

IN THE COMMON PLEAS COURT OF LAWRENCE COUNTY, OHIO

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.

DENISE SHOEMAKER, RFR
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THURSDAY AFTERNOON SESSION.

July 8, 1999

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 character and qualification of the notary is waived.

Page

APPEARANCES:

Amy Sue 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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INDEX TO EXHIBITS (Marked Prior)

A Page from "Intraepithelial Disease of the Cervix, Vagina and Vulva"

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

4 Thereupon,

5 STEPHEN J. DEVOE, M.D.

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

8 DIRECT EXAMINATION

9 By Mr. Bender:

10 Q For the record, this is the deposition
11 of Dr. Stephen DeVoe. It's being taken at Riverside
12 Hospital in Columbus, Ohio. It is July the 8th of
13 1999, and it's very close to 20 minutes after 4:00.

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

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

19 Q Doctor, what is obstetrics and
20 gynecology?

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

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

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

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

13 A Yes, I am.

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

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

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1 come up during the pregnancy.

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

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

11 A Yes, it does.

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

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

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

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

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

5 A Yes, I am.

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

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

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

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

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

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

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1 Q Have you had situations in the past
2 where you were asked to review cases such as this and
3 you have expressed opinions adverse to the doctors
4 involved?
5 A Yes, I have.
6 Q In fact, have you had at least one
7 situation where you have testified against a medical
8 doctor before the state medical board on behalf of
9 patients?
10 A Yes, I have. I've done that.
11 Q At my request did you review the
12 medical records of Mrs. Noel and the depositions of
13 Mr. and Mrs. Noel and both Drs. Canos and Dr. Essig in
14 this case?
15 A Yes, I did.
16 Q And let me ask you some opinions here
17 and then we're going to get into the specifics of the
18 case.
19 Based upon your review of these records
20 and documents and your education and your training and
21 your experience, in your opinion, did Dr. Canos and
22 Dr. Canos in recommending to Mrs. Noel a hysterectomy
23 in February of 1996 meet appropriate medical standards
24 of care?
25 A It is my opinion that they did meet the

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1 appropriate relevant medical standards of care.
2 Q Let me say that in legal terms that we
3 have to do as lawyers. Do you have an opinion as to
4 whether or not both Drs. Canos in their treatment and
5 management of Mrs. Noel acted as physicians of
6 ordinary skill, care and diligence would have done
7 under similar circumstances, not only in recommending
8 this hysterectomy, but in managing her case in
9 general?
10 A I do have an opinion.
11 Q And what is your opinion?
12 A My opinion is that they did meet the
13 relevant medical standards in the management of her
14 case recommending that surgery, carrying out the
15 surgery and rendering the care they gave her.
16 Q Let me ask you to tell the jury after
17 your review of these records and these depositions
18 what you think the pertinent facts are in trying to
19 evaluate this situation.
20 A The pertinent facts are that at a very
21 young age, I believe about 21, Mrs. Noel developed a
22 severely abnormal pap smear and underwent a cone
23 biopsy. A cone biopsy is a procedure in which a
24 cone-shaped piece of tissue is removed from the cervix
25 in order to diagnose why somebody has an abnormal pap

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

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1 uterus is up here like this, the cervix sticks down
2 into the vagina. We put an instrument into the vagina
3 and take a look at the cervix and see this circular
4 picture.
5 A cone biopsy then, an incision is made
6 basically where this line is around the cervix, and
7 I'll make it brighter or bigger. Sort of circular
8 piece of tissue is removed from the cervix. In the
9 other direction it looks like this. The bottom
0 picture is the uterus looking at it from the front as
1 if looking at the palm of my hand, the uterus or
2 cervix is at the bottom and the top of the uterus is
3 my fingertips, and you take out a cone-shaped piece of
4 tissue to get the surface area of the cervix where the
5 abnormal pap smear cells are coming from. The purpose
6 of this is to diagnose what's wrong with the patient's
7 cervix or what's wrong with the pap smear is to find
8 out what the problem is.
9 Q Let me back up for just a little bit.
0 I notice that you have some notes here that you've
1 taken in the course of reviewing this.
2 A I have some notes.
3 Q Feel free to use any whenever you want.
4 A Thank you.
5 Q Mrs. Noel presented to Drs. Canos in

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1 November of '94 and there was something about her that
2 they wanted to do a cervical conization for.
3 A There was an abnormal pap smear.
4 Q Now, we've heard the phrase "pap smear"
5 a lot. Can you tell us what that is?
6 A That's a good question. A pap smear is
7 named after a man who described the process. But
8 basically it involves scraping some cells off the
9 cervix, putting them onto a slide usually, some stains
0 to fix the cells so they don't deteriorate. Then
1 they're evaluated under the microscope by an expert,
2 pathologist or cytologist, to see if they're normal or
3 not. This is something every woman should do at least
4 every year.
5 Q Are pap smears -- well, a pap smear is
6 designed to show the presence of abnormal cells; is
7 that correct?
8 A That's correct.
9 Q If a pap smear does not show abnormal
0 cells, does that mean definitely that there are no
1 abnormal cells there?
2 A No, it does not mean that.
3 Unfortunately, like most medical tests, pap smears
4 have a false-negative rate. In fact, even when a
5 patient has invasive cervical cancer, 5 percent of the

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1 time the pap smears will be normal. This is the
2 reason behind getting them every year, to cut down the
3 chance of someone having a false-negative pap smear
4 every year and having it being missed.
5 Q I've heard pap smears described this
6 way and you tell me if I'm mischaracterizing this. I
7 have heard pap smears described not as something that
8 is necessarily diagnostic of any condition but is
9 something that is useful --
10 MS. TAYLOR: Objection.
11 Q I haven't finish the question yet.
12 -- something that is useful as a
13 screening device. Would you agree or disagree with
14 that characterization?
15 MS. TAYLOR: Objection; leading the
16 witness.
17 A I would agree with that
18 characterization. That's definitely true. Pap smears
19 are screening tests and simply when they work,
20 identify the patients who need further evaluation or
21 treatment.
22 Q Now, when this young lady presented in
23 November of '94 and had this cervical conization and
24 you told us that she had an abnormal pap smear, is a
25 cone biopsy in your mind an acceptable way for the

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1 Drs. Canos in this case to follow-up on that abnormal
2 pap smear?
3 A Yes, it is. Her pap smear was severely
4 abnormal, and the severity of it warranted a
5 conization biopsy to identify why it was abnormal,
6 exactly what the abnormality was.
7 Q How do you do a cone biopsy? I know
8 you started to explain that to us and I interrupted
9 you. But explain how that is done.
10 A This kind of cone biopsy, which I also
11 do, is done in the operating room. In this particular
12 case a laser beam was used, which is basically a light
13 beam of stimulated, in this case, carbon dioxide
14 instrument of high energy that will cut through
15 tissue, and it's used to excise or remove a
16 cone-shaped piece of tissue. If I turn this upside
17 down, this looks like an ice cream cone at the top.
18 That's the piece of tissue that would be excised.
19 The operator goes around in a circle of
20 the cervix and then angles the beam toward the middle
21 of the cervix and takes out a cone-shaped piece of
22 tissue to remove the area where the pap smears are
23 coming from and where the abnormalities are arising so
24 it can be studied further under the microscope.
25 Q Now, when a doctor takes out this

1 patient's tissue with a cone biopsy, what is then done
2 with that tissue?
3 A That tissue is then fixed so it doesn't
4 deteriorate and studied by a pathologist. It's sliced
5 into sections, and they make a diagnosis based on what
6 the section showed under the microscope.

7 Q Now, what is a pathologist?

8 A A pathologist is an M.D. usually or an
9 osteopathic physician who is trained in the special
0 field of pathology. And one of the areas of that is
1 anatomic pathology, and they look at tissue samples,
2 blood samples under the microscope or by other
3 technologies to make diagnoses.

4 Q Now, once a pathologist examines
5 tissues such as in this case, does a pathologist
6 typically make a written report that is then given
7 back to the attending physician to be used in the
8 further treatment of the patient?

9 A Yes, they do. That's exactly how it
0 works.

1 Q And was that done in this case. and do
2 you have a copy of that pathology report that you
3 might look at?

4 A I do.

5 Q Why don't you take a minute to get that

1 and I want to ask you some questions about it.

2 A I have it. I have a copy of it anyway.

3 Q By this point in this trial, this
4 pathology report has been identified into evidence and
5 I want to read a section of this to you and have you
6 explain it to us, please. With reference to the
7 microscopic examination, this pathology report said,
8 "sections reveal a circumferential carcinoma in situ
9 occupying the area of the transitional zone." Let's
10 digest that much first. Can you explain that to the
11 jury? And if you need to use your drawing, please
12 feel free to do so.

13 A I can. The transition zone or
14 transformation zone is where two different cell types
15 meet. The skin-like cells or squamous cells align the
16 surface of the cervix, the lining of the vagina and
17 the skin on the outside. The columnar cells or mucous
18 reducing cells line the canal on up into the uterine
19 cavity. Where they meet is the transition zone or
20 transformation zone. That's where new cells grow,
21 that's where abnormalities develop, including cancers,
22 and that's the area you're interested in removing when
23 you do a cone so you can see it under the microscope.

24 Q I'm interested in particular in the
25 word "circumferential." What does that mean in this

1 case, if you know?

2 A Circumference, of course, is the
3 distance around a circle. And what that means to me
4 is the pathologist's description of how extensive the
5 carcinoma in situ is. To me it means it's all over
6 the specimen, all around the specimen in a circular
7 manner.

8 In other words, in this drawing I made
9 earlier, this is the surface of the cervix and the
10 circumferential carcinoma in situ goes all the way
11 around the cervix. He described it as the face of a
12 clock. He said that also at the section between 12:00
13 and 3:00, which would be this quadrant on the
14 patient's left, it appeared that the carcinoma in situ
15 went through the edges of the specimen, which means
16 some of the disease was left behind.

17 Q Okay. Now, let me stop you there.
18 Hold that up, if you will.

19 When you describe or the pathologist
20 describes this carcinoma as being circumferential in
21 the cervix, does that mean that it's just localized in
22 one spot or does that mean it goes all the way around
23 this clock?

24 A It means it goes all the way around the
25 face of the clock, if you will. And it also by

1 description here involves the whole surface. To think
2 in another dimension, from the surface of the cervix
3 on into the lining of the surface or basement
4 membrane, the whole surface, the whole thickness is
5 involved from the surface down as well as all over on
6 the surface. So it's very extensive.

7 Q All right. Now, we have heard the
8 phrase many, many times at this point in the trial
9 "carcinoma in situ." Can you tell us what that is?

10 A In a technical term, that technical
11 definition means cancer cells. They're malignant
12 cells. They're limited to the surface of the cervix.
13 They've not broken through the basement membrane,
14 which is a lining that can be identified under the
15 microscope as the bottom part of the surface lining.
16 It's a malignancy limited to the surface of the
17 cervix. It's not invasive at that point.

18 Q Correct me if I'm wrong, what you're
19 telling us is and what the pathology folks are telling
20 us here is that this lady has a cancer that has not
21 yet invaded the out -- farther than the outside cells
22 of her cervix but it has done it pretty much over the
23 entire cervix?

24 MS. TAYLOR: Objection.

25 A That's exactly right.

1 MS. TAYLOR Objection; move to
2 strike. Leading the witness. Testifying for the
3 witness.

4 By Mr. Bender:

5 Q Now, doctor, is this something that's
6 going to have to be treated?

7 A Absolutely.

8 Q Let's assume for a minute that a
9 carcinoma in situ is not treated or that it is treated
0 in a substandard fashion, and by substandard fashion I
1 mean you don't get it all, and it is allowed to invade
2 into the body. Does that happen from time to time?

3 A Yes, it does.

4 Q And can you tell the jury what happens
5 if you allow this carcinoma to escape'?

6 A Well, if it escapes and goes through
7 the cervix, it then becomes an invasive cancer with
8 the potential to become a fatal disease. If it's
9 diagnosed at that late stage, the patient has a chance
0 of dying from it and has to have a radical
1 hysterectomy and/or radiation and still has a chance
2 of dying down the road from recurrent or persistent
3 cancer.

4 Q You were telling us earlier when Ms.
5 Taylor was asking you some questions about the number

1 of people who may die each year from this sort of
2 thing. Do you remember that?

3 A There are about 5,000 deaths a year in
4 the United States from cancer of the cervix.

5 Q Is it prudent for any gynecologist who
6 is faced with carcinoma in situ to do everything that
7 he or she can to ensure that this does not escape?

8 A Yes, it is, of course.

9 Q Now, when you -- when one does a cone
0 biopsy, which is what was done in this case, is it
1 always possible to ensure when one does that cone
2 biopsy that you get all of this bad tissue? They call
3 that a lesion, then don't they?

4 A Yeah, it's a lesion. Just means
5 something abnormal.

6 Q Is it always possible to ensure that
7 you get all of the bad tissue?

8 A It's not possible to ensure that
9 because the process is going on microscopically, and
0 we don't have a microscope where you can see in the
1 operating room how extensive the disease is. So you
2 take an approximation of the cervix trying to get this
3 transformation zone or transition zone completely
4 removed and then you send it to a pathologist to see
5 what the result is and how extensive the disease is.

1 Q Now, in this case, in this pathology
2 report, was the pathologist able to guarantee or
3 ensure Drs. Canos that all of the bad tissue, all the
4 lesion was removed?

5 A No. In fact, there was a specific
6 comment that a source of concern.

7 Q Would you read that comment into the
8 record, please?

9 A Yes. This is at the conclusion of the
0 report that you started reading a few minutes ago.
1 This is only a problem -- back up. In the 12:00 to
2 3:00 quadrant where the carcinoma in situ appears to
3 extend through one of the margins.

4 Q Now, what does extending through one of
5 the margins mean here medically?

6 A It means that some of the disease was
7 left behind. Some of the microscopic cancer cells
8 were left behind in the cervix inadvertently by Dr.
9 Canos during the cone.

0 Q Is that malpractice or is that just
1 something that happens in conizations?

2 A It's one of the limits of the
3 procedure. It happens in conizations. And again, as
4 I said a few minutes ago, this is a microscopic
5 process and one can't tell how extensive it is in the

1 operating room.

2 Q Can you hold Exhibit A up and show to
3 the jury where this 12:00 to 3:00 area might be?

4 A I'll make another mark on this thing.
5 Again, we're looking at the cervix and considering it
6 as if it were the face of a clock. This is the
7 picture the doctor sees doing a cone or even for that
8 matter taking a pap smear. And then pathologist will
9 divide this cervix into quadrants and make some
10 sections of each quadrant. So now he's got four
11 pieces, at least for his description he has maybe one
12 piece, but he's going to describe it in four parts, A,
13 B, C, and D or 12 to 3, 3 to 6, 6 to 9.

14 The 12 to 3 segment would be on her
15 left toward the front of her body, toward her
16 abdominal wall. In that 12 to 3 segment the
17 pathologist said the carcinoma in situ goes through
18 the margins. "Appears to extend through one of the
19 margins" is a quote.

20 Q We talked a little bit about what a
21 carcinoma in situ is. Can you tell us how these
22 cancerous lesions or microscopic cancerous lesions
23 develop, what they are typically associated with?

24 A In almost all cases, microscopic cancer
25 or invasive cancer are due to infection with a virus

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

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

4 A We used to believe that was the case.
5 We think now that it's true for a minority of cervical
6 cancers. Actually there are a lot of reasons to
7 support this. One of them is there seems to be two
8 peak ages for cancer to be diagnosed. One is around
9 52 and the other is much younger than that. And it
0 appears that because of that, that the progression
1 theory applies to a minority of the patients but a
2 majority of patients who develop cervical cancer
3 develop it rapidly after acquiring this virus that
4 damages their cells in their cervix and the lead time
5 can be as short as two years from the first abnormal

1 pap smear to the development of invasive cancer.

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

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

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

7 A Yes.

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

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

1 thought.

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

3 A Oh, I'm *sorry*.

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

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

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

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

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

1 follow-up is another option.

2 Q Is a hysterectomy a definitive way of
3 treating it?

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

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

12 A Yes.

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

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

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

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

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

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

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

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1 postoperative course.

2 Q Doctor, let me ask you this: If this
3 young lady had not had this hysterectomy and this
4 cancer had escaped the margins or she had developed a
5 new carcinoma in situ because her increased risk and
6 it became invasive, in other words, it got away from
7 the doctors and from her, can you explain to the jury
8 how that would progress and what could have happened
9 to her and the kinds of treatments that she would had
10 to have undergone? What if What if ..

1 A Once a cancer of the cervix becomes
2 invasive and escapes through that basement membrane I
3 was describing earlier, it requires invasive and/or
4 radical treatment in an attempt to cure it. For young
5 people, the situation is usually a radical
6 hysterectomy, which is an extensive operation removing
7 the cervix and uterus and the tissues around the
8 cervix in order to get the cancer invaded off the
9 cervix.

0 If it's advanced too far to be treated
1 surgically, and there are stages for invasive cancer,
2 stage 1, 2, 3, 4, if it is past 1B, they have to be
3 treated with radiation. And there is -- each of these
4 stages has a percentage chance of dying within five
5 years depending on how aggressive the cancer is and

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1 how indignant it appears under the microscope. There
2 are degrees-of malignancy. And if it's very
3 aggressive and very extensive, the chances of dying
4 are considerable, depending on the stage. They get
5 worse with each successive stage.

6 Q In this case and -- well, let me ask
7 you this: Was removal of the cervix through the
8 hysterectomy, did that eliminate that situation for
9 this young lady?

10 A It eliminates their chance of having
11 invasive cancer. It appears to, and it's highly
12 unlikely that she is cured from this problem. It
13 could develop in the upper vagina. She should
14 continue to have pap smears annually. But more
15 likely -- much more likely than not she's cured.

16 Q Let me ask you this: The pathology
17 report where the doctor looks at the tissue and so
18 forth, the cervix after it was removed did not show
19 any carcinoma in situ or cancer; is that correct?

20 A That's correct, it did not.

21 Q Is there any way for anyone to have
22 known before the hysterectomy that in fact there was
23 no cancer currently present at that time?

24 A Not really. All they had was the cone
25 biopsy report from the fall of '94 that showed the

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1 disease went through the margins of the specimen and
2 suspicion therefore that there was residual carcinoma
3 in situ.

4 Q Even if there was not found to have
5 been in retrospect after the hysterectomy was
6 performed any cancer at that point, does that mean
7 cancer would not have recurred again because of her
8 susceptibility due to the virus?

9 A It does not mean that she's going to be
10 cancer free for a lifetime. It also doesn't mean
11 these she's cancer free at that time. Pathology is
12 not a perfect science either, just like our pap
13 smears. And once in a blue moon a cancer will be so
14 small that it's not detectable even with an
15 appropriate thorough exam of the cervix and uterus
16 specimen, the cancer will recur later.

17 Q Something else I wanted to ask you
18 about that I have read about this disease is its
19 relationship or its seemed occurrence with people who
20 smoke. Can you comment on that for us'?

21 A That is what's called an
22 epidemiological observation. That is, people sit down
23 and study large groups of patients and see what
24 happens to them. And in several studies, enough so
25 that it's accepted as a fact, the risk of precancerous

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1 changes is about five or six times higher in smokers
2 compared to nonsmokers. The reasons aren't
3 understood, but obviously the smoking does something
4 to the membrane or surface of the cervix.

5 Q You have had a chance by now to review
6 the deposition of Dr. Essig, I believe.

7 A Yes.

8 Q And this is somebody who is known to
9 you.

10 A Yes.

11 Q It may surprise you to know that not
12 all lawyers agree on everything. Do all doctors
13 necessarily agree on everything?

14 A No, they don't. And I'm sure that Dr.
15 Essig, like I, will allow that there is more than one
16 way to skin a cat.

17 Q In reviewing Dr. Essig's deposition
18 testimony, his testimony under oath, were there
19 things, comments that he made that perhaps you
20 disagreed with?

21 A There were some.

22 Q Would you share those with us, please?

23 A Well, one is, the most important one I
24 think that bears on this case is a comment that
25 there's the progressive -- that these conditions

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

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

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

25 Q Anything else that leaps out at you in

1 Dr. Essig's deposition?

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

14 Q Is there anything benign or harmless
15 about cancer?

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

25 Q Let me ask you about two other things

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

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

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

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

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

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

16 A That's true.

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

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

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

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

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

5 MS. TAYLOR Objection; overbroad.

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

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

1 A Yes, they are.

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

6 A Yes, I do.

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

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

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

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

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

23 - - -

24 Recess taken.

25 - - -

CROSS-EXAMINATION

1 By Ms. Taylor:

2 Q Hello, doctor.

3 A Hello, Ms. Taylor.

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

6 A Indeed.

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

0 A I remember, with a new baby.

1 Q Yes. Your partner delivered me.

2 A That's right.

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

6 A That's right.

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

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

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

3 A In that particular case, yes.

4 Q And we know from your earlier
5

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

4 A Yes.

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

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

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

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

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

0 A That's correct.

1 Q Physicians and hospitals?

2 A That's correct.

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

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

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

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

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

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

1 Q I don't know.
2 A Talk to him himself.
3 Q I don't know, sir.
4 Have you ever met Dr. Canos?
5 A No, I haven't.
6 Q Are you familiar with how easy he is to
7 understand or not understand?
8 A I'm not.
9 Q So you don't know if he's somebody that
10 would be easy to understand on the phone or not, do
11 you?
12 A Well, he's been practicing and getting
13 along, I assume he's easy enough to understand. He
14 has been in this country quite a while.
15 Q That will be something for the jury to
16 know and for you -- well, you won't have that
17 opportunity to know that.
18 MR. BENDER: Excuse me. I want to wD
19 object to the commentary. Ask it be stricken.
20 By Ms. Taylor:
21 Q Now, in this case, doctor, after
22 reviewing the records, if Terri had been your patient
23 and she had gone on and had the cone biopsy performed
24 had two negative pap smears afterwards, am I correct
25 based upon what you told me during your deposition

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

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

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

1 this cone biopsy that was done on Tem, which was in
2 Defendant's Exhibit A, you identified an area, that
3 12:00 to 3:00 range, where it was thought there was a
4 break-through of the lesion through the margin of the
5 cone.
6 A Right.
7 Q Now, that would be information that Dr.
8 Canos, both Dr. Rudy Canos and Dr. Portia Canos would
9 be aware of that; correct?
10 A Yes.
11 Q You would agree with me, wouldn't you,
12 that when Dr. Portia Canos went on to do the second
13 pap smear on Terri after the cone biopsy, that she
14 would have put special emphasis on making sure that
15 she got tissue or scrapings from that area?
16 A I think if you're talking about the
17 December '94, Dr. Rudy took her back to the OR to get
18 a pap -- got a pap smear and that was abnormal again.
19 He did not do a biopsy because he thought there was
20 too much inflammation and healing, but he did do a pap
21 smear which was interpreted as abnormal again.
22 Q I'm not talking about that one. After
23 that pap smear Terri went on and had a pap smear by
24 Dr. Laura, correct, that was normal?
25 A That was early '95, yes.

1 Q Correct. She then went on and had a
2 second pap-smear done; correct?
3 A In early '96.
4 Q Correct.
5 A Right.
6 Q And that was normal too, and that was
7 done by Dr. Portia --
8 A Right.
9 Q -- Canos.
10 A Right.
11 Q And would you agree with me that you
12 would expect Dr. Portia Canos when she did that pap
13 smear to put a special emphasis in making sure that
14 she got scrapings from that 12:00 to 3:00 area?
15 A I would assume so, yes, sure.
16 Q And that pap smear was negative;
17 correct?
18 A Right.
19 Q Are you aware from reading the
20 deposition of Terri that she says that she was told by
21 Dr. Portia Canos that the pap smear that Dr. Portia
22 had done in February showed cancer; correct?
23 A She said that she was told that, that's
24 right.
25 O And if Tem were told that she had

1 cervical cancer in February of '96, that was wrong?
2 A Yes. She either misunderstood it or
3 she made a mistake or they told her the wrong thing,
4 yes.
5 Q Now, doctor, if Terri were told that
6 she had cervical cancer and she based her decision to
7 have the hysterectomy on that false statement that she
8 had cervical cancer, then Terri based her decision
9 upon false information; correct?
10 A None of us were there. If she was told
11 that that pap smear in February was abnormal and that
12 it showed cancer, then she did base it on false
13 information.
14 Q Now, Dr. DeVoe, you have also told us
15 that there is a good success rate with treatment of
16 Stage I invasive carcinoma of the cervix; correct?
17 A In general. Depends on the
18 aggressiveness of the disease and the stage of the
19 lymph nodes.
20 Q In fact, sir, Stage I cervical cancer
21 without lymph node involvement has a cure rate --
22 survival rate of 5 years of greater than 95 percent,
23 doesn't it?
24 A I think I said up to 95 percent.
25 Around 95 percent.

1 Q Around 95 percent. So if Terri says
2 that she was told that if she developed invasive
3 carcinoma of the cervix Stage I that she would die, a
4 hundred percent chance that she would die in five
5 years, that would be wrong; correct?
6 A If it was treated, that would be wrong.
7 Your data might be right for untreated.
8 Q But for treated invasive carcinoma that
9 would be wrong?
10 A I think so.
11 Q And we have no indication that --
12 MR. BENDER: Do you think you can
13 turn your phone off while we get this done?
14 Q That's exactly what I am doing. Sorry.
15 Husband.
16 We have no -- I'm sorry, sir. I've
17 lost my train of thought for a moment.
18 MR. BENDER: 95 percent.
19 Q Thank you. We have no indication in
20 this case that Terri was a noncompliant patient?
21 A That's correct.
22 Q She was a compliant patient, she
23 followed up, didn't she, with treatments?
24 A Yes.
25 Q In fact, she had a pap smear done

1 during her pregnancy, and then she followed up with
2 another one time wise just when she was supposed to,
3 three to four months after the other pap smear?

4 A Right.

5 Q And if Terri had not had the
5 hysterectomy performed, am I correct you cannot say
7 when to a probability she would have gotten recurrent
3 disease, can you?

3 A That's correct --

3 Q You can't --

1 A -- I can't tell you when.

2 Q And you can't even say if she would
3 have had recurrent disease to a probability?

4 A I don't know that for certain that she
5 would have. We never have a crystal ball in medicine.
6 We have to make decisions based on the information at
7 hand.

8 Q But we're talking about more likely
9 than not. You can't say if she would have had
0 recurrent disease; correct?

1 A No. But if she does, she's in deep
2 trouble. And the stakes are pretty high for a person
3 that gets recurrent disease.

4 MS. TAYLOR: Objection; move to
5 strike, nonresponsive.

OK

1 By Ms. Taylor:

2 Q Dr. DeVoe, during your deposition I
3 read to you a portion of a statement that -- of a
4 conversation between Terri and Dr. Canos.

5 A This is the tape-recorded conversation?

6 Q Correct.

7 And assume for me, if you will, that
8 Dr. Canos said to Terri, when you get Stage 1, even if
9 you do a radical and strip, first of all, is that a
0 radical hysterectomy?

1 A I don't know what the strip means. It
2 may mean radiation plus hysterectomy.

3 Q We take everything out, tubes, ovaries,
4 all the fat, all the muscle, your survival rate is 50
5 percent. Even with x-ray and chemotherapy, only 50
6 out of a hundred survive in two to three years and all
7 of them die in five years. If he told you that, if he
8 told Tem that, that would be incorrect?

9 A This is first Stage 1 cancer, cervical
10 cancer?

11 Q Correct.

12 MR. BENDER: Excuse me just a
13 minute, doctor. Let me object. Number one, I don't
14 think the tape is going to be in evidence. So I think
15 she's asking you questions about something that's not

WBT

1 a part of the record. You may answer, sir.

2 A If that statement was made referring to
3 Stage 1 cervical cancer, the statement is not true.

4 Q And if Terri were told that any delay
5 in having the hysterectomy increased her rate of
6 having -- her risk of having invasive carcinoma, even
7 if she had colposcopies and pap smears, that would be
8 incorrect. too?

9 A No, that's not true. If you're
0 watching and it develops into invasive cancer, then
1 you got invasive cancer and you got to deal with that.
2 That's the whole point of the follow-up.

3 Q Well, hopefully during the follow-up
4 you find it pretty evasive again.

5 A But what are you going to do? You have
6 the same situation you had when you decided to
7 follow-up.

8 Q Now, doctor, going back to about the
9 colposcopy you were -- excuse me. Going and -- I want
10 to talk to you about this cone biopsy that was done --

11 A Okay.

12 Q -- by Dr. Canos. He used a laser on
13 that case.

14 A That's right.

15 Q What affect does laser have on the

1 tissue surrounding?

2 A Basically it cuts through the tissue
3 with a heated light beam and can destroy the cells
4 right at the edge of the beam that are left behind.

5 Q Now, am I correct -- well, strike that.

6 Doctor, can you explain to me how Terri
7 could have no cancer present, negative pap smears
8 after the cone biopsy if there had been this
9 break-through?

10 A It could be missed because we talked
11 about the false-negative pap smear, that is, a pap
12 smear that's normal even when there is disease
13 present. The disease could have been destroyed by her
14 body in its healing process.

15 Q How frequently -- excuse me.

16 A The laser, the heat from the laser
17 could have destroyed the residual disease.

18 Q And when you're saying it could be
19 destroyed by her body, am I correct that there's a
20 percentage of these patients that have -- that the
21 tumor just goes away?

22 A The immune or the inflammatory response
23 is such that in these preinvasive diseases and some of
24 the premalignant dysplasias or abnormal cells the body
25 will simply eradicate them. That can happen

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

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

1 that virus, is there?
 2 A No. But we know from more
 3 sophisticated studies that are not done on a routine
 4 hospital basis that HPV is almost always associated
 5 with this kind of problem.
 6 Q Now, doctor, what do you think is a
 7 reasonable charge for a surgeon such as you to perform
 8 a hysterectomy?
 9 A What we charge and what we get are two
 0 different things because of managed care.
 1 Q What do you normally charge for a
 2 hysterectomy?
 3 A What I charge or the hospital charges?
 4 Q You charge, sir.
 5 A We have a fee charge, and I think ours
 6 is around \$2,000 for a hysterectomy. We get far less
 7 than that unfortunately.
 8 Q And what do you think the hospital
 9 charges?
 0 A I have no idea. Depends on how long
 1 the patient's in the OR, how long they are in the
 2 hospital, how much of the hospital's supplies and
 3 equipment and personnel they use.
 4 Q And would a five-day hospitalization be
 5 usual for a patient having had a total abdominal

1 hysterectomy?
 2 A A little unusual now but not
 3 extraordinary. Depends on how well she recovers and
 4 how vigorously she pursues her recovery.
 5 Q Doctor, I have no further questions at
 6 this time. Thank you.
 7 - - -
 8 REDIRECT EXAMINATION
 9 By Mr. Bender:
 0 Q Doctor, let me ask you couple things,
 1 then I'll let you go because we have been at this for
 2 some length.
 3 Would you agree with me that one of the
 4 issues in this was how anxious was Mrs. Noel to have
 5 more children at the time she elected to do the
 6 hysterectomy?
 7 A Yes. That's an issue. The issue of
 8 more children is always a question for hysterectomy in
 9 someone who's not through menopause.
 0 Q Let me ask you to assume that issue was
 1 broached with Mrs. Noel, and that here is what she
 2 told Drs. Canos by her own admission. I want to read
 3 this verbatim. "They," being Drs. Canos, "they asked
 4 us if we wanted more children and we said, not right
 5 at the present time we don't. We have a

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

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

13 A No, it does not.

14 MS. TAYLOR: Objection. *sustained*

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

19 MS. TAYLOR: Objection.

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

22 MS. TAYLOR: Objection; move to
23 strike.

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

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

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

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

10 A Yes.

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

17 A Yes, I would.

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

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

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

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

10 A Correct.

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

18 A Absolutely.

19 Q Can you explain that to the jury?

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

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

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

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

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

17 A Uh-huh.

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

21 A I agree with him on that.

22 Q Can you explain that for us?

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

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

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

14 A I do agree with that.

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

17 MR. BENDER No, sir.

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

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

24 MR. BENDER: Thank very much. sir.

25 MS. TAYLOR I move to strike all

1 the testimony. The doctor's lacking qualifications ^{WD}
2 under Ohio law. Thank you.

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

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

8 (Signature waived.)

9 - - -

10 Thereupon, at 5:45 p.m., Thursday, June
11 8, 1999, the deposition was concluded.

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1 CERTIFICATE

2 STATE OF OHIO ss:

3 COUNTY OF MADISON :

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

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

22
23 DENISE L. SHOEMAKER, RPR
24 NOTARY PUBLIC-STATE OF OHIO

25 My Commission Expires: January 20, 1999.

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-V- vagina [8] 4:9 13:2.2 18:16 34:13 66:23 69:4.8 variety [2] 68:24.25 various [1] 41:23 verbatim [1] 64:23 versus [1] 41:7 video [1] 44:1 Videotaped [1] 1:13 view [1] 69:19 vigorously [1] 64:4 viral [1] 30:12 virulent [1] 30:15 virus [8] 24:25 25:4.23 30:15 35:8 63:1 68:19.25 vs [1] 1:7 Vulva [1] 4:9	-X- x-ray [1] 58:15			
	-Y- year [12] 6:17 7:22.24 14:14 15:2.4 22:1.3 31:11 40:2 44:3 46:19 years [25] 6:21 8:8 9:4 25:12.25 26:4 30:9.10 33:25 37:1.12.19 43:9.15 43:18.20 45:16 46:10.11 46:12 55:22 56:5 58:16 58:17 68:3 yet [4] 8:11 15:11 20:21 27:2			

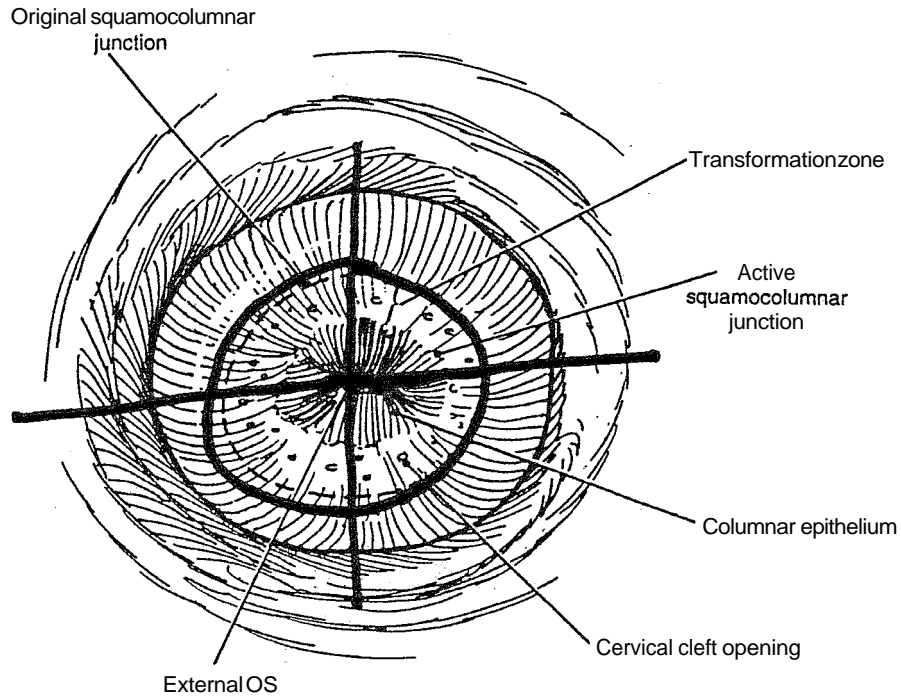


Figure 16.2 The cervix and the transformation zone.

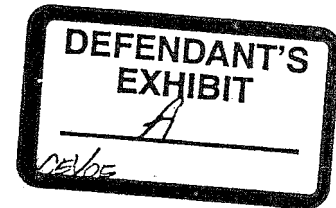


Figure 16.3 Cross-section of the cervix and the endocervix.

