1	IN THE COURT OF COMMON PLEAS	13:10
2	OF SUMMIT COUNTY, OHIO	
3	DOROTHY S. MAYNARD, et al.,	
4	Plaintiffs,	
5	V S .	
6	AKRON GENERAL MEDICAL Case No.	
7	CENTER, et al., CV 97 01 0228	
8	Defendants. Judge Whitmore	
9		
10	Deposition of DANIEL P. GUYTON, M.D.,	
11	called for examination under the statute, taken	
12	before me, Amie R. First, a Registered Professional	
13	Reporter and Notary Public in and for the State of	
14	Ohio, by agreement of counsel, at the offices of	
15	Jacobson, Maynard, Tuschman & Kalur Co., L.P.A.,	
16	202 Montrose Avenue West, Suite 200, Akron, Ohio,	
17	on Friday, July 11, 1997, at 1:10 p.m.	
18		
19	Computer-aided Transcription and	
20	Litigation Support Services by:	
21	KALAPODIS REPORTING SERVICES, INC.	
22	926 First National Tower	
23	Akron, Ohio 44308	
24		
25	ORIGINAL	
	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	2 OF SUMMIT COUNTY, OHIO 3 DOROTHY S. MAYNARD, et al., 4 Plaintiffs, 5 vs. 6 AKRON GENERAL MEDICAL Case No. 7 CENTER, et al., CV 97 01 0228 8 Defendants. Judge Whitmore 9 10 Deposition of DANIEL P. GUYTON, M.D., 11 called for examination under the statute, taken 12 before me, Amie R. First, a Registered Professional 13 Reporter and Notary Public in and for the State of 14 Ohio, by agreement of counsel, at the offices of 15 Jacobson, Maynard, Tuschman & Kalur Co., L.P.A., 16 202 Montrose Avenue West, Suite 200, Akron, Ohio, 17 on Friday, July 11, 1997, at 1:10 p.m. 18 19 Computer-aided Transcription and 20 Litigation Support Services by: 21 KALAPODIS REPORTING SERVICES, INC. 22 926 First National Tower 23 Akron, Ohio 44308 24

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1 DANIEL P. GUYTON, M.D., of lawful age, called for examination, as provided by the 2 Ohio Rules of Civil Procedure, being by me first 3 duly sworn, as hereinafter certified, deposed and 4 said as follows: 5 CROSS EXAMINATION OF DANIEL P. GUYTON, M.D. 6 BY MS. KOLIS: 13:10 7 Dr. Guyton, as you know, we've been 13:10 8 Q. introduced. My name is Donna Kolis. I've been 13:10 9 retained to represent Dorothy and Cecil Maynard. 13:10 10 My purpose today in taking your 13:10 11 deposition is to clarify information hopefully 13:10 12 that's contained in the medical charts and ask you 13 13:10 some hopefully short and direct questions. 1413:1015 If at any point I ask a question that 13:10 16 doesn't seemingly make any good common sense to 13:10 you, you'll let me know if you don't understand my 13:10 17 question? 13:1018 19 Α. I will. 13:10 20 Q. And the reason I put it that way is if 13:10 21 I ask a question on the record and there's an 13:1013:10 22 affirmative response of some sort, it will be 13:10 23 assumed at a later point you understood my question 13:10 24 generally. 25 13:11 If at any time you want to take a break

1 -- perhaps you have a surgical page -- that's 13:11 acceptable. If at any time you want to confer with 2 13:11 Michael, unlike some lawyers, I don't object to 3 that. You need to indicate that for the record. 4 13:11 with that in mind, also, you have to 5 13:116 answer all questions verbally. We try not to put 13:11 7 the court reporter in the duty of interpreting 13:11 anyone's body language. Do you understand? 13:11 8 Yes, I do. Α. 13:119 Q. Starting with an easy issue, can you 13:11 10 tell me briefly about the education which led you 11 13:11 12to your current profession? 13:11 Well, I went to college and medical 13:11 13 Α. school at Case Western Reserve and then completed a 13:11 14 15 surgical residency at New York University Medical 13:11 Center in Manhattan. 13:11 16 17 Q. Okay. When did you graduate from Case? 13:11 1975. 13:11 18 Α. Q. At a time other than today, if you 13:11 19 would, provide a copy of your CV to your counsel. 13:11 20 He'll forward it to me. 13:1121 13:11 I will. 22 Α. 13:12 23 Q. All right. You indicated when you 13:12 24 graduated from Case you then did a surgical 13:12 25 residency in New York; correct?

1	A. C	orrect.	13:12
2	Q · 03	kay. What kind of surgical residency	13:12
3	program was i	t? Number of years and specialty, I	13:12
4	guess is what	I'm asking.	13:12
5	A. We	ell, it was five years, and it was a	13:12
6	specialty in	surgery.	13:12
7	Q. 03	kay. Just general surgery?	13:12
8	A. R	ight.	13:12
9	Q. A.	ll right. During your last year, were	13:12
10	you the chief	resident?	13:12
11	A. Y	es, I was.	13:12
12	Q. 01	kay. Did you publish any articles or	13:12
13	have any area	of interest during that five-year	13:12
14	residency prog	gram?	13:12
15	A. D [*]	uring that five-year residency, I did	13:12
16	not publish a	ny articles.	13:12
17	Q. 01	kay. When you finished that program,	13:12
18	did you under	take another surgical residency at	13:12
19	another hospi	tal?	13:12
20	A. N	o, I did not.	13:12
21	Q. 0	kay. Following that, what did you	13:12
22	then do?		13: 12
23	A. I	entered private practice.	13 :12
24	Q. 0	kay. Where did you enter private	13:12
25	practice?		13:12

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1	A. Akron, Ohio.	13:12
2	Q. Okay. What year would that have been?	13:12
3	A. 1980.	13:12
4	Q. Okay. Prior to going into private	13:13
5	practice, did you become boarded in general	13:13
6	surgery?	13:13
7	A. To become boarded in general surgery,	13:13
8	you have to be in practice for several years. So	13:13
9	once I completed that time period, yes, I did	13:13
10	become boarded in general surgery.	13:13
11	Q. What year did you obtain that board?	13:13
12	A. I think around 1982 or 1983.	13:13
13	Q. Okay. You won't be punished for not	13:13
14	knowing it today, but just generally speaking that	13:13
15	time frame?	13:13
16	A. Approximately.	13:13
17	Q. Okay. When you came here in 1980 and	13:13
18	went into private practice, who were you in	13:13
19	practice with?	13:13
20	A. Solo practice.	13:13
21	Q. Solo practice. How long were you in	13:13
22	solo practice?	13:13
23	A. I've been in solo practice since that	13:13
24	time.	13:13
25	Q. See, I'm disadvantaged here. I've	13:13

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never met you before, and I don't have your CV, so 1 13:13 I have to ask these kinds of questions. 2 13:13 From 1980 to the present, which is 3 13:13 1997, you've maintained a surgical practice on your 4 13:13 5 You have no partners; correct? own. 13:13 13:13 6 Α. Correct. 7 Q. All right. What hospitals have you 13:14 been affiliated with since 1980? 13:148 Well, from 1980 to 1983, I was 13:149 Α. affiliated with Akron General, and from 1983 until 13:1410 approximately 1987, I was affiliated with Huron 13:1411 13:14 12 Road Hospital in Cleveland. And then from 1987 to the present time, I've been back at Akron General. 13:14 13 Q. Okay. Now, in '83 to '87, when I asked 13:14 14 about affiliation, of course what I want is what 13:1415 13:14hospitals you did have privileges at. 16 The 17 hospitals you had privileges at was to do surgery; 13:14 13:1418 correct? Α. Correct. 13:1419 Ο. Were you also doing surgeries at Akron 20 13:14 21 General during that four-year period of time? 13:1422 Α. What four-year period? 13:14Q. '83 to '87. 23 24 No. I was in Cleveland, Ohio. 13:14Α. 25 Q. Okay. Did you relocate your medical 13:14

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1 practice? Yes, I did. 2 Α. 13:14Q. During the years 1983 to 1987 while you 3 13:14 were at Huron Road Hospital, what chiefs of surgery 4 13:15 did you work under? 5 13:156 Α. Dr. Helmet Schreiber. 13:15 Okay. Was he the chief the whole four 13:15 7 Ο. 13:15 8 years you were there? 13:159 Α. Yes, he was. 13:15 It is my understanding you are 10 **a** . currently the chief at Akron General. 13:15 11 Α. That's correct. 13:15 12 When did you become the chief of 13:15 13 Q. surgery at Akron General? 13:1514 13:15 Α. I believe it was 1991. 15 16 Q. Okay. And you've remained the same 13:15 17since; right? 13:15 13:1518 Α. Correct. 13:15 Q. Okay. As part of that program, are you 19 13:15 involved in the teaching in the hospital setting of 20 13:15 21 the residents at Akron General? 13:15 Yes, I am. 2.2 Α. 13:15 23 Q. Okay. Being a general surgeon, can you 13:15describe for me -- let's just sort of say the last 24 13:15 ten-year period, 1987 to 1997 -- what kinds of 25

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1 surgeries do you regularly perform? 13:15 Most commonly they have to do with 2 Α. 13:15 malignancies. Most recently it seems to be 3 13:15concentrated more on breast disease and breast 4 13:15 Prior to that, I was doing a lot of colon 5 cancer. 13:16 6 surgery, breast surgery. 13:16 7 Q. I quess, you know, all folks who are 13:1613:16 8 general surgeons seem to have some area that they 9 focus on more than others, perhaps that they get a 13:16 reputation in or just something they actively do. 13:16 10 13:16 And, you know, that's what I was asking you. 11 12And if I understand the answer you're 13:16 giving me, in the past ten years, you said -- let's 13:16 13 13:16 14start with A, you told me your focus was on malignancies; correct? 13:16 15 Α. 13:16 16 Correct. Q. Malignancies of any particular organ or 13:16 17 18 area of the body more so than others? 13:16 13:16 19 I would say pretty much all. Α. No. Okay. Let's talk about whipple 20 Q. 13:16 procedures. I'm going to call it a whipple 21 13:16 22 procedure, the operation that you did on 13:16 Mrs. Maynard. Is that all right with you, if I 23 13:16 call it a whipple? 24 13:15 That's fine. 25 Α.

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Q. 1 It's easier than trying to spell it out 13:17 and pronounce it, the complete name of the surgery, 2 13:17 all the names. When did you first learn how to 3 13:17 perform a whipple? 13:17 4 5 Α. 1975, probably. 13:17 13:17 6 Ο. And you were still at -- was it New 13:17 York University? 7 That's correct. 13:17 Α. 8 13:17 Q. I wasn't listening too well. You were 9 at NYU. And how many did you perform during your 13:17 10 13:1711 residency program? 13:17 Oh, I have no idea. 12 Α. Q. 13:17 Okay. You don't keep a chart or 13 13:1714 anything, of course? 13:17 15 Α. (Witness shakes head from side to 15 side.) Ο. In the time since you've come back to 13:17 17 13:17 18 Akron General after leaving Huron through the 13:17present, what is the frequency with which you 19 13:17 20 perform whipple procedures? 13:17 I would estimate somewhere between two 21 Α. 13:17 22 and four a year. 13:17 Q. Okay. At Akron General, as part of the 23 13:17 24 doctors who have privileges in general surgery, is 13:18 25 there anyone who you would consider to be a

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she did not have cancer. Have you looked at those 1 13:19 2 records? 13:19 3 Α. Most recently, yes. 13:19 That's fine. The first Q. Okay. 4 13:19 question, I guess, I want to ask you is -- let's 5 13:19see what points of agreement, I suppose, we can 6 13:19 arrive at. Is it clear to you, Doctor, based upon 13:19 7 your overall analysis of the records that we've 8 13:19just discussed that Dorothy Maynard in the final 13:19 9 10 analysis did not actually need a whipple procedure? 13:19 Α. No. That would be an incorrect L3:19 11 12 statement. 13:19 Q. Okay. Tell me what would be incorrect 13 13:19 13:19 about that statement. 14 15 Α. The reason Mrs. Maynard had her 13:19procedure was because she presented with signs of L3:19 16 17 obstructive jaundice as well as radiographic 13:20 18 evidence of a lesion in the distal common bile 13:20 13:20 duct. 19 13:20 20 Ο. Okay. The answer that you've just 13:20 given me leads me to conclude that I probably 21 22 inartfully asked the first question. So we'll 13:20 13:20 23 break it up this way. 13:20 It's clear from the record that at the 24 13:20 time the operation was performed, there were 25

adequate indications for the surgery to occur. 1 Do 13:20 you agree with that? 2 13:20 Α. I think we had every indication to 3 13:20 perform the operation. 4 13:20 5 Q. Okay. All right. The question I'm 13:20 asking you is, based upon information which 6 13:20 7 subsequently became available to you, are you and I 13:20 in agreement that ultimately she really didn't need 13:20 8 a whipple? 13:20 9 10 MR. EDMINISTER: Objection. Asked 13:20 13:20 11 and answered. I would stand 13:20 THE WITNESS: No. 12 13:2013 by my first answer. Q. Okay. Well, let's go through it then. 13:20 14 Do you have a copy of your office chart available 13:20 15 to look at? 13:20 16 13:20 Α. 17 Sure. 13:20 MR. EDMINISTER: 18 Sure. Q. Okay. Great. When did you first meet 19 13:21 20 Dorothy Maynard? My office note is dictated 2/19/96. 13:21 21 Α. 13:21 Q. Okay. It's my understanding that 2.2 Mrs. Maynard was referred to you by another 23 13:21 24 physician who has privileges at Akron General; is 13:21 25 that accurate?

I don't know if this individual has Α. 1 13:21 privileges at Akron General or not. 2 13:21 Ο. Okay. I cannot pronounce the doctor's 3 13:21 name. It's Dr. --4 13:21 Maseelall. 5 Α. 13:21 Q. Maseelall. Is this somebody who had 6 13:217 previously referred patients to you? 13:2113:218 Α. On rare occasions, yes. Q. Do you know what kind of doctor he is? 9 13:21I believe he is an internist. 10 Α. 13:21Okay. It's my understanding that he Q. 11 13:21 examined her on that date and sent her directly 12 13:21 across the street to see you. Do you know if 13:21 13 13:2114 that's accurate or not? I believe that was the sequence of 15 13:21Α. 13:21 16 events. Q. Okay. Tell me what her presenting 13:21 17 18 symptoms were as are recorded in the chart. 13:21 13:22 19 Α. I see here, "The patient states that 13:22 20 since August she has had the following constellation of symptoms. Whenever she eats, she 13:2221 13:22 22 develops nausea, midepigastric pain and then vomits 13:22 23 her dinner." 13:22 24 Q. Okay. Why did that history cause the 13:22 other doctor to send Mrs. Maynard to you? I'm not 25

asking you to get into his brain, but can you tell 13:22 1 2 me what about those symptoms would have required an 13:22 3 evaluation by yourself? 13:22 MR. EDMINISTER: Objection. 4 Go 13:22 ahead, if you can answer. 5 13:22 THE WITNESS: Well --6 13:22 7 MR. EDMINISTER: What does he 13:22 13:22 8 think? Can you rephrase it? Q. 13:22 Yeah. Based upon the symptoms she 9 13:22 presented with, why was the referral to a surgeon a 10 13:22 necessary thing? 11 From his MR. EDMINISTER: 12 13:22 perspective? 13 MS. KOLIS: Uh-huh. 13:22 14 THE WITNESS: He was worried, as I 13:22 15 said here. "He called me today and informed me 13:22 16 17 that in his opinion she had obstructive jaundice 13:22 13:23 and required surgical evaluation." 18 13:23 Q. Okay. You physically examined 19 13:23 Mrs. Maynard at that point in time; correct? 20 13:23 I did. 21 Α. i 3:23 22 Q. And you found some evidence of jaundice 13:23 23 both in her eyes and in her mouth. Am I fairly 13:23 24 reading your note? 13:23 25 Α. Correct.

Q. Okay. Fair enough. It also says, "The 1 13:23 2 examination suggests the presence of a 13:23 midepigastric right upper quadrant mass as well." 3 13:23 I wasn't there, so I don't know what you're telling 4 13:23 Can you explain to me in laymen's terms what 5 me. 13:23 was suggestive in that physical that there was a 6 13:23 7 mass in that area? 13:23 On exam, there was an irregularity to 13:23 Α. 8 the examination that would be consistent with this. 13:23 9 Q. 13:23 And when you say "there was an 10 irregularity, " was there something you could 13:23 11 12 palpate or feel as you examined her? 13:23 I believed I could. 13:23 Α. 13 13:23 Ο. Okay. I'm just asking. 14 13:23 Right. 15 Α. Q. Okay. And at that point in time, it's 13:23 16 17 pretty evident from the note and subsequent course 13:23 of events that you thought she should be admitted 13:23 18 for an evaluation; is that correct? 13:23 19 13:23 That's correct. 20 Α. 13:24 Q. And it's pretty clear you had a concern 21 13:24 22 there might be a malignancy? 13:24 Α. Correct. 23 13:24 Q. Okay. Did you communicate that concern 24 to Mrs. Maynard at that time, if you remember? 13:24 25

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1	A. I can't recall exactly what I said to	13:24
2	her, but I believe I expressed with them she could	13:24
3	have a serious problem that could need prompt	:13:24
4	attention.	:13:24
5	Q. Fair enough. Do you remember her	:13:24
6	husband being present at that first evaluation?	:13:24
7	A. I believe he was.	:13:24
8	Q. Do you have a pretty clear memory of	:13:24
9	both Mr. and Mrs. Maynard at this point in time?	:13:24
10	MR. EDMINISTER: In what way?	13:24
11	Q. If you saw them, would you remember who	:13:24
12	they were?	:13:24
13	A. I don't know if I would recognize them,	:13:24
14	no.	:13:24
15	Q. Okay. Fair enough. What was your plan	13:24
16	of diagnostic exams during this admission?	13:24
17	A. Well, I think I would have to refer to	13:24
18	the hospital chart on that, but I think we	13:24
19	proceeded right with a CAT scan and the like.	13:24
20	Q. Okay. Well, I guess we'll go over	13:25
21	those things in detail. I guess what I'm asking is	13:25
22	customarily when I read a doctor's chart, it	13:25
23	usually tells me what the plan is, what series of	13:25
24	testing is going to occur. Would you like to look	13:25
25	at the hospital chart?	13:25

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Α. Sure. 1 13:25 Because that might help you answer some 2 Q. 13:25 of these questions. And it's chronological, and 3 13:25 it's tabbed. 4 13:25 MS. BARKER: Off the record for a 5 13:25 6 moment. 13:25 7 (Discussion had off the record.) Ο. I think the first section is the 13:25 8 admission of 2/19/96. 13:25 9 Okay. We admitted her and went right 13:25 10 Α. to a CAT scan with IV contrast done the same day of 13:25 11 12 admission. L3 :25 Ο. Okay. What else is in there? Are you L3 :25 13 reading your order sheets from the first admission? 13:2514 13:2515 Α. Yes. Q. Okay. Why don't you just, for the 13:25 16 17 record, tell us what the plan was on admission? 13:25 Well, the plan was to try to pinpoint 13:2618 Α. L3:26 exactly what was causing the obstructive jaundice. 19 13:26 Okay. An important thing obviously. 20 Q. 13:26 What were you going to do in the endeavor to find 21 13:26 22 out what was causing the jaundice? 13:26 23 Our first step, as I said, was to have Α. 13:26 a CAT scan of the abdomen and pelvis. 24 Okay. And initially you weren't going 13:26 Q. 25

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to do anything past -- you wanted to see what the 1 13:26 2 results of the CAT scan were before you decided on 13:26 3 further testing? 13:26 We were going to get some blood work. 4 Α. 13:26 Q. Okay. Did you get the blood work? 5 13:26 6 Α. Yes. 13:26 7 Q. I probably have labs in a 13:26 Okay. 13:26 section marked labs, I would guess. What kind of 8 13:26 blood work were you going to do for Mrs. Maynard? 9 Well, we were going to get a liver 13:26 10 Α. 13:26 profile which would tell us indeed the degree of 11 13:26 the obstructive jaundice. 12 13:26 Q. Okay. What were the results of those 13 13:26 blood studies? 14 MR. EDMINISTER: Which ones? 13:26 15 MS. KOLIS: The ones that he's 13:27 16 17 indicating he initially ordered to do the liver 13:27 profile to see how much obstruction there was, I 13:27 18 19 suppose, if I'm paraphrasing. 13:27 THE WITNESS: I don't see them in 20 13:27 here. 21 13:2722 Q . You don't see them in here. All 13:27 right. Well, let me just represent to you that --23 13:27 maybe we should have counsel for Akron General get 24 her records. What's in that notebook is everything 13:27 25

I received under a subpoena from the hospital, and L3:27 1 I quess I'm surprised what you're looking for may 13:28 2 3 not be there. 13:28 These are Dr. Rehmus' lab reports from 4 Α. 13:28 April 1996. Well, postop. L3 : 28 5 MR. EDMINISTER: Donna --13:28 6 7 MS. KOLIS: I don't want him to 13:28 13:28 8 have to sit here and dig all day. 13:28 MR. EDMINISTER: You have this 9 13:28 organized in a chronological fashion? 10 13:28 MS. KOLIS: Right. 11 MR. EDMINISTER: But in the 13:28 12 13:28 13 initial admit, there is no breakdown for labs, so 13:28 14 if they're in here, they must be mixed in with 13:28 15 progress notes. MS. KOLIS: Well, that's possible. 13:28 16 MR. EDMINISTER: I think so. 13:28 17 Here's a CT. That's all within that same admit. 13:29 18 13:29 19 Is there any more? 13:29 No. THE WITNESS: 20 13:29 21 MR. EDMINISTER: And there's i3:29 22 nothing there. 13:29 Okay. Let's do it this way. 23 Ο. In your L3:29 office chart, customarily when you order labs on a 24 13:29 25 patient, does the hospital forward those labs to

you to keep a copy in your office chart? 13:29 1 Not as an inpatient. 2 Α. 13:29 Q . Not as an inpatient. Okay. Because I 3 13:29didn't see any labs. Do you have any way of 4 13:29 telling from looking at the chart what the result 5 13:29 of that blood work was? 6 13:29 Well, it's not readily available. 13:30 7 Α. Okay. For the moment, I think we're 8 Q. 13:30 13:30 going to let that go. 9 I would say they were consistent with 13:3010 Α. 13:30 obstructive jaundice. 11 Q. Okay. And I suspect that would be true 13:30 12 13:30 13 since she had a polypoid lesion, correct, in the 13:30 14 bile duct; is that right? We did not know that at the time. 13:30 15 Α. 16 Q. Right. But what I'm saying to you now 13:30 17 is you ordered a liver series; correct? That's 13:30 13:30 what you told me? 18 Yes, that's correct. 13:30 19 Α. Ο. 13:30 You and I cannot locate those results; 20 right? 13:3021 (Witness nods head up and down.) 13:3022 Α. 13:30 23 MR. EDMINISTER: At present. Q. 13:3024 At present. That doesn't mean they 13:30 don't exist. It just means we don't have them. 25

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And I quess the question I was looking for, was 1 13:30 2 there anything remarkable about the liver series 13:30 that you ordered that aided you and assisted you in 3 13:30 any way in coming to a preliminary diagnosis as to 13:30 4 the nature of her problem? 5 13:30 MR. EDMINISTER: Off the record. 13:30 б (Discussion had off the record.) 7 THE WITNESS: Yes. Here. Here 13:31 8 13:31 9 they are. 13:31 10 Ο. Okay. What Bates stamp page is that 13:3*i* on, just for reference? 11 12 Α. 000460. 13:31 Thanks a lot. Okay. You've located 13:31 Ο. 13 13:31 14 the results now? 13:32 15 Α. Yes, I have. 13:32 16 Can you tell me what they were? Ο. 17 Α. They are indicative of obstructive 13:32 13:32 jaundice. 18 13:32 That's all I wanted to know. 19 Q. Fine. Do 13:32 you see how hard this can be? All right. You had 20 **13**:32 the blood work done. You also ordered a CT; 21 13:32 22 correct? 13:32 23 Correct. Α. Okay. What did the CAT scan reveal? Q. 24 13:32 25 It's probably easier to use your own chart for

1	that. (Handing to witness.)	13:32
2	A. Thanks. Let's see. Here we are.	13:32
3	Q. Okay.	13:32
a	A. "CAT scan reveals cholelithiasis and	13:32
5	intrahepatic biliary duct dilatation. Prominent	13:32
6	pancreatic head without definite CT evidence of	13:32
7	pancreatic mass. Etiology of the biliary duct	13:32
8	dilatation, however, remains uncertain and further	13:32
9	evaluation of ERCP is suggested as indicated."	13:32
10	Q. Okay. Let's talk about where you would	13:33
11	have been at diagnostically at that point. You've	13:33
12	received lab work, I assume, somewhere around the	13:33
1.3	time you got the CT results that tell you, in fact,	13:33
14	she's got obstructive jaundice; correct?	13:33
15	A. Correct.	13:33
16	Q. And then you get CT results, and the CT	13:33
17	is telling you that A, she's got some sort of	13:33
18	problem with her gallbladder; right?	13:33
19	A. She has gallstones.	13:33
20	Q. Stones. Okay. Does this CT reading,	13:33
21	as you interpret it, tell you that there let me	13:33
22	ask you what it tells you about the pancreas. I'll	13:33
23	change it to that way.	13:33
24	A. It tells me that the pancreatic head is	13:33
25	enlarged.	13:33

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1 Q. Okay. What concern does that raise for 13:33 2 you? That there may be a tumor in the distal 3 Α. 13:33 bile duct or in the head of the pancreas that's 4 13:33 causing the obstructive jaundice. 5 13:33 Q. Okay. Now, at that point, based upon 13:33 6 7 this examination, are you aware that there is a 13:33 13:34 8 polypoid mass? 13:34 Α. No. 9 So you've done your blood work. 13:34 Ο. Okay. 10 13:34 You've done your physical exam. You've taken her 11 13:34 12 history and physical. You've got the CT. What at this point in time is your diagnosis for this 13:34 13 13:34 14 person? Still obstructive jaundice. 13:34 15 Α. Okay. All right. And, of course, you 13:34 16 Q. 17 follow-up on the advice of getting an ERCP; 13:34 13:34 correct? 18 13:34 Correct. 19 Α. Q. 13:34 All right. Who is Dr. Maxwell? 20 21 Dr. Maxwell is a gastroenterologist. 13:34 Α. 13:34 2.2 Q. Okay. Is that someone you regularly 13:34worked with at that time? 23 13:34 Pretty much. 24 Α. Q. Okay. You don't do ERCPs yourself? 25

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No, I do not. 1 Α. 13:34 Q. That's his thing; right? 2 13:34 Α. Correct. 3 13:34 Q. All right. You ordered that, I 4 13:34 believe, for the following day. I think that was 5 13:34 the 20th. Let's take a look at the results that 13:34 б 13:34 7 you got from the ERCP. 13:34 Α. Okay. 8 13:34 Q. Are we at the same page? You've 9 Okay. got one -- oh, I'm looking at the radiology 13:34 10 report. You're looking at Dr. Maxwell's report; 13:35 11 13:35 12 right? 13:35 Right. 13 Α. Q. Tell me what Dr. Maxwell revealed to 13:35 14 13:35 15 you based on the ERCP. 13:35 16 Α. Polypoid lesion distal common bile duct, biliary tumor. 13:35 17 Q. Now, at that point, he doesn't know 13:35 18 13:35 19 what, this mass represents; is that right? 13:35 He says it's a biliary tumor. 2.0 Α. Q. Okay. Were you convinced that it was a 13:35 21 13:35 biliary tumor at that point? 22 13:35 23 Α. Yes, I was. 13:35 24 Ο. Okay. What would be the basis upon 13:35 which you were convinced it was a biliary tumor? 25

Its appearance on the X-ray film, the 1 Α. 13:35 fact that it could not be dislodged as Dr. Maxwell 2 13:35 performed several brushings for cytology. 3 13:35 Q. Okay. Just to make sure we're speaking 4 13:35 the same language, when I say are you sure that it 5 13:35 was a biliary tumor, I guess what I'm trying to б 13:35 7 distinguish is at that point in time were you 13:35 convinced that this mass that is in the common bile 13:35 8 duct is cancerous, or do you just not know at that 13:36 9 13:36 10 point? I think the probability is very high 13:36 11 Α. 13:36 12 this was a cancerous mass. So in your mind, based upon your 13:36 13 Q. 13:36 experience, the probability mitigated higher in 14 13:36 15 favor of malignancy versus a mass alone --16 Correct. L3:36 Α. 17 Q. ... that would be nonmalignant; right? 13:36 13:36 That is correct. 18 Α. Okay. As we sit here today knowing all 13:36 19 Q. 13:36 2.0 the things that transpired, what do you believe 13:36 that mass was that was actually in the common bile 21 13:36 duct? 2.2 13:36 23 Α. I think it was a benign mass. 13:36 24 Ο. Do you know or do you have an opinion 13:36 based upon your experience as to what caused that 25

1	benign mass?	13:36
2	A. No.	13:36
3	Q. Do you have when I say	13:36
4	"probability," I believe it would have occurred to	13:36
5	you subsequent to learning that Dorothy did not	13:36
6	really have cancer to think as to what kind of	13:36
7	conditions would have caused the mass. Maybe I'm	13:36
8	wrong.	13:36
9	Do you believe that the mass that was	13:36
10	in the common bile duct had anything to do with	13:37
11	calculus from the gallbladder because she had	13:37
12	stones?	13:37
13	A. It would be unlikely for a calculus of	13:37
14	the gallbladder to cause a growth. Usually you see	13:37
15	an indentation or ulcer. This was a growth	13:37
16	protruding.	13:37
17	Q. So you don't have an opinion today as	13:37
18	to what caused that mass to grow?	13:37
19	A. No.	13:37
20	Q. I'm just asking. I don't want to be	
21	surprised later when someone has rethought the	
22	issue.	
23	Now, at the time of the ERCP, did they	
24	do brushings on the mass at that point?	1
25	A. Dr. Maxwell said he had cytologically	13:37

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1 brushed the mass. 13:37 Ο. You obviously got the results of those 2 13:37 cytology brushings; right? 3 Α. That's correct. 4 Ο. Let's take a look at those. Those are 5 13:37 6 in your chart? 13:37 13:37 7 Α. Right. 13:37 Q. It's my understanding that the brush 8 biopsy was interpreted by a cytotechnician probably 13:38 9 and a cytologist, both. Do you agree with that? 13:38 10 Both have signed this. 13:38 11 Α. Q. Okay. Fine. And it reflects, "Acute 13:38 12 and chronic inflammatory cells. Features of 13:38 13 malignancy are not identified.!' 13:38 1415 Α. Right before this it says, "Reactive 13:38 13:38 16 glandular cells." It could be very indicative of a 13:38 17 growth within the bile duct. Q. Okay. We know there's a growth within 13:38 18 the bile duct at this point; right? 13:38 19 13:38 20 Α. Correct. 13:38 Q. 21 We just don't know what it is? 13:38 22 Α. Correct. 13:38 Q. It happens to be -- I didn't highlight 23 13:38 that. I left it out -- reactive glandular cells. 24 13:38 You can see that in a nonmalignant growth; correct? 25

Reactive glandular cells, correct. 1 Α. 13:38 So those do exist in nonmalignant 2 Ο. 13:38 growth? 3 13:38 Α. Right. 4 13:38 5 Q. What did you make of the acute and 13:38 chronic inflammatory cell description? 6 13:38 This is cytology. This is a surface 13:38 7 Α. brushing. 13:38 8 Ο. Right. 13:38 9 10 Α. I don't place much evidence in that. 13:39 All right. So it's just one additional 13:39 11 Ο. piece of information that you had, and it didn't 13:39 12 necessarily change your impression that it was more 13:39 13 likely than not that a malignancy existed; right? 13:39 14 13:39 15 Α. Correct. Ο. Okay. I want to do this nice and 13:39 16 13:39 sequentially. All right. You've got the CT 17 results, blood results. You know what the ERCP 13:39 18 says, and now you know the cytology; right? 13:39 19 13:39 20 Α. Right. Okay. At this point, what decision do 13:39 21 Q. 13:39 2.2 you make? 23 Well, we talked it over, Dr. Maxwell 13:39 Α. 13:39 24 and I, and we both agreed that the patient needed 13:39 25 exploration.

1	Q. Okay. So the record is clear you	
2	are a very soft-spoken person, but I think the	13:39
3	court reporter may have gotten it. You referred to	13:39
4	Dr. Maxwell?	13:39
5	A. Correct.	13:39
6	Q. And you were both in agreement based	13:39
7	upon what you had seen on exploration of	13:39
8	Mrs. Maynard's bile duct. Am I right about that?	13:39
9	A. Correct, correct. Dr. Maxwell says at	13:40
10	the bottom of his note here, "Will review films.	13:40
11	Will likely need surgery."	13:40
12	Q. Okay. But you were going to be the	13:40
13	surgeon and the person to make the decision on what	13:40
14	direction to go; right?	13:40
15	A. Correct.	13:40
16	Q. Okay. Let's go back. We get to do a	13:40
17	lot of flipping of papers here. I would like to go	13:40
18	back and look at your 2/21/96 office note together;	13:40
19	okay?	13:40
20	A. All right.	13:40
21	Q. Now, at this point in time, you	13:40
22	obviously have all the information, and you are	i3:40
23	going to meet with the patient and her husband to	13:40
24	discuss what it probably means. Is that a fair	13:40
25	assessment of where you would have been at on	13:40

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February 21, 1996? 13:40 1 Α. According to my note here, I already 13:40 2 had met with them. 3 13:40 Q. All right. I'm assuming you had met 4 13:40 with them after you had all the test results back. 5 13:40 That's correct. Α. 6 Q. Okay. At that point, you indicate in 7 your note -- and by the way, her daughter was also 13:40 8 there; right? 13:40 9 13:40 I can't remember. Α. 10 Q. Your note says she was there. 13:40 11 13:40 12 Α. Fine, fine. Q. Okay. Your note says, "We will open 13:41 13 the bile duct and excise the tumor"; correct? I'm 13:41 14 13:41 reading that with no problem? 15 Correct. 13:41 16 Α. "We will send this for frozen section 17 Q. 13:41 13:4118 analysis." 13:41 Α. Correct. 19 Q. "If it is returned as a cancer, we will 13:41 20 proceed with a" -- I can never say the word -- a 13:41 21 E3:41 22 whipple, but it obviously says the correct name of 13:41the procedure. "I've informed them we will take 2.3 13:41 out part of the stomach, pancreas and some of the 24intestines, et cetera. I've informed them this is 13:41 25

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	a larg [₽] o p ⊮ration, dot, dot, dot I•we in€orm⊮d	13:41
7	them, how⊵wer, i≷ this i∃ benign, whot w⊵ will do	13:41
С	is just excise the tu m or and close the EuoDenum';	13:41
4	COLTPCT?	13:41
ហ	A Corract	13:41
6	Q Anw owiously your not ^w reflects,	13:41
7	"Unfortunately, we will not know this until the	13:41
ω	tim® of ∎urgøry Shø undørstands t⊅is and	13:41
σ	concurs '	13:41
10	This is the sum and su c stance of t y e	13:41
11	e×planation you gaw¤ to Mr. and Mrs MagnarD a D out	13:41
12	what p rocedure Dorothy would undergo the following	13:41
1	day; am I right?	13:41
4 4	A This is a summory o≤ a worg long	13:41
ц Ц	meeting we had where we outlined all of this where	13:42
16	I Aeli¤we I rew t⊁em s¤weral pictur¤a o≲ things	13:42
17	Q. I think that you did.	13:42
1 8	A and <code>wxp</code> lai <code>wp</code> to them exactly uSat	13:42
19	was what and what we were doing	13:42
2 0	Q. Okay. Now, in your decision with them,	13:42
21	your not® Hak®∃ it clmar and I think thmrms	13:42
22	some hospital notes. We'll get to that.	13:42
23	You explained to them one of two things	13:42
24	will happen Rased upon positiwe or negatiue	13:42
7	pathology That's what I∙m going to call it	13:42
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1	can I assume that this paper that you wrote is	13:43
2	included in the publications section of your CV?	13:43
3	A. I'm sure it will be.	13:43
4	Q. Can you tell me when you wrote it?	13:43
5	A. It was in the late `80s.	13:43
6	Q. Okay. Who were you working under, or	13:44
7	were you doing this on your own at the time?	13:44
8	A. Helmet Schreiber.	13:44
9	Q. Okay. Why doesn't that surprise me?	13:44
10	Okay. Did you do tell me a little bit about	13:44
11	that paper. Did you do a retrospective analysis of	13:44
12	cases? Is that what you did?	13:44
13	A. No. Actually as I'm sitting here	13:44
14	recalling this now, we had a patient who had a	13:44
15	similar situation but who had congenital problems	13:44
16	with the colon who also developed polyps in this	13:44
17	area.	13:44
18	Q. Okay. So it was a paper based upon a	13:44
19	case study of one patient?	13:44
20	A. No. We reviewed many others.	13:44
21	Q. Okay. I'm just trying to get a flavor	13:44
22	for writing it. And can you tell me what the title	13:44
23	of the paper is?	13:44
24	A. I can't recall the exact title.	13:44
25	Q. That's all right. Who published this	13:44

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1	paper?	13:44
2	A. I can't recall. I think it was the	13:44
3	Journal of Surgical Oncology.	13:44
4	Q. Okay. My initial question although	13:45
5	I'm glad you gave me that answer was prior to	13:45
6	Mrs. Maynard	13:45
7	A. Uh-huh.	13:45
8	Q undergoing this exploration by	13:45
9	yourself, had you encountered a situation where the	13 : 45
10	pathology as it was I'm going to use the phrase	13:45
11	"read out to you during the time of	13:45
12	surgery" was equivocal?	13:45
13	A. Usually pathologists can state yes or	13:45
14	no. So no, I am not	13:45
15	Q. You had not previously encountered	:13 : 45
16	that?	13:45
17	A. No.	13:45
18	Q. Did you, Doctor, discuss with Mr. and	13:45
19	Mrs. Maynard what you would do in a situation where	13:45
20	you encountered an equivocal pathology call at the	13:45
21	time of surgery?	13:45
22	A. I can't specifically remember that.	13:45
23	Q. Okay. Well, while we're on the subject	13:45
24	of equivocal, what, to you, would be an equivocal	13:46
25	pathology call from a bile duct tumor?	13:46

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MR. EDMINISTER: Objection. 1 THE WITNESS: I quess the 2 13:46pathologist just says I can't tell one way or the 3 13:46other. 13:46 4 5 Q. Are you and I discussing the pathology 13:46 call of defer? I'm trying to --6 13:46 They would have to defer to permanent 13:46 7 Α. 13:46 sections. 8 Q. 13:46 Okay. If you had received a pathology 9 13:46 10 reading during this particular surgery from frozen 13:46 section that indicated from the pathologist that 11 the pathologist would need to defer because it was 13:46 12 13:46 not clear evidence of malignancy, what would you 13 13:46 have done? 14 13:47 I would have done the same thing after 15 Α. 13:47 discussing it with the Maynards. 16 13:47 Q. Now, you added "after discussing it 17 with the Maynards." 13:4718 13:47 Right. 19 Α. 13:47 Let's talk about that for a second. 20 Q. 13:47 21 First, I need to ask you why you would have gone 13:47 ahead and done the surgery if you would have 2.2 13:47 received an interoperative pathology read of 23 13:47 24 defer. Well, because of the age of the 25 Α.

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patient, because of the location of the polyp, 1 13:47because of its appearance on the ERCP, all of these 2 13:47 make a very strong indication this is a malignant 13:47 3 4 tumor and not a benign tumor. And had we found what we found with a dilated bile duct, I would 5 13:47 have to call this a malignancy or there was a 13:47 6 7 malignancy lurking in the general region of that 13:47 area. We hadn't biopsied, and it would have been 13:47 8 13:48 picked up, then, on the permanent sections. 9 13:48 Q. Given that you've published at least 10 13:48one article as you're relating -- you think it's in 11 the Journal of Surgical Oncology -- are you 13:4812 13:48 familiar with the statistical percentages in terms 13 of increasing a person's life expectancy by doing a 13:48 14 13:48 15 whipple when they actually have a pancreatic 13:48 16 cancer? 17 Α. Pancreatic cancer is different than 13:48 13:48 18 bile duct. 13:48 Q. I agree with you. Let me first ask for 19 13:48 pancreatic cancer. Are you aware of whether or not 20 13:48 a whipple actually statistically improves the 21 13:48 22 chance of survival? 13:48 23 Α. Yes. 13:48 Objection. 24 MR. EDMINISTER: 13:48Q. What do you believe the 25 Okay.

statistics are? 1 13:48 MR. EDMINISTER: Objection. 2 13:48MS. KOLIS: He says that he's 3 13:48 aware of them. 13:48 4 MR. EDMINISTER: Correct. 13:485 THE WITNESS: In pancreatic 13:48 6 7 cancers that can be resected without lymphatic 13:49 spread that are confined to the pancreas that are 13:49 а under two centimeters in size, as many as 40 13:49 3 percent of those patients can live five years. 13:49 10 11 Q. What about a bile duct cancer? 13:49 13:49 1 2 Α. Even higher percent. Okay. Can you tell me what studies or 13:49 13 Ο. literature you rely upon in making that assertion? 13:49 14 Any number of standard textbooks. 13:49 15 Α. Can you tell me which textbooks you 13:49 16 Ο. 13:49 relied on for those statistics? 17 Schwartz Principles of Surgery, 13:43 18 Α. Sabiston Biological Basis of Modern Surgical 13:4913 13:49 Practice, <u>Cameron's Current Surgical Therapy</u>. 2013:50 Okay. If you are uncertain if there is 2 1 Q. 13:50 22 a malignancy, do you believe that you have an 13:50 obligation to advise the patient that there is 23 13:50 24uncertainty as to whether or not there's a 13:50malignancy? 25

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1	A. Well, the patient will be asleep at	13:50
2	this time.	13:50
3	Q. Right.	13:50
4	A. So what I would do is speak to the	13:50
5	patient's family and explain the situation.	13:50
6	Q. Okay. Under that circumstance, if you	13:50
7	hadn't explained to a person prior to going under	13:50
8	anesthesia that there is a third potential category	13:50
9	of pathology readings that could occur not just	13:50
10	positive and negative but equivocal from whom	13:50
11	would you obtain the consent to then complete the	13:50
12	operation?	13:50
13	A. Well, first of all, the equivocal	13:50
14	reading in one of these must be very, very low.	13:50
15	But in that situation, what I would do is speak to	13:50
16	the patient's husband or wife.	13:50
17	Q. Okay. In this case just so we clear	13:51
18	things up and you don't think I'm looking at issues	13:51
19	I'm not looking at you didn't have the	13:51
20	opportunity to discuss an equivocal reading with	13:51
21	Mr. Maynard because you weren't given an equivocal	13:51
22	reading; correct?	13:51
23	A. That's correct.	4
24	Q. All right. If there's an equivocal	13:51
25	reading and a patient and/or her family at that	
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point in time does not wish for you to proceed with 1 13:51 a whipple for whatever reason, at that moment if 2 13:51 3 they chose not to proceed with the surgery, 13:51 theoretically -- or not even theoretically --4 13:51 realistically could you not close the patient, wait 5 for the final section read and then if it was 6 13:51 confirmed to be a malignancy, go back in and do the 13:51 7 13:51 whipple? 8 Well, from an oncologic point of view, 13:51 9 Α. you would be worried about contamination of the 13:51 10 operative field with potential tumor cells. 13:5111 Т would be personally worried about leaving a 13:5112 residual tumor behind in that situation. 13:52 13 Q. Doctor, how long does it take to get to 13:52 14 13:52 frozen section from final read on pathology, 15 13:52 generally speaking? 16 MR. EDMINISTER: If you know. 13:52 17 THE WITNESS: Well, I think this 13:52 18 case took four or five days. 19 13:52 We are talking about four or five days 20 Ο. 13:52 21 of delay; correct? 13:52 22 Α. Four or five days of delay, right. 13:52 23 Ο. So understanding and accepting that at 13:52 least at Akron General, you're able to get a final 24 13:52 25 read in four to five days, my first simple question

, -1	was, you could close and wait for a final section	13:52
0	reading and then go Dack in and do this proce ure	13:52
м	if there was found to a e a true malignancy in t > e	13:52
4	final rwadhng; corract?	13:52
ம	A You could I would not apwocate tPat	13:52
9	u t	13:52
7	Q Okay Let s go t>rough this we mig>t	13:52
ω	as well get ewerything out on the talle Why	13:52
თ	wouldn•t you adwocat? t≻at if a family did not want	13:52
10	a p∉rson to unđ∉rgo a surg∞ry su∈h as t⊅is and	13:52
다 다	wanted to wait ≷or the final rea c ?	13:52
12	A Wµll, ≷irst of all, H would nµwer go	13:52
13	agaènst a famèly s wis>ga	13:53
14	Q. I understand that.	13:53
15	А SuHRPrronp Number teo, н eoul try	13:53
19	my Apst to pducate the ≤amily as to the	13:53
17	probabilities of a malignancy wersus a D enign	13:53
- 17 19	tumor.	13:53
1-0	Q. Right.	13:53
2 0	A. And I would strast to than sometimes wa	13:53
7	just Don-t know and you haws to go ahwan ann do a	13:53
22	resection ⊵wgn though on ≲inal report it may A e	13:53
7 7	benign.	13:53
2 4	Q. Okay What I.m asking is this. I'm	13:53
7	just trying to listen and write, and that s always	13:53
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1 hard. There is no medical standard or no 2 13:53 3 medical issue that would prevent you from closing 13:53 4 and then doing a whipple five to six days later if 13:53 the final came out that it was actually a 5 13:53 6 malignancy? 13:53 MR. EDMINISTER: Objection. 13:53 7 THE WITNESS: No, there is, 13:53 8 9 because you may not have done a proper biopsy of 13:53 13:53 10 the lesion. You may have missed the lesion, and the lesion can be hidden in these tissues. 11 This 13:53 was a very tiny lesion we were after, but big 13:5412 enough -- and she was very, very fortunate that 13:54 13 this caused obstructive jaundice because that's 13:5414 13:54 what led to this whole thing. 15 13:54 16 Q. Doctor, excuse me. Let's talk about the size of this since we're on this issue. This 13:5417 18 particular lesion was five milliliters; am I 13:54 13:54 19 right? You can look. 13:54 I don't know the exact size. 20 Α. 13:54 21 Q. Don't ever trust my --22 Α. It was fairly small. 13:54 13:54 2.3 Q. Well, your office note of 2/21 says 13:54 24 five to six. I've seen it reported as four to 13:54 five. So I just rounded it and said that it's 25

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five. Does that seem accurate? 1 13:54 2 Α. My note says it measures about five to 13:54 six millimeters in size and was obstructing the 3 13:54 4 common bile duct. 13:54 Q . Okay. Five to six milliliters is --5 13:54 6 here. I'm going to give you a piece of paper. 13:54 Don't worry. We're not going to bring out a ruler 13:54 7 13:54 later and say you don't know what five to six 8 milliliters is. 13:54 9 13:55 10 Draw a line approximately five to six 13:55 millimeters. 11 13:55 12 Α. (Complying.) Somewhere between here 13:55 and here. (Indicating.) 13 13:55 14 Q. Okay. That is a relatively small 13:55 15 polypoid lesion, isn't it? That's correct. 13:55 16 Α. Q. Given that it's a small lesion, if you 13:55 17 took the entire lesion out and had the pathology 13:55 18 13:55 done on it, do you think it's a high likelihood if 19 13:55 it was truly cancerous you would have received a 20 13:55 21 benign -i3:55 Α. A small lesion like that -- I was 2.2 13:55 23 worried we had missed the lesion, or there was an 13:55 24 additional tumor around that area. 13:55 At what point were you worried you had 25 Q.

missed the lesion? 1 13:55 What point was I worried in this case? 13:55 2 Α. When our initial biopsies came back as benign 3 13:55 tissue. 13:55 4 Q. When they came back as benign tissue, 5 13:55 were you inclined to disbelieve those other areas 13:55 6 were benign? I'm paraphrasing what I thought I 13:55 7 13:55 heard you say. 8 13:55 Α. I was very concerned -- because a 9 biopsy is a superficial sampling -- that there was 13:56 10 13:56 a tumor deeper to our biopsies. 11 13:56 Q . If you had that concern that there was 12 13:56 a tumor, as you're phrasing it, "deeper to your 13 13:56 biopsies" -- I think I know what you mean -- what 14 13:56 15 additional areas could you excise to have sent for 13:56 16 pathology if you were concerned about that? 13:56 17 A. Well, you try to biopsy around as much as you can in other areas. 13:56 18 13:56 Q . And you did, in fact, do some 19 13:56 additional biopsying, didn't you, at the time of 20 13:56 21 the surgery? 13:56 22 A. Well, I think we were very persistent in attempting to delineate exactly what the problem 13:56 23 13:56 24 was here. 13:56 Q. Right. 25

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And we sent out one, two, three, four, 1 Α. 13:56 five different samples for frozen section. 2 13:56 Q. Okay. Do you have a recollection --3 13:56 and I'm just asking what you recall. I assume you 4 13:56 5 have not reviewed the pathology slides; is that 13:56 6 right? No, I have not. 13:56 7 Α. Q. I have them today. I gave them to 13:57 8 And if Michael because I've had them for a while. 13:57 9 10 you needed to look at them, that would be 13:57 13:57 acceptable, of course. 11 Do you have a recollection that 13:57 12 specimen C, which was sent, was a very small 13:57 13 13:57 sample? 14 Α. I can't recall the size of the frozen 13:57 15 13:57 16 sections. Q. Okay. If you had received a readback 13:57 17 from the pathologist that indicated defer on two 13:57 18 basis -- one, there wasn't clear evidence of 13:57 19 13:57 20 malignancies, and B, that the sample size was inadequate -- could you have rebiopsied in that 13:57 21 13:57 approximate same area to obtain additional tissue? 2.2 23 Α. Yes. 13:57 13:57 24 Q. Okay. But that didn't happen in this case either? You didn't get that phone call from 25

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1	the pathologist; right?	13:57
2	A. That's correct.	13:57
3	Q. Okay. Fair enough. Let me ask you	13:57
4	this hypothetically, since, I guess, it's important	13:57
5	to know it now. Based upon what I hear you saying,	13:57
6	if all of these biopsies that were done had come	13:58
7	back is it okay if I say negative instead of	13:58
8	nonmalignant? Whatever you're comfortable with.	13:58
9	We'll call them negative would you have	13:58
10	proceeded to do a whipple at that point?	13:58
11	A. I said in my office notes we would	13:58
12	biopsy, and if it was benign, we would simply	
13	excise the tumor.	13:58
14	Q. Right.	13:58
15	A. A lot of this depends on where the	13:58
16	tumor was located, which we could not determine	
17	from the ERCP. If the tumor let me refer to the	13:58
18	report here.	13:58
19	Q. That would be fine.	13:58
20	A. Do we have it?	13:58
21	Q. Sure. There's an op report. But I	13:58
22	have one highlighted, if you want it. I know	13:58
23	there's one in your chart because I got one when	13:58
24	you answered my subpoena.	13:58
25	A. Here we are.	13:59

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Q. 1 00051 or so. 13:59 2 Okay. Here we are. The first thing we Α. 13:59 did was to -- let me just read this right here. 3 13:59 Q. Doctor, we've got plenty of time. You 4 13:59 can read whatever you want. 5 13:59 Α. The first thing we did was open the 13:59 6 13:59 7 duodenum to visualize the ampulla. In my mind, the benign tumors are not in the bile duct for the most 13:59 8 13:59 part but in the ampulla region in the bile duct. 9 This is the part within the duodenum. So we didn't 13:59 10 know from the ERCP where this tumor was. 13:5911 Q. Let me stop you right now. Now, you 13:59 12 13:59 normally don't do ERCPs; right? 13 13:59 Α. Right. 14 Q. What information does an ERCP give you 13:59 15 13:59 16 about the location of the mass? 13:5917 Well, it can tell you if it's high Α. 13:59 within the bile duct or low within the bile duct. 18 Q. 13:59 19 Okay. 14:00 20 So this says distal common bile duct. Α. Q. So you assumed that it was where? 14:00 2 1 14:00 Low in the bile duct, but I did not 22 Α. 14:00 23 know exactly where this was until the time of 14:00 24 surgery when I could visualize this area. 14:00 Q. 25 Okay.

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1	A. We visualized this area, and the	14:00
2	ampulla appeared normal. So, therefore, in that	14:00
3	situation, this tumor was up in the distal portion	14:00
4	of the bile duct in an area that has a very high	14:00
5	probability of it being a malignancy.	14:00
6	So to answer your question, if	14:00
7	everything had come back negative, what I would	14:00
8	have done was to walk over to the telephone, call	14:00
9	Mr. Maynard and say here is the situation. My	14:00
10	recommendation is that we proceed with surgery	14:00
11	because we simply cannot 100 percent tell you that	14:00
12	this is not a cancer.	14:00
13	Q. You didn't tell Mr. and Mrs. Maynard	14:01
14	that before the surgery, did you?	14:01
15	A. I did not know where in the bile duct	14:01
16	this was.	14:01
17	Q. I understand.	14:01
18	A. This could be in the ampulla or the	14:01
19	distal bile duct. And what I told them, I believe,	14:01
20	is pretty well recorded in my notes; that if it was	14:01
21	benign I was trying to be very hopeful here this	14:01
22	was a benign bile duct tumor. "We will excise the	14:01
23	tumor and close the duodenum."	14:01
24	Q. Let's say two things today, in fact, we	14:01
2 5	know. It was a benign tumor?	14:01

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l	A. We know there was no cancer.	14:01
2	Q. Okay. Doctor, is it clear to you as	14:01
3	you sit here and talk to me today that you never	14:01
4	discussed with the Maynards the possibility that if	14:01
5	all of the pathology was benign, that based on	14:01
6	location, you would still go ahead and do this	14:01
7	surgery?	14:01
8	A. Well, as I said, I would discuss it	14:01
9	with him at the time of operation.	14:01
10	Q. Okay. But you didn't I'm just	14:01
11	clarifying. You didn't discuss that particular	14:01
12	suspicion that the ERCP had not defined clearly	14:02
13	enough for you	14:02
14	A. Right.	14:02
15	Q where it was? And maybe even based	14:02
16	on that, even if it was benign, you were going to	14:02
17	do it anyway?	
18	A. I didn't have my mind made up. I	14:02
19	didn't know what we would do. They were very, very	14:0'2
20	anxious about this. I gave them a straightforward	14:02
21	analysis about what we would do in a	14:02
22	straightforward fashion.	14:02
23	Q. Prior to going in for this surgery, did	14:02
24	you explain to Mrs. Maynard the morbidity that	14:02
25	follows a whipple procedure?	14:02

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1	A. I'm certain I did.	14:02
2	Q. Okay. You've reviewed the Cleveland	14:02
3	Clinic records; correct?	14:02
4	A. Yes.	14:02
5	Q. And this is not a very lawyerly	14:02
6	question, but you were not surprised that she has	14:02
7	had to undergo the surgery that she did with	14:02
8	Dr. Ponski?	14:02
9	A. I've not seen Mrs. Maynard since we had	14:02
10	that conference, and at that time according to	14:03
11	Dr. Rehmus who was following her she seemed to	14:03
12	be doing quite well.	14:03
13	Q. That wasn't the question I asked. In	14:03
14	terms of your knowledge, the subsequent morbidity	14:03
15	that follows logically from doing this rather large	14:03
16	operation, you're not surprised that she has	14:03
17	developed a problem which required yet another	14:03
18	corrective surgery?	14:03
19	A. To the contrary, I'm very surprised.	14: <i>03</i>
20	MR. EDMINISTER: Objection.	14:03
21	Q. You're surprised because you think	14:03
22	that's uncommon following a whipple?	14:03
23	A. It is uncommon.	14:03
24	Q. Do you know why she had to have the	14:03
25	surgery with Dr. Ponski?	14:03

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Α. According to his note, she had 14:03 1 gastroparesis. 2 14:03 Q. Do you know what the cause of that 3 14:03 4 gastroparesis was? 14:03 I'm not sure anyone knows what the 5 Α. 14:03 6 cause was. 14:03 Ο. Recently I provided to your counsel the 14:03 7 final discharge summaries from the Cleveland 14:03а Clinic. Have you seen those? Maybe Mike hasn't 14:03 9 even seen them. He gets a lot of mail. 14:03 10 MR. EDMINISTER: I think what 14:03 11 you're referring to has just arrived within days. 14:04 12 MS. KOLIS: It did. That's why 14:04 13 14:04 14 I'm asking if he got to see it. MR. EDMINISTER: So I think he 14:04 15 16 only had an opportunity to briefly review those, 14:04 and I think what you're reviewing is the discharge 14:04 17 18 dates of 2/14/97 and 3/10/97. 14:04 MS. KOLIS: Right. It's the 14:04 19 3/10/97 following -- he doesn't have to read it. 14:04 20 Ι was just asking if he had an opportunity to see it 14:0421 14:0422 as of yet. 14:04 23 Q. When did you receive the final section 14:04 24 reads on this surgery? Final section is not the 14:04 right phrase for it, but --25

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I don't know when I received it. Α. Ιt 14:04 1 was -- according to the note, it was completed on 14:04 2 3 2/27/96. 14:05 4 Q . Okay. Did you see the actual printed 14:05 copy of the pathologist's analysis at that time? 5 14:05 MR. EDMINISTER: You mean as 14:05 6 7 opposed to on the computer? 14:05 Q. As opposed to being told what the final 14:05 8 14:05 9 was. Did they actually forward you a copy of the 14:05 10 pathology? It's right here, surgical pathology 14:05 Α. 11 14:05 12 report. 14:05 Q . Fine. Was there anything in the 13 description by Dr. Mucitelli -- I can never 14:05 1414:05 pronounce her name -- that caused you concern that, 15 14:05 in fact, this was not really a cancer? 16 Α. 14:05 17 No. 18 Q. All right. When did you learn that 14:05 14:05 19 there was a possibility that there had been a 14:05 20 misread surgically? 14:05 Let me see if I dictated it. 21 Α. 14:05 Q. That's fine. 2.2 14:06 In my note of 8/17/96, I say I was 23 Α. 14:06 24 informed last week. 14:06 25 Q. Okay. Do you recall how you were

It says by Scott Shorten. 1 informed? 14:06 2 Α. Right. 14:06 Q. Dr. Shorten is whom? 3 14:06 Α. He's a pathologist. 4 14:06 Q. 5 And do you know if he -- well, you 14:06 might not know, but is he -- does he work for Akron 6 14:06 14:06 7 Pathology? I don't know who he works for. 14:06 Α. 8 9 Ο. He's in an office at the hospital? 14:06 He works there. 10 Α. 14:06 Okay. How did he let you know what 14:06 11 Ο. 14:06 happened? 12 I think he called me, as I remember. 14:06 13 Α. All right. And at that point in time, 14:06 14 Ο. he told you that he had discovered a misdiagnosis 14:06 15 in the case of Dorothy Maynard? 14:06 16 That's what I see here. 14:06 17 Α. Okay. At that time, he let you know 14:06 18 Q. there was an internal review as well as one 14:06 19 14:06external review at the Cleveland Clinic suggesting 20 that is what it says. Your note says, "Both their 14:07 21 14:07 own internal review as well as the outside review 22 23 at the Cleveland Clinic suggests strongly there was 24 no evidence of cancer in the resected head." Is 25 that what you meant to say?

Α. Well, in the bile duct, within the head 14:07 1 of the pancreas, so --2 14:07 Q. Okay. I just wanted to make sure we 3 14:074 were -- that this information meant what I thought 14:07 5 it meant. That wasn't just a different way of 14:07 stating it; right? 14:07 6 Α. (No response.) 7 Q. 14:07 All right. You then discuss this with 8 14:07 9 Dr. Rehmus; correct? 14:07 I did. 10 Α. And the two of you -- at least your 14:07 Q. 11 note indicates -- decided to have a meeting with 14:07 12 Mr. and Mrs. Maynard; right? 13 14:07 Α. Correct. 14 14:07 Q. Okay. And, in fact -- now, this note 15 is dictated 8/27/96, and it says, "There's a third 16 outside opinion being sought." Am I right that 17 that's what it says? 18 14:07 Α. Yes. 19 14:08 Q. Okay. Did you know that that was 20 14:08 already out for review at the Mayo Clinic? 21 14:08 I believe I asked Dr. Shorten to send Α. 2.2 14:08 it out to the Mayo Clinic. 23 14:08 24 Q. You think you suggested that? 14:08 I'm fairly certain I did. 25 Α.

Q. Do you know pathologists at the Mayo 14:08 1 Clinic? 2 14:08 No, I didn't, but I wanted 3 Α. 14:08 experienced --4 14:08 5 Q., You wanted a good facility that you 14:08 would feel confident about the read? 6 14:08 I wanted to be certain this is what 7 Α. 14:08 14:08this was. 8 Q. 14:08 Okay. To make it clear to you that 9 Dorothy Maynard never needed chemotherapy or 14:08 10 14:08 11 radiation treatment? 14:08 MR. EDMINISTER: Objection. 12 THE WITNESS: On the basis of the 14:08 13 14:08 final pathology from the operation --1414:08 15 Ο. Right. -- we were dealing with an invasive 14:08 16 Α. bile duct tumor. I'm not an expert in chemotherapy 14:08 17 or radiation. 14:08 18 14:08 Q. All right. Well, let me ask this. 19 At 14:08 the time that you dictated this note back in August 20 14:09 21 of 1996, basically what you say is as follows. And 14:09 I want to talk to you about what you 22 contemporaneously wrote with your discovery at the 14:09 23 14:09 situation. 24 14:09 25 "I'm extremely upset with this.

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1	Review of everything shows that indeed the surgical	14:09
2	indications were clearly there, i.e., the	14:09
3	intraluminal obstruction of the bile duct, frozen	14:09
4	section, report positive for adenocarcinoma." I'm	14:09
5	reading what you put in your chart; correct?	14:09
6	A. Right.	14:09
7	Q. And that tells me you believe that the	14:09
8	surgical indications were the obstruction and the	14:09
9	report being positive; right?	14:09
10	A. Well, the indications for the operation	14:09
11	were the laboratory tests, the ERCP, the CAT scan.	14:09
12	The whole picture pointed to a tumor, not just what	14:09
13	I said here.	14:09
14	Q. Then you went on to write, "However,	14:10
15	the upsetting factor here is that this patient	
16	suffered a great deal due to her chemotherapy and	14:10
17	radiation."	14:10
18	A. Correct.	14:10
19	Q. All right. Did Dr. Rehmus tell you she	14:10
20	was upset because if she had known the correct	14:10
21	pathology, she would not have had the patient	14:10
22	undergo chemo and radiation?	14:10
23	A. I can't remember most certainly what	14:10
24	Dr. Rehmus' comments were.	14:10
25	Q. To be fair for the record, are you	14:10

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telling me you don't remember her saying that? 1 She might very well have, but a lot of 2 Α. 14:10people were very upset with this. I can't remember 3 14:10 her specific comments. 4 14:10 Q. Doctor, let me ask you a question. 5 Why 14:10was everyone so upset if all this was indicated 6 14:10anyway, irrespective of the misread? 7 14:10Α. As I said, I was upset here because she 14:108 9 had had complications from the chemotherapy and the 14:10radiation. She had been hospitalized several times 14:10 10 for this. I had seen her once or twice actually in 14:1111 the hospital. 14:1112 Q. So that's what you were upset about? 14:11 13 I was upset that she had suffered from 14 Α. 14:11 the chemotherapy and the radiation. 15 14:11 You weren't upset because you thought Q. 14:1116 17 that she had received needless medical treatment 14:11for a condition she didn't have? 14:1118 14:11 19 MR. EDMINISTER: Objection. 14:11 THE WITNESS: That's not my 20 14:1121 decision on the chemotherapy and the radiation. 14:11Q. I know it's not your decision. That 22 wasn't what I asked you. But there was a meeting 14:11 23 14:11 24 approximately August 30. I don't see a note, but 25 does that sound right to you, a couple days

1 after --14:11MR. EDMINISTER: What kind of 14:112 3 meeting? 14:11 4 MS. KOLIS: with Mrs. Maynard. 14:11 MR. EDMINISTER: Between T.4 :11 5 6 Dr. Guyton and Mrs. Maynard? L4:11 Q. You were in attendance at a meeting 7 14:11 14:11with Mrs. Maynard; correct? 8 At Akron General Hospital with 9 Α. L4:11 Dr. Rehmus and Dr. Fromm from radiation and, I 14:1110 14:11 11 believe, Dr. Button. Q. Who is he? L4:12 12 L4:12 Α. The chief of pathology. 13 Q. So the chief came, not Dr. Shorten? 14:1214 That's correct. L4:12 15 Α. Q. Okay. Because there's another note we 14:12 16 can refer to that Dr. Rehmus wrote. That's how I 14:1217 14:12 18 knew who was there. You didn't dictate a note 14:1219 about the meeting; right? 14:12 Α. (Witness shakes head from side to 20 21 side.) Dorothy was there without her husband, 14:12 22 Q. 14:1223 wasn't she? 14:1224 Α. Yes. 14:12Q . You were surprised by that? 25

1	A. I was surprised by that.	14:12
2	Q. This has nothing to do with the case,	14 : 12
3	believe me, but it was your understanding that	14:12
4	Dr. Rehmus was going to tell Dorothy tell her to	14:12
5	come down with her husband for a meeting?	14:12
6	A. Right.	:14:12
7	Q. Did you subsequently learn that that	14:12
8	didn't happen; that Dorothy just happened to be	:14:12
9	there for an appointment?	14:12
10	A. I don't believe I learned anything	14:12
11	about that.	14:12
12	Q. That's fine. Had this group of doctors	L4:12
13	that we've just discussed Dr. Fromm, Dr. Rehmus,	14:12
14	yourself, Dr. Button had you folks had a meeting	14:12
15	prior to meeting with Mrs. Maynard?	14:13
16	A. I don't believe we had a meeting, no.	14:13
17	Q. As you recall it, were you told that	14:13
18	there was going to be a meeting at a certain day at	14:13
19	a certain time at the hospital, or did you just	14:13
20	happen to get called to that meeting?	14:13
21	MR. EDMINISTER: To the meeting on	14:13
22	the 30th with the patient?	14:13
23	MS. KOLIS: Right.	14:13
24	THE WITNESS: I think the meeting	14:13
25	with the patient was at my suggestion and	14:13

Dr. Rehmus' suggestion. We set this up to get all 14:13 1 of her doctors involved and explain to her what had 2 14:13 happened. 3 14:13Q . 4 Okay. I agree that that's what the notes reflect, of course. But, I guess, what my 5 question was, do you remember if -- because there's б nothing in your chart that a meeting was set up. 14:137 I'm asking if you remember happening to get called 14:138 to a meeting saying, gee, Mrs. Maynard is here. 14:139 14:13 Let's meet with her. 10 No. I'm sure it would have been 14:13 Α. 11 scheduled. 14:1312 14:14Q. What if I told you it wasn't scheduled? 13 14:14MR. EDMINISTER: Objection. 14 MS. KOLIS: I'll withdraw that. 14:1415 14:14Do you recall what you told 16 Q. Mrs. Maynard at this meeting, if anything? 14:1417 18 Α. As I remember the meeting, I didn't say 14:1414:14much. The others did most of the talking. 19 Well, did Mrs. Maynard ask you any 14:14Q. 20 14:14 21 questions that you can recall today at that 14:1422 meeting? 14:1423 Α. No. I can't recall that she said a 14:142.4 word. She was very shocked and surprised.

Q. You say other people did the talking; 14:14

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Ч	right?	14:14
N	A. Right.	14:14
m	Q wo you recall Mr¤ Maynard asking you	14:14
4	if she could Daw? awoided the surgerk?	14:14
ம	A No I don t t>ink she did	14:14
6	Q Hawe You seen Sster Rebaus. Cbart?	14:14
7	A No	14:14
ω	MS KOLIS: OKAY I will b ^p	14:14
თ	deposing EstDer Rehaus in the not too distant	14:15
0	<pre>\$wturp = Bo I'H going to ask you to assume t>is is</pre>	14:15
년 년	what #De has written. In fact it is what I hawe	14:15
1	in writ¢ng Mik⊵ may r⊵≤ut⊵ it	14:15
1	MR ≲DMHNISMER; What are you	14:15
14	r⊵≼errino to?	14:15
ы Ц	MS KOLIS: It' e b atex stamp	14:15
Р 1	00028	14:15
17	MR ≋DMINISM≅R: H don•t Þa⊌e th₽	14:15
50 1 1	wat⊵s stamp T≻at do⊵∎n•t help mp	14:15
61	MS. KOLIS: I sent you guys all	14:15
50	these records Mhates why I	14:15
21	MR EDMIGISMER: Oh, gou did.	14:15
2 2	MS BARKZR: It's a docu m ent	14:15
7 M	dated	14:15
24	MR EDMINISMER. With p at⊵¤ stamp∎	14:15
20	on it?	14:15
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1	MS. KOLIS: Yes. I got everything	14:15
2	from records depositions and copied it in that	14:15
3	order and gave it to everyone.	14:15
4	MR. EDMINISTER: What are you	14:15
5	looking at?	14:15
6	MS. KOLIS: It is in Dr. Rehmus'	14:15
7	dictated notes dated 8/30/96; okay? It's close to	14:16
8	the bottom of the page, the impression.	14:16
9	Q. We'll start close to the bottom	14:16
10	one-third where it says "Impression. No evidence	14:16
11	of cancer. I discussed this with her at length and	14:16
12	again in the presence of Dr. Guyton, Fromm and	14:16
13	Button. We all assured her that her surgery would	14:16
14	have been the same whether or not the frozen	14:16
15	section would have been read as equivocal for	14:16
16	cancer."	14:16
17	Does that refresh your memory of what	14:16
18	was told to her at that meeting?	14:16
19	A. I'm sorry. I wasn't looking at that.	14:16
20	Q. I'm sorry. It's approximately at the	14:16
21	bottom one-third of the page.	14:16
22	A. And what did you read here? I did read	14:16
23	this second paragraph from the bottom here.	14:16
24	Q. Yeah. The indication from Dr. Rehmus	14:16
	in her note is that, "We all assured her that her	14:16

1	surgery would have been the same whether or not the	14:17
2	frozen section would have been read as equivocal	14:17
3	for cancer."	14:17
4	Does that refresh your memory as to	:14:17
5	whether you discussed this issue with her at that	14:17
6	meeting?	:14:17
7	A. I did not say a lot at that meeting, as	14:17
8	I remember, and she did not ask me many questions.	:14:17
9	But equivocal here should be replaced by positive	:14:17
10	for cancer because that's what the frozen section	14:17
11	was.	14:17
12	Q. All right. Yeah, I don't want to	14:17
13	dispute what she wrote. I'm asking if that at all	14:17
14	helped refresh your memory that you made some	14:17
15	representations to Mrs. Maynard at that meeting or	14:17
16	not.	14:17
17	A. I might have explained to her,	14:17
18	Mrs. Maynard, given everything here, we would have	14:17
19	done the same operation, but I can't recall that	14:17
20	specifically.	14:17
21	Q. Okay. Had you seen the corrected	14:18
22	pathology readings as well as the outside	14:18
23	evaluations prior to that meeting?	14:18
24	A. Let's see. That meeting was 8/30?	14:18
25	Q. Yeah. I can assure you it was August	14:18

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30. 1 14:18 I'm sorry. August 28 is when the 2 Α. 14:18 report came back from Mayo Clinic. 3 14:18 Q. I'm asking you if you know if you saw 4 14:18 their pathology and interpretations prior to that 5 14:18 6 meeting? 14:18I can't remember. 7 Α. 14:18 Q. You don't know? 14:18 8 I can't remember. Α. 14:18 9 Q. If Dr. Rehmus testifies that had she 14:18 10 11 had the correct final reading, Mrs. Maynard would 14:18not have had to have undergone chemotherapy and 1213 radiation, will you personally be disputing that at trial? 14 15 MR. EDMINISTER: Objection. He's 16 told you he's not an expert in that field. He has no opinion. 17 18 Ο. I just thought I would ask. Let's talk a little bit more about the actual operation that 19 14:19you did on Dorothy. Why did you do a vagotomy? 14:1920 So that there's no ulceration that 14:1921 Α. 14:19 22 forms between the stomach and the intestine. 14:19 23 Ο. Okay. Let's talk about that. Under 14:19 24 whose training did you learn you should do a 14:19 2s vagotomy as part of a whipple?

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1	A. Well, Dr. S. Arthur Localio was the	14:19
2	professor of surgery.	14:19
3	Q. Was that at NYU?	14:19
4	A. That's correct.	14:19
5	Q. Okay. Have you read literature	14:19
6	subsequent to graduation from NYU's program that	14:19
7	indicates that a vagotomy is not a good idea?	14:19
8	A. • There have been papers published that	14 :19
9	raise the issue of vagotomy. However, in this	14:20
10	particular case, we were dealing with a bile duct	14:20
11	cancer which has a much longer survival than the	14:20
12	more common pancreatic cancer.	14:20
13	The reason there's an issue with the	14:20
14	vagotomy and hepatic cancer is most people don't	14:20
15	live that long. Bile duct cancer, on the other	:14 : 20
16	hand, the longevity is much greater.	14:20
17	Q. Okay. Once again, the reason you did	14:20
18	the vagotomy was to I don't like to use the	14:20
19	phrase "head off at the pass," but to avoid the	14:20
20	potential complication of ulcerations; is that	14:20
21	right?	
22	A. That's correct.	Ì4:20
23	Q. Okay. Do all people who have a whipple	14:20
24	without a vagotomy get ulcers?	14:20
25	A. I'm certain there are a number that	14:20

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1 don't. 14:20When was the last time you reviewed the 2 Q . 14:20literature as to what that incidence of 3 14:20complication really is? 4 14:20 I can't give you an incidence. 5 Α. 14:200. Okay. Let me just look through a 14:21 6 7 couple of note cards I have. Do you have any 14:21recollection from your own office notes or your own 14:218 memory of Mrs. Maynard's general state of health at 14:21 9 the time you examined her other than the problem 14:2110 14:21 with the obstructive jaundice? 11 12 Α. You mean when I initially saw her? 14:21 Q. Yes. 14:2113 She had some weight loss, but other 14:2114 Α. than that, it seemed to be --14:2115 Q. It seemed to be a person in relatively 14:2116 14:21 17 good health? Pretty good health. 14:21 18 Α. Q. Do you happen to know -- of course, 14:21 19 preoperatively -- that there was an anesthesia 14:21 20 14:21 assessment done for your patient; right? 21 14:22 22 Α. Well, I have not seen one, but --14:22 Okay. It's been a while. As we sit 23 Q . 14:22here today, you don't know her ASA, how they --24 14:22No, I don't. 25 Α.

1	Q. Okay. Did you discuss this case with	14:22
2	Dr. Mucitelli after you found out the pathology	14:22
3	readings were wrong?	14:22
4	MR. EDMINISTER: Who?	14:22
5	MS. KOLIS: Diane Mucitelli. I	14:22
6	can never pronounce her name.	14:22
7	THE WITNESS: No, I did not.	14:22
8	Q. Okay. Had you worked with her as a	14:22
9	pathologist before in your surgery cases?	14:23
10	A. Yes, I have.	14:23
11	Q. Are you still working with her?	14:23
12	A. No, I'm not.	14:23
13	Q. She's no longer at Akron General or at	14:23
14	least temporarily perhaps; is that right?	14:23
15	MR. EDMINISTER: Objection. I'm	14:23
16	not sure he knows what Dr. Mucitelli's status is.	14:23
17	Q. I was just curious if you did know.	14:23
18	A. I no longer work with her.	14:23
19	Q. And why is that?	14:23
2 0	A. I haven't seen her.	14:23
2 1	Q. Okay. It isn't that you requested not	14:23
22	to work with her?	14:23
23	A. No.	14:23
24	Q. Okay. Are any of the opinions which	14:23
25	you are rendering today regarding what you $would$	14:23

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have done had you had the correct readings on the 14:23 1 2 basis of or in an effort to assist a colleague? Do 14:23 you know what I'm asking you? 3 14:23 Α. No. 4 14:23 Q. I don't usually ask rude questions, but 14:23 5 sometimes I feel like I have to. I'm asking you if 6 14:23 any of the opinions that you are rendering today 14:23 7 14:24 about what you would have done had you known the 8 correct reading, are any of those opinions based on 14:24 9 a desire on your part to help the pathologist who 14:24 10 14:24 misread the pathology in this case? 11 14:24 No. 12Α. MS. KOLIS: Okay. Doctor, I don't 14:2413 14:24 have any further questions for you, and I 14 14:24 15 appreciate the time that you gave me today. 14:24 16 THE WITNESS: Okay. 14:24 17 MS. BARKER: No questions. Thank 14:24 you, Doctor. 18 MR. EDMINISTER: He'll read and 14:24 19 14:24 Thanks. 20 sign. 14:24 MS. KOLIS: That's fine. 21 22 (Thereupon, deposition concluded at 2:24 p.m.) 23 24 25

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1	CERTIFICATE
2	STATE OF OHIO)
3)
4	COUNTY OF SUMMIT)
5	I, Amie R. First, Registered
6	Professional Reporter and Notary Public in and for
7	the County of Summit and State of Ohio, do hereby
8	certify that DANIEL P. GUYTON, M.D. was by me first
9	duly sworn to testify the truth, the whole truth,
10	and nothing but the truth, and that the above
11	deposition, was recorded stenographically by me and
12	reduced to typewriting by me.
13	
14	I FURTHER CERTIFY that the
15	foregoing transcript of the said deposition is a
16	true and correct transcript of the testimony given
17	by said witness at the time and place specified
18	hereinbefore.
19	
20	I FURTHER CERTIFY that I am not a
21	relative or employee or attorney or counsel of any
22	of the parties, nor a relative or employee of such
23	attorney or counsel, financially interested
24	directly or indirectly in this action.
25	

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1	IN WITNESS WHEREOF, I have
2	hereunto set my hand and seal of office at Akron,
3	Ohio, this day of July, 1997.
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10	amie R. First
11	Amie R. First,
12	Registered Professional Reporter
13	and Notary Public in and for the
14	State of Ohio.
15	
16	
17	My notary commission expires August 21, 1997.
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1	CROSS EXAMINATION OF DANIEL P. GUYTON,
2	M.D.
3	BY MS. KOLIS
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		44115[1]	2:7	affiliated [3]	7:8	areas [3] 44:6	44:15	37:4 41:17	41:23
!		44308 [2]	1:23	7:10 7:11		44:18		43:21 44:3	44:5 47:8
'80s [1] 34:5		2:23		affiliation [1]	7:15	arrive[1]	12:7	44:7 46:12 48:21 48:22	47:8 48:25
'83 [2] 7:14	7:23	44321[1]	2:16	again _[2]	62:12	arrived [1]	51:12	48:21 48:22 49:16	48:23
				65:17		Arthur [1]	65:1		41.10
'87 [2] 7:14	7:23	-6-		against[1]	41:13	article	37:11	best [2] 33:21	41:16
				age [2] 3:2	36:25	articles[2]	5:12	between [4]	10:21
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000460[1]	22:12	696-9330[1]	2:8	agreed [1]	29:24	asleep [1]	39:1	bile [32] 12:18	21:14
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0228 [1] 1:7		/ 5 [x] 2.22		33:16 36:22	41:21		(0.0	37:18 38:11	43:4
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-1-				aided[1]	22:3	assisted [1]	22:3	47:18 47:20	47:22
100 [1] 48:11		8/17/96 [1]	52:23	Akron [23]	1:6	assume[4]	23:12	48:4 48:15	48:19
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1975 [2] 4:18 1980 [5] 6:3	6:17	849-6694[1]	2:24	8:11 8:14	8:21	assuming[1]	31:4	25:20 25:22	25:17
7:3 7:8	0:17 7:9			10:18 10:23	13:24	assure[1]	63:25	26:6	43.43
1982[1] 6:12	1.7	-9-		14:2 19:24 53:6 58:9	40:24 67:13	assured[2]	62:13		38:19
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1		97 [1] 1:7		alone[1]	26:15	attendance[1]	58:7	44:11 44:14	44:3 46:6
1987 [4] 7:11 8:3 8:25	7:12					attention[1]	17:4		28:9
		-A-		always[1]	41:25	attorney[2]	69:21	biopsy [5] 42:9 44:10	28:9 44:17
1991 [1] 8:15		abdomen[1]	18:24	Amie [3]	1:12	69:23		46:12	77.17
1996[3] 20:5	31:1	able[1] 40:24	10.47	69:5 70:11	10 0	August [6]	14:20	biopsying[1]	44:20
55:21	- ·		60.10	ampulla[4]	47:7	55:20 57:24	63:25	bit [2] 34:10	64:19
1997 [5] 1:17	7:4	above[1]	69:10	47:9 48:2	48:18	64:2 70:17			
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1:10 [1] 1:17			10.00	analysis [6]	12:8	13:15 21:7		21:6 22:21	24:10
		accepting[1]	40:23	12:10 31:18 49:21 52:5	34:11	Avenue [3]	1:16	29:18	
-2-		according[4]	31:2		2.20	2:6 2:14		board [1]	6:11
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	4.14	29:5	26.15	anxious [1]	49:20	BARKER[4] 18:5 61:22	2:21 68:17	12:23	v
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2:24 [1] 68:22		adenocarcino	ma [1]	37:2	20.1	34:18 46:5	49:5	51:16	****
		56:4	12.1	APPEARAN	CESm	49:15 68:9		bring[1]	43:7
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