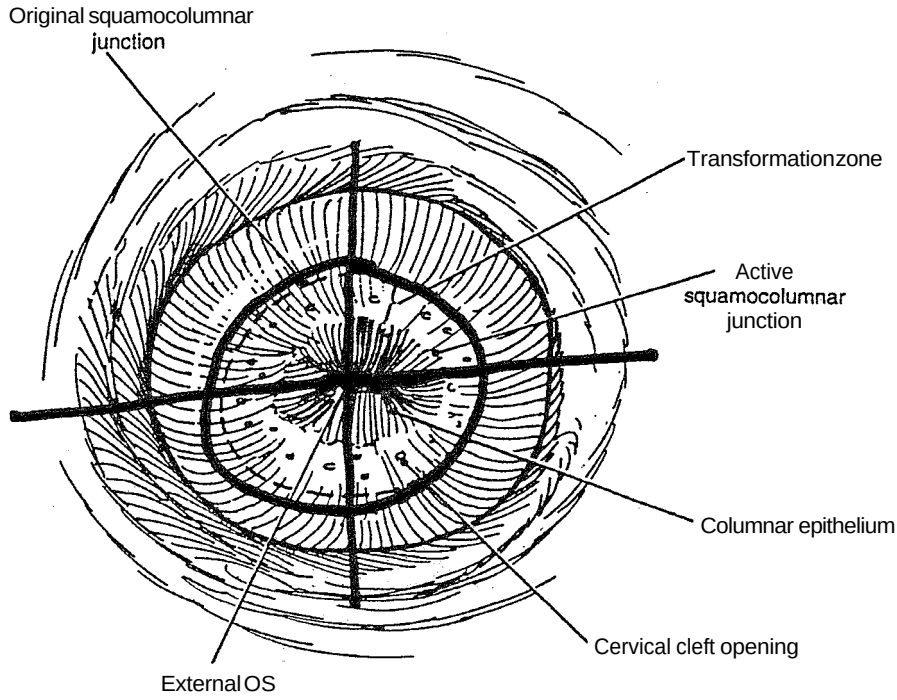

Figure **16.2** The cervix and the transformation zone.

Figure **16.3** Cross-section **of** the cervix **and** the endocervix.