IN THE COURT OF COMMON PLEAS 13:10

OF SUMMIT COUNTY, OHIO

DOROTHY S. MAYNARD, et al.,

Plaintiffs,

vs.

AKRON GENERAL MEDICAL CENTER, et al., Case No. CV 97 01 0228

Defendants. Judge Whitmore

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Deposition of DANIEL P. GUYTON, M.D., called for examination under the statute, taken before me, Amie R. First, a Registered Professional Reporter and Notary Public in and for the State of Ohio, by agreement of counsel, at the offices of Jacobson, Maynard, Tuschman & Kalur Co., L.P.A., 202 Montrose Avenue West, Suite 200, Akron, Ohio, on Friday, July 11, 1997, at 1:10 p.m.

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ORIGINAL

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DANIEL P. GUYTON, M.D., of lawful age, called for examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS EXAMINATION OF DANIEL P. GUYTON, M.D.

BY MS. KOLIS: 13:10

Q. Dr. Guyton, as you know, we've been 13:10
introduced. My name is Donna Kolis. I've been 13:10
retained to represent Dorothy and Cecil Maynard. 13:10

My purpose today in taking your 13:10
deposition is to clarify information hopefully 13:10
that's contained in the medical charts and ask you 13:10
some hopefully short and direct questions. 13:10

If at any point I ask a question that 13:10
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
question? 13:10

A. I will. 13:10

Q. And the reason I put it that way is if 13:10
I ask a question on the record and there's an 13:10
affirmative response of some sort, it will be 13:10
assumed at a later point you understood my question 13:10
generally. 13:10

If at any time you want to take a break 13:11

-- perhaps you have a surgical page -- that's acceptable. If at any time you want to confer with Michael, unlike some lawyers, I don't object to that. You need to indicate that for the record.

with that in mind, also, you have to answer all questions verbally. We try not to put the court reporter in the duty of interpreting anyone's body language. Do you understand?

A. Yes, I do.

Q. Starting with an easy issue, can you tell me briefly about the education which led you to your current profession?

A. Well, I went to college and medical school at Case Western Reserve and then completed a surgical residency at New York University Medical Center in Manhattan.

Q. Okay. When did you graduate from Case?

A. 1975.

Q. At a time other than today, if you would, provide a copy of your CV to your counsel. He'll forward it to me.

A. I will.

Q. All right. You indicated when you graduated from Case you then did a surgical residency in New York; correct?

A. Correct. 13:12
Q. Okay. What kind of surgical residency 13:12
program was it? Number of years and specialty, I 13:12
guess is what I'm asking. 13:12
A. Well, it was five years, and it was a 13:12
specialty in surgery. 13:12
Q. Okay. Just general surgery? 13:12
A. Right. 13:12
Q. All right. During your last year, were 13:12
you the chief resident? 13:12
A. Yes, I was. 13:12
Q. Okay. Did you publish any articles or 13:12
have any area of interest during that five-year 13:12
residency program? 13:12
A. During that five-year residency, I did 13:12
not publish any articles. 13:12
Q. Okay. When you finished that program, 13:12
did you undertake another surgical residency at 13:12
another hospital? 13:12
A. No, I did not. 13:12
Q. Okay. Following that, what did you 13:12
then do? 13:12
A. I entered private practice. 13:12
Q. Okay. Where did you enter private 13:12
practice? 13:12

A. Akron, Ohio. 13:12
Q. Okay. What year would that have been? 13:12
A. 1980. 13:12
Q. Okay. Prior to going into private practice, did you become boarded in general surgery? 13:13
A. To become boarded in general surgery, you have to be in practice for several years. So once I completed that time period, yes, I did become boarded in general surgery. 13:13
Q. What year did you obtain that board? 13:13
A. I think around 1982 or 1983. 13:13
Q. Okay. You won't be punished for not knowing it today, but just generally speaking that time frame? 13:13
A. Approximately. 13:13
Q. Okay. When you came here in 1980 and went into private practice, who were you in practice with? 13:13
A. Solo practice. 13:13
Q. Solo practice. How long were you in solo practice? 13:13
A. I've been in solo practice since that time. 13:13
Q. See, I'm disadvantaged here. I've 13:13

never met you before, and I don't have your CV, so I have to ask these kinds of questions. 13:13

From 1980 to the present, which is 1997, you've maintained a surgical practice on your own. You have no partners; correct? 13:13

A. Correct. 13:13

Q. All right. What hospitals have you been affiliated with since 1980? 13:14

A. Well, from 1980 to 1983, I was affiliated with Akron General, and from 1983 until approximately 1987, I was affiliated with Huron Road Hospital in Cleveland. And then from 1987 to the present time, I've been back at Akron General. 13:14

Q. Okay. Now, in '83 to '87, when I asked about affiliation, of course what I want is what hospitals you did have privileges at. The hospitals you had privileges at was to do surgery; correct? 13:14

A. Correct. 13:14

Q. Were you also doing surgeries at Akron General during that four-year period of time? 13:14

A. What four-year period? 13:14

Q. '83 to '87. 13:14

A. No. I was in Cleveland, Ohio. 13:14

Q. Okay. Did you relocate your medical 13:14

practice?

A. Yes, I did. 13:14

Q. During the years 1983 to 1987 while you were at Huron Road Hospital, what chiefs of surgery did you work under? 13:14 13:15 13:15

A. Dr. Helmet Schreiber. 13:15

Q. Okay. Was he the chief the whole four years you were there? 13:15 13:15 13:15

A. Yes, he was. 13:15

a. It is my understanding you are currently the chief at Akron General. 13:15 13:15

A. That's correct. 13:15

Q. When did you become the chief of surgery at Akron General? 13:15 13:15

A. I believe it was 1991. 13:15

Q. Okay. And you've remained the same since; right? 13:15 13:15

A. Correct. 13:15

Q. Okay. As part of that program, are you involved in the teaching in the hospital setting of the residents at Akron General? 13:15 13:15 13:15

A. Yes, I am. 13:15

Q. Okay. Being a general surgeon, can you describe for me -- let's just sort of say the last ten-year period, 1987 to 1997 -- what kinds of 13:15 13:15 13:15

surgeries do you regularly perform? 13:15

A. Most commonly they have to do with malignancies. Most recently it seems to be concentrated more on breast disease and breast cancer. Prior to that, I was doing a lot of colon surgery, breast surgery. 13:15 13:15 13:15 13:16 13:16

Q. I guess, you know, all folks who are general surgeons seem to have some area that they focus on more than others, perhaps that they get a reputation in or just something they actively do. And, you know, that's what I was asking you. 13:16 13:16 13:16 13:16 13:16

And if I understand the answer you're giving me, in the past ten years, you said -- let's start with A, you told me your focus was on malignancies; correct? 13:16 13:16 13:16 13:16 13:16

A. Correct. 13:16

Q. Malignancies of any particular organ or area of the body more so than others? 13:16 13:16

A. No. I would say pretty much all. 13:16

Q. Okay. Let's talk about whipple procedures. I'm going to call it a whipple procedure, the operation that you did on Mrs. Maynard. Is that all right with you, if I call it a whipple? 13:16 13:16 13:16 13:16 13:16

A. That's fine. 13:15

Q. It's easier than trying to spell it out and pronounce it, the complete name of the surgery, all the names. When did you first learn how to perform a whipple? 13:17

A. 1975, probably. 13:17

Q. And you were still at -- was it New York University? 13:17

A. That's correct. 13:17

Q. I wasn't listening too well. You were at NYU. And how many did you perform during your residency program? 13:17

A. Oh, I have no idea. 13:17

Q. Okay. You don't keep a chart or anything, of course? 13:17

A. (Witness shakes head from side to side.) 13:17

Q. In the time since you've come back to Akron General after leaving Huron through the present, what is the frequency with which you perform whipple procedures? 13:17

A. I would estimate somewhere between two and four a year. 13:17

Q. Okay. At Akron General, as part of the doctors who have privileges in general surgery, is there anyone who you would consider to be a 13:18

specialist in hepatic biliary surgeries? 13:18

A No 13:18

Q Okay In preparation for today's 13:18

deposition, can you tell me what medical documents 13:18

you've reviewed? 13:18

A Well, I've reviewed my office notes 13:18

Q Okay 13:18

A The X-ray reports 13:18

Q Oh, X-ray reports Okay 13:18

A The pathology reports, and that's it 13:18

Q Have you had an occasion since I filed 13:18

this lawsuit to re-review the hospital chart 13:18

itself? 13:18

A No, I did not look at the hospital 13:18

c art 13:18

Q Okay Well, I have some pages paper 13:18

clipped. We'll probably look at them. But I was 13:18

just curious if you had looked at it 13:18

Have you been provided with 13:18

Mrs Maynard's subsequent care records from the 13:19

Cleveland Clinic? 13:19

A. Regarding? 13:19

Q Any care and treatment that she 13:19

received from the department of gastroenterology 13:19

and the department of surgery after she was told 13:19

she did not have cancer. Have you looked at those records? 13:19

A. Most recently, yes. 13:19

Q. Okay. That's fine. The first question, I guess, I want to ask you is -- let's see what points of agreement, I suppose, we can arrive at. Is it clear to you, Doctor, based upon your overall analysis of the records that we've just discussed that Dorothy Maynard in the final analysis did not actually need a whipple procedure? 13:19

A. No. That would be an incorrect statement. 13:19

Q. Okay. Tell me what would be incorrect about that statement. 13:19

A. The reason Mrs. Maynard had her procedure was because she presented with signs of obstructive jaundice as well as radiographic evidence of a lesion in the distal common bile duct. 13:20

Q. Okay. The answer that you've just given me leads me to conclude that I probably inartfully asked the first question. So we'll break it up this way. 13:20

It's clear from the record that at the time the operation was performed, there were 13:20

adequate indications for the surgery to occur. Do you agree with that? 13:20

A. I think we had every indication to perform the operation. 13:20

Q. Okay. All right. The question I'm asking you is, based upon information which subsequently became available to you, are you and I in agreement that ultimately she really didn't need a whipple? 13:20

MR. EDMINISTER: Objection. Asked and answered. 13:20

THE WITNESS: No. I would stand by my first answer. 13:20

Q. Okay. Well, let's go through it then. Do you have a copy of your office chart available to look at? 13:20

A. Sure. 13:20

MR. EDMINISTER: Sure. 13:20

Q. Okay. Great. When did you first meet Dorothy Maynard? 13:21

A. My office note is dictated 2/19/96. 13:21

Q. Okay. It's my understanding that Mrs. Maynard was referred to you by another physician who has privileges at Akron General; is that accurate? 13:21

A. I don't know if this individual has privileges at Akron General or not. 13:21

Q. Okay. I cannot pronounce the doctor's name. It's Dr. -- 13:21

A. Maseelall. 13:21

Q. Maseelall. Is this somebody who had previously referred patients to you? 13:21

A. On rare occasions, yes. 13:21

Q. Do you know what kind of doctor he is? 13:21

A. I believe he is an internist. 13:21

Q. Okay. It's my understanding that he examined her on that date and sent her directly across the street to see you. Do you know if that's accurate or not? 13:21

A. I believe that was the sequence of events. 13:21

Q. Okay. Tell me what her presenting symptoms were as are recorded in the chart. 13:21

A. I see here, "The patient states that since August she has had the following constellation of symptoms. Whenever she eats, she develops nausea, midepigastric pain and then vomits her dinner." 13:22

Q. Okay. Why did that history cause the other doctor to send Mrs. Maynard to you? I'm not 13:22

asking you to get into his brain, but can you tell me what about those symptoms would have required an evaluation by yourself? 13:22

MR. EDMINISTER: Objection. Go ahead, if you can answer. 13:22

THE WITNESS: Well -- 13:22

MR. EDMINISTER: What does he think? Can you rephrase it? 13:22

Q. Yeah. Based upon the symptoms she presented with, why was the referral to a surgeon a necessary thing? 13:22

MR. EDMINISTER: From his perspective? 13:22

MS. KOLIS: Uh-huh. 13:22

THE WITNESS: He was worried, as I said here. "He called me today and informed me that in his opinion she had obstructive jaundice and required surgical evaluation." 13:22

Q. Okay. You physically examined Mrs. Maynard at that point in time; correct? 13:23

A. I did. 13:23

Q. And you found some evidence of jaundice both in her eyes and in her mouth. Am I fairly reading your note? 13:23

A. Correct. 13:23

Q. Okay. Fair enough. It also says, "The examination suggests the presence of a midepigastric right upper quadrant mass as well." I wasn't there, so I don't know what you're telling me. Can you explain to me in laymen's terms what was suggestive in that physical that there was a mass in that area? 13:23

A. On exam, there was an irregularity to the examination that would be consistent with this. 13:23

Q. And when you say "there was an irregularity," was there something you could palpate or feel as you examined her? 13:23

A. I believed I could. 13:23

Q. Okay. I'm just asking. 13:23

A. Right. 13:23

Q. Okay. And at that point in time, it's pretty evident from the note and subsequent course of events that you thought she should be admitted for an evaluation; is that correct? 13:23

A. That's correct. 13:23

Q. And it's pretty clear you had a concern there might be a malignancy? 13:24

A. Correct. 13:24

Q. Okay. Did you communicate that concern to Mrs. Maynard at that time, if you remember? 13:24

A. I can't recall exactly what I said to her, but I believe I expressed with them she could have a serious problem that could need prompt attention. 13:24

Q. Fair enough. Do you remember her husband being present at that first evaluation? 13:24

A. I believe he was. 13:24

Q. Do you have a pretty clear memory of both Mr. and Mrs. Maynard at this point in time? 13:24

MR. EDMINISTER: In what way? 13:24

Q. If you saw them, would you remember who they were? 13:24

A. I don't know if I would recognize them, no. 13:24

Q. Okay. Fair enough. What was your plan of diagnostic exams during this admission? 13:24

A. Well, I think I would have to refer to the hospital chart on that, but I think we proceeded right with a CAT scan and the like. 13:24

Q. Okay. Well, I guess we'll go over those things in detail. I guess what I'm asking is customarily when I read a doctor's chart, it usually tells me what the plan **is**, what series of testing is going to occur. Would you like to look at the hospital chart? 13:25

A. Sure. 13:25

Q. Because that might help you answer some of these questions. And it's chronological, and it's tabbed. 13:25

MS. BARKER: Off the record for a moment. 13:25

(Discussion had off the record.)

Q. I think the first section is the admission of 2/19/96. 13:25

A. Okay. We admitted her and went right to a CAT scan with IV contrast done the same day of admission. 13:25

Q. Okay. What else is in there? Are you reading your order sheets from the first admission? 13:25

A. Yes. 13:25

Q. Okay. Why don't you just, for the record, tell us what the plan was on admission? 13:25

A. Well, the plan was to try to pinpoint exactly what was causing the obstructive jaundice. 13:26

Q. Okay. An important thing obviously. What were you going to do in the endeavor to find out what was causing the jaundice? 13:26

A. Our first step, as I said, was to have a CAT scan of the abdomen and pelvis. 13:26

Q. Okay. And initially you weren't going 13:26

to do anything past -- you wanted to see what the results of the CAT scan were before you decided on further testing? 13:26

A. We were going to get some blood work. 13:26

Q. Okay. Did you get the blood work? 13:26

A. Yes. 13:26

Q. Okay. I probably have labs in a section marked labs, I would guess. What kind of blood work were you going to do for Mrs. Maynard? 13:26

A. Well, we were going to get a liver profile which would tell us indeed the degree of the obstructive jaundice. 13:26

Q. Okay. What were the results of those blood studies? 13:26

MR. EDMINISTER: Which ones? 13:26

MS. KOLIS: The ones that he's indicating he initially ordered to do the liver profile to see how much obstruction there was, I suppose, if I'm paraphrasing. 13:27

THE WITNESS: I don't see them in here. 13:27

Q. You don't see them in here. All right. Well, let me just represent to you that -- maybe we should have counsel for Akron General get her records. What's in that notebook is everything 13:27

I received under a subpoena from the hospital, and I guess I'm surprised what you're looking for may not be there. 13:27 13:28 13:28

A. These are Dr. Rehmus' lab reports from April 1996. Well, postop. 13:28 13:28

MR. EDMINISTER: Donna -- 13:28

MS. KOLIS: I don't want him to have to sit here and dig all day. 13:28 13:28

MR. EDMINISTER: You have this organized in a chronological fashion? 13:28 13:28

MS. KOLIS: Right. 13:28

MR. EDMINISTER: But in the initial admit, there is no breakdown for labs, so if they're in here, they must be mixed in with progress notes. 13:28 13:28 13:28

MS. KOLIS: Well, that's possible. 13:28

MR. EDMINISTER: I think so. Here's a CT. That's all within that same admit. Is there any more? 13:28 13:29 13:29

THE WITNESS: No. 13:29

MR. EDMINISTER: And there's nothing there. 13:29 13:29

Q. Okay. Let's do it this way. In your office chart, customarily when you order labs on a patient, does the hospital forward those labs to 13:29 13:29 13:29

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

And I guess the question I was looking for, was there anything remarkable about the liver series that you ordered that aided you and assisted you in any way in coming to a preliminary diagnosis as to the nature of her problem? 13:30 13:30 13:30 13:30 13:30

MR. EDMINISTER: Off the record. 13:30

(Discussion had off the record.)

THE WITNESS: Yes. Here. Here they are. 13:31 13:31

Q. Okay. What Bates stamp page is that on, just for reference? 13:31 13:31

A. 000460. 13:31

Q. Thanks a lot. Okay. You've located the results now? 13:31 13:31

A. Yes, I have. 13:32

Q. Can you tell me what they were? 13:32

A. They are indicative of obstructive jaundice. 13:32 13:32

Q. Fine. That's all I wanted to know. Do you see how hard this can be? All right. You had the blood work done. You also ordered a CT; correct? 13:32 13:32 13:32 13:32

A. Correct. 13:32

Q. Okay. What did the CAT scan reveal? It's probably easier to use your own chart for 13:32

that. (Handing to witness.) 13:32

A. Thanks. Let's see. Here we are. 13:32

Q. Okay. 13:32

A. "CAT scan reveals cholelithiasis and 13:32
intrahepatic biliary duct dilatation. Prominent 13:32
pancreatic head without definite CT evidence of 13:32
pancreatic mass. Etiology of the biliary duct 13:32
dilatation, however, remains uncertain and further 13:32
evaluation of ERCP is suggested as indicated." 13:32

Q. Okay. Let's talk about where you would 13:33
have been at diagnostically at that point. You've 13:33
received lab work, I assume, somewhere around the 13:33
time you got the CT results that tell you, in fact, 13:33
she's got obstructive jaundice; correct? 13:33

A. Correct. 13:33

Q. And then you get CT results, and the CT 13:33
is telling you that A, she's got some sort of 13:33
problem with her gallbladder; right? 13:33

A. She has gallstones. 13:33

Q. Stones. Okay. Does this CT reading, 13:33
as you interpret it, tell you that there -- let me 13:33
ask you what it tells you about the pancreas. I'll 13:33
change it to that way. 13:33

A. It tells me that the pancreatic head is 13:33
enlarged. 13:33

Q. Okay. What concern does that raise for you? 13:33

A. That there may be a tumor in the distal bile duct or in the head of the pancreas that's causing the obstructive jaundice. 13:33

Q. Okay. Now, at that point, based upon this examination, are you aware that there is a polypoid mass? 13:33

A. No. 13:34

Q. Okay. So you've done your blood work. You've done your physical exam. You've taken her history and physical. You've got the CT. What at this point in time is your diagnosis for this person? 13:34

A. Still obstructive jaundice. 13:34

Q. Okay. All right. And, of course, you follow-up on the advice of getting an ERCP; correct? 13:34

A. Correct. 13:34

Q. All right. Who is Dr. Maxwell? 13:34

A. Dr. Maxwell is a gastroenterologist. 13:34

Q. Okay. Is that someone you regularly worked with at that time? 13:34

A. Pretty much. 13:34

Q. Okay. You don't do ERCPs yourself?

A. No, I do not. 13:34
Q. That's his thing; right? 13:34
A. Correct. 13:34
Q. All right. You ordered that, I 13:34
believe, for the following day. I think that was 13:34
the 20th. Let's take a look at the results that 13:34
you got from the ERCP. 13:34
A. Okay. 13:34
Q. Okay. Are we at the same page? You've 13:34
got one -- oh, I'm looking at the radiology 13:34
report. You're looking at Dr. Maxwell's report; 13:35
right? 13:35
A. Right. 13:35
Q. Tell me what Dr. Maxwell revealed to 13:35
you based on the ERCP. 13:35
A. Polypoid lesion distal common bile 13:35
duct, biliary tumor. 13:35
Q. Now, at that point, he doesn't know 13:35
what, this mass represents; is that right? 13:35
A. He says it's a biliary tumor. 13:35
Q. Okay. Were you convinced that it was a 13:35
biliary tumor at that point? 13:35
A. Yes, I was. 13:35
Q. Okay. What would be the basis upon 13:35
which you were convinced it was a biliary tumor? 13:35

A. Its appearance on the X-ray film, the fact that it could not be dislodged as Dr. Maxwell performed several brushings for cytology. 13:35

Q. Okay. Just to make sure we're speaking the same language, when I say are you sure that it was a biliary tumor, I guess what I'm trying to distinguish is at that point in time were you convinced that this mass that is in the common bile duct is cancerous, or do you just not know at that point? 13:35 13:35 13:35 13:35 13:35 13:36 13:36

A. I think the probability is very high this was a cancerous mass. 13:36 13:36

Q. So in your mind, based upon your experience, the probability mitigated higher in favor of malignancy versus a mass alone -- 13:36 13:36 13:36

A. Correct. 13:36

Q. -- that would be nonmalignant; right? 13:36

A. That is correct. 13:36

Q. Okay. As we sit here today knowing all the things that transpired, what do you believe that mass was that was actually in the common bile duct? 13:36 13:36 13:36 13:36

A. I think it was a benign mass. 13:36

Q. Do you know or do you have an opinion based upon your experience as to what caused that 13:36 13:36

benign mass? 13:36

A. No. 13:36

Q. Do you have -- when I say "probability," I believe it would have occurred to you subsequent to learning that Dorothy did not really have cancer to think as to what kind of conditions would have caused the mass. Maybe I'm wrong. 13:36

Do you believe that the mass that was in the common bile duct had anything to do with calculus from the gallbladder because she had stones? 13:37

A. It would be unlikely for a calculus of the gallbladder to cause a growth. Usually you see an indentation or ulcer. This was a growth protruding. 13:37

Q. So you don't have an opinion today as to what caused that mass to grow? 13:37

A. No. 13:37

Q. I'm just asking. I don't want to be surprised later when someone has rethought the issue.

Now, at the time of the ERCP, did they do brushings on the mass at that point?

A. Dr. Maxwell said he had cytologically 13:37

brushed the mass. 13:37

Q. You obviously got the results of those 13:37
cytology brushings; right?

A. That's correct.

Q. Let's take a look at those. Those are 13:37
in your chart? 13:37

A. Right. 13:37

Q. It's my understanding that the brush 13:37
biopsy was interpreted by a cytotechnician probably 13:38
and a cytologist, both. Do you agree with that? 13:38

A. Both have signed this. 13:38

Q. Okay. Fine. And it reflects, "Acute 13:38
and chronic inflammatory cells. Features of 13:38
malignancy are not identified.!' 13:38

A. Right before this it says, "Reactive 13:38
glandular cells." It could be very indicative of a 13:38
growth within the bile duct. 13:38

Q. Okay. We know there's a growth within 13:38
the bile duct at this point; right? 13:38

A. Correct. 13:38

Q. We just don't know what it is? 13:38

A. Correct. 13:38

Q. It happens to be -- I didn't highlight 13:38
that. I left it out -- reactive glandular cells. 13:38
You can see that in a nonmalignant growth; correct? 13:38

A. Reactive glandular cells, correct. 13:38
Q. So those do exist in nonmalignant growth? 13:38
A. Right. 13:38
Q. What did you make of the acute and chronic inflammatory cell description? 13:38
A. This is cytology. This is a surface brushing. 13:38
Q. Right. 13:38
A. I don't place much evidence in that. 13:39
Q. All right. So it's just one additional piece of information that you had, and it didn't necessarily change your impression that it was more likely than not that a malignancy existed; right? 13:39
A. Correct. 13:39
Q. Okay. I want to do this nice and sequentially. All right. You've got the CT results, blood results. You know what the ERCP says, and now you know the cytology; right? 13:39
A. Right. 13:39
Q. Okay. At this point, what decision do you make? 13:39
A. Well, we talked it over, Dr. Maxwell and I, and we both agreed that the patient needed exploration. 13:39

Q. Okay. So the record is clear -- you are a very soft-spoken person, but I think -- the court reporter may have gotten it. You referred to Dr. Maxwell? 13:39 13:39 13:39

A. Correct. 13:39

Q. And you were both in agreement based upon what you had seen on exploration of Mrs. Maynard's bile duct. Am I right about that? 13:39 13:39 13:39

A. Correct, correct. Dr. Maxwell says at the bottom of his note here, "Will review films. Will likely need surgery." 13:40 13:40 13:40

Q. Okay. But you were going to be the surgeon and the person to make the decision on what direction to go; right? 13:40 13:40 13:40

A. Correct. 13:40

Q. Okay. Let's go back. We get to do a lot of flipping of papers here. I would like to go back and look at your 2/21/96 office note together; okay? 13:40 13:40 13:40 13:40

A. All right. 13:40

Q. Now, at this point in time, you obviously have all the information, and you are going to meet with the patient and her husband to discuss what it probably means. Is that a fair assessment of where you would have been at on 13:40 13:40 13:40 13:40 13:40

February 21, 1996?
A. According to my note here, I already had met with them.
Q. All right. I'm assuming you had met with them after you had all the test results back.
A. That's correct.
Q. Okay. At that point, you indicate in your note -- and by the way, her daughter was also there; right?
A. I can't remember.
Q. Your note says she was there.
A. Fine, fine.
Q. Okay. Your note says, "We will open the bile duct and excise the tumor"; correct? I'm reading that with no problem?
A. Correct.
Q. "We will send this for frozen section analysis."
A. Correct.
Q. "If it is returned as a cancer, we will proceed with a" -- I can never say the word -- a whipple, but it obviously says the correct name of the procedure. "I've informed them we will take out part of the stomach, pancreas and some of the intestines, et cetera. I've informed them this is

a large operation, dot, dot, dot I've informed them, however, if this is benign, what we will do is just excise the tumor and close the abdomen'; correct? 13:41

A Correct 13:41

Q And obviously your note reflects, "Unfortunately, we will not know this until the time of surgery She understands this and concurs ' 13:41

This is the sum and substance of the explanation you gave to Mr. and Mrs Maynard about what procedure Dorothy would undergo the following day; am I right? 13:41

A This is a summary of a very long meeting we had where we outlined all of this, where I believe I drew them several pictures of things -- 13:41

Q. I think that you did. 13:42

A -- and explained to them exactly what was what and what we were doing 13:42

Q. Okay. Now, in your decision with them, your note makes it clear -- and I think there's some hospital notes. We'll get to that. 13:42

You explained to them one of two things will happen based upon positive or negative pathology That's what I'm going to call it 13:42

Malignant or benign pathology; correct? 13:42

A Correct 13:42

Q And as your memory seems to be pretty 13:42
good -- your lawyer will find that out -- you did 13:42
have a very lengthy conversation with the Maynards 13:42
about it; right? 13:42

A As I recall, I believe i was lengthy, 13:42
right 13:42

Q Okay In your experience as a general 13:42
surgeon, before Dorothy Maynard -- 13:42

A. Uh-huh. 13:42

Q -- had you ever encountered a situation 13:42
where the pathology of a growth in a bile duct was 13:43
equivocal? 13:43

MR KOMINISMER: Objection to the 13:43
form of the question. Go ahead 13:43

THE WITNESS: I wrote a paper on 13:43
this topic, as a matter of fact, on ampullary 13:43
tumors And the sense is that at that time -- and 13:43
I believe I said this in the paper -- that one is 13:43
best to proceed with surgery if the diagnosis is 13:43
base on suspicion, clinical presentation and 13:43
things like that 13:43

Q Okay I don't know that that answered 13:43
my question We're getting close First of all, 13:43

can I assume that this paper that you wrote is included in the publications section of your CV? 13:43

A. I'm sure it will be. 13:43

Q. Can you tell me when you wrote it? 13:43

A. It was in the late '80s. 13:43

Q. Okay. Who were you working under, or were you doing this on your own at the time? 13:44

A. Helmet Schreiber. 13:44

Q. Okay. Why doesn't that surprise me? 13:44

Okay. Did you do -- tell me a little bit about that paper. Did you do a retrospective analysis of cases? Is that what you did? 13:44

A. No. Actually as I'm sitting here recalling this now, we had a patient who had a similar situation but who had congenital problems with the colon who also developed polyps in this area. 13:44

Q. Okay. So it was a paper based upon a case study of one patient? 13:44

A. No. We reviewed many others. 13:44

Q. Okay. I'm just trying to get a flavor for writing it. And can you tell me what the title of the paper is? 13:44

A. I can't recall the exact title. 13:44

Q. That's all right. Who published this 13:44

paper? 13:44

A. I can't recall. I think it was the 13:44

Journal of Surgical Oncology. 13:44

Q. Okay. My initial question -- although 13:45

I'm glad you gave me that answer -- was prior to 13:45

Mrs. Maynard -- 13:45

A. Uh-huh. 13:45

Q. -- undergoing this exploration by 13:45

yourself, had you encountered a situation where the 13:45

pathology as it was -- I'm going to use the phrase 13:45

"read out to you during the time of 13:45

surgery" -- was equivocal? 13:45

A. Usually pathologists can state yes or 13:45

no. So no, I am not -- 13:45

Q. You had not previously encountered 13:45

that? 13:45

A. No. 13:45

Q. Did you, Doctor, discuss with Mr. and 13:45

Mrs. Maynard what you would do in a situation where 13:45

you encountered an equivocal pathology call at the 13:45

time of surgery? 13:45

A. I can't specifically remember that. 13:45

Q. Okay. Well, while we're on the subject 13:45

of equivocal, what, to you, would be an equivocal 13:46

pathology call from a bile duct tumor? 13:46

MR. EDMINISTER: Objection.
THE WITNESS: I guess the pathologist just says I can't tell one way or the other. 13:46
Q. Are you and I discussing the pathology call of defer? I'm trying to -- 13:46
A. They would have to defer to permanent sections. 13:46
Q. Okay. If you had received a pathology reading during this particular surgery from frozen section that indicated from the pathologist that the pathologist would need to defer because it was not clear evidence of malignancy, what would you have done? 13:46
A. I would have done the same thing after discussing it with the Maynards. 13:47
Q. Now, you added "after discussing it with the Maynards." 13:47
A. Right. 13:47
Q. Let's talk about that for a second. First, I need to ask you why you would have gone ahead and done the surgery if you would have received an interoperative pathology read of defer. 13:47
A. Well, because of the age of the

patient, because of the location of the polyp, because of its appearance on the ERCP, all of these make a very strong indication this is a malignant tumor and not a benign tumor. And had we found what we found with a dilated bile duct, I would have to call this a malignancy or there was a malignancy lurking in the general region of that area. We hadn't biopsied, and it would have been picked up, then, on the permanent sections. 13:47 13:47 13:47 13:47 13:47 13:47 13:47 13:48

Q. Given that you've published at least one article as you're relating -- you think it's in the Journal of Surgical Oncology -- are you familiar with the statistical percentages in terms of increasing a person's life expectancy by doing a whipple when they actually have a pancreatic cancer? 13:48 13:48 13:48 13:48 13:48 13:48 13:48

A. Pancreatic cancer is different than bile duct. 13:48 13:48

Q. I agree with you. Let me first ask for pancreatic cancer. Are you aware of whether or not a whipple actually statistically improves the chance of survival? 13:48 13:48 13:48 13:48

A. Yes. 13:48

MR. EDMINISTER: Objection. 13:48

Q. Okay. What do you believe the 13:48

statistics are? 13:48

MR. EDMINISTER: Objection. 13:48

MS. KOLIS: He says that he's aware of them. 13:48

MR. EDMINISTER: Correct. 13:48

THE WITNESS: In pancreatic cancers that can be resected without lymphatic spread that are confined to the pancreas that are under two centimeters in size, as many as 40 percent of those patients can live five years. 13:48 13:49 13:49 13:49 13:49

Q. What about a bile duct cancer? 13:49

A. Even higher percent. 13:49

Q. Okay. Can you tell me what studies or literature you rely upon in making that assertion? 13:49 13:49

A. Any number of standard textbooks. 13:49

Q. Can you tell me which textbooks you relied on for those statistics? 13:49 13:49

A. Schwartz Principles of Surgery, Sabiston Biological Basis of Modern Surgical Practice, Cameron's Current Surgical Therapy. 13:43 13:49 13:49

Q. Okay. If you are uncertain if there is a malignancy, do you believe that you have an obligation to advise the patient that there is uncertainty as to whether or not there's a malignancy? 13:50 13:50 13:50 13:50

A. Well, the patient will be asleep at this time. 13:50

Q. Right. 13:50

A. So what I would do is speak to the patient's family and explain the situation. 13:50

Q. Okay. Under that circumstance, if you hadn't explained to a person prior to going under anesthesia that there is a third potential category of pathology readings that could occur -- not just positive and negative but equivocal -- from whom would you obtain the consent to then complete the operation? 13:50

A. Well, first of all, the equivocal reading in one of these must be very, very low. But in that situation, what I would do is speak to the patient's husband or wife. 13:50

Q. Okay. In this case -- just so we clear things up and you don't think I'm looking at issues I'm not looking at -- you didn't have the opportunity to discuss an equivocal reading with Mr. Maynard because you weren't given an equivocal reading; correct? 13:51

A. That's correct.

Q. All right. If there's an equivocal reading and a patient and/or her family at that 13:51

point in time does not wish for you to proceed with a whipple for whatever reason, at that moment if they chose not to proceed with the surgery, theoretically -- or not even theoretically -- realistically could you not close the patient, wait for the final section read and then if it was confirmed to be a malignancy, go back in and do the whipple? 13:51

A. Well, from an oncologic point of view, you would be worried about contamination of the operative field with potential tumor cells. I would be personally worried about leaving a residual tumor behind in that situation. 13:51

Q. Doctor, how long does it take to get to frozen section from final read on pathology, generally speaking? 13:52

MR. EDMINISTER: If you know. 13:52

THE WITNESS: Well, I think this case took four or five days. 13:52

Q. We are talking about four or five days of delay; correct? 13:52

A. Four or five days of delay, right. 13:52

Q. So understanding and accepting that at least at Akron General, you're able to get a final read in four to five days, my first simple question 13:52

was, you could close and wait for a final section 13:52
reading and then go back in and do this procedure 13:52
if there was found to be a true malignancy in the 13:52
final reading; correct? 13:52
A You could I would not advocate that. 13:52
But -- 13:52
Q Okay Let s go through this We might 13:52
as well get everything out on the table Why 13:52
wouldn't you advocate that if a family did not want 13:52
a person to undergo a surgery such as this and 13:52
wanted to wait for the final read? 13:52
A Well, first of all, I would never go 13:52
against a family's wishes -- 13:53
Q. I understand that. 13:53
A -- number one Number two, I would try 13:53
my best to educate the family as to the 13:53
probabilities of a malignancy versus a benign 13:53
tumor. 13:53
Q. Right. 13:53
A. And I would stress to them sometimes we 13:53
just don't know and you have to go ahead and do a 13:53
resection even though on final report it may be 13:53
benign. 13:53
Q. Okay What I'm asking is this. I'm 13:53
just trying to listen and write, and that's always 13:53

hard.

There is no medical standard or no medical issue that would prevent you from closing and then doing a whipple five to six days later if the final came out that it was actually a malignancy? 13:53 13:53 13:53 13:53 13:53

MR. EDMINISTER: Objection. 13:53

THE WITNESS: No, there is, because you may not have done a proper biopsy of the lesion. You may have missed the lesion, and the lesion can be hidden in these tissues. This was a very tiny lesion we were after, but big enough -- and she was very, very fortunate that this caused obstructive jaundice because that's what led to this whole thing. 13:53 13:53 13:53 13:53 13:54 13:54 13:54 13:54

Q. Doctor, excuse me. Let's talk about the size of this since we're on this issue. This particular lesion was five milliliters; am I right? You can look. 13:54 13:54 13:54 13:54

A. I don't know the exact size. 13:54

Q. Don't ever trust my -- 13:54

A. It was fairly small. 13:54

Q. Well, your office note of 2/21 says five to six. I've seen it reported as four to five. So I just rounded it and said that it's 13:54 13:54 13:54

five. Does that seem accurate? 13:54

A. My note says it measures about five to six millimeters in size and was obstructing the common bile duct. 13:54

Q. Okay. Five to six milliliters is -- here. I'm going to give you a piece of paper. Don't worry. We're not going to bring out a ruler later and say you don't know what five to six milliliters is. 13:54

Draw a line approximately five to six millimeters. 13:55

A. (Complying.) Somewhere between here and here. (Indicating.) 13:55

Q. Okay. That is a relatively small polypoid lesion, isn't it? 13:55

A. That's correct. 13:55

Q. Given that it's a small lesion, if you took the entire lesion out and had the pathology done on it, do you think it's a high likelihood if it was truly cancerous you would have received a benign -- 13:55

A. A small lesion like that -- I was worried we had missed the lesion, or there was an additional tumor around that area. 13:55

Q. At what point were you worried you had 13:55

missed the lesion? 13:55

A. What point was I worried in this case? 13:55
When our initial biopsies came back as benign 13:55
tissue. 13:55

Q. When they came back as benign tissue, 13:55
were you inclined to disbelieve those other areas 13:55
were benign? I'm paraphrasing what I thought I 13:55
heard you say. 13:55

A. I was very concerned -- because a 13:55
biopsy is a superficial sampling -- that there was 13:56
a tumor deeper to our biopsies. 13:56

Q. If you had that concern that there was 13:56
a tumor, as you're phrasing it, "deeper to your 13:56
biopsies" -- I think I know what you mean -- what 13:56
additional areas could you excise to have sent for 13:56
pathology if you were concerned about that? 13:56

A. Well, you try to biopsy around as much 13:56
as you can in other areas. 13:56

Q. And you did, in fact, do some 13:56
additional biopsying, didn't you, at the time of 13:56
the surgery? 13:56

A. Well, I think we were very persistent 13:56
in attempting to delineate exactly what the problem 13:56
was here. 13:56

Q. Right. 13:56

A. And we sent out one, two, three, four, five different samples for frozen section. 13:56 13:56

Q. Okay. Do you have a recollection -- and I'm just asking what you recall. I assume you have not reviewed the pathology slides; is that right? 13:56 13:56

A. No, I have not. 13:56

Q. I have them today. I gave them to Michael because I've had them for a while. And if you needed to look at them, that would be acceptable, of course. 13:57 13:57 13:57

Do you have a recollection that specimen C, which was sent, was a very small sample? 13:57 13:57

A. I can't recall the size of the frozen sections. 13:57 13:57

Q. Okay. If you had received a readback from the pathologist that indicated defer on two basis -- one, there wasn't clear evidence of malignancies, and B, that the sample size was inadequate -- could you have rebiopsied in that approximate same area to obtain additional tissue? 13:57 13:57 13:57 13:57

A. Yes. 13:57

Q. Okay. But that didn't happen in this case either? You didn't get that phone call from 13:57

the pathologist; right? 13:57

A. That's correct. 13:57

Q. Okay. Fair enough. Let me ask you this hypothetically, since, I guess, it's important to know it now. Based upon what I hear you saying, if all of these biopsies that were done had come back -- is it okay if I say negative instead of nonmalignant? Whatever you're comfortable with. We'll call them negative -- would you have proceeded to do a whipple at that point? 13:57 13:57 13:57 13:58 13:58 13:58 13:58 13:58

A. I said in my office notes we would biopsy, and if it was benign, we would simply excise the tumor. 13:58 13:58

Q. Right. 13:58

A. A lot of this depends on where the tumor was located, which we could not determine from the ERCP. If the tumor -- let me refer to the report here. 13:58 13:58 13:58

Q. That would be fine. 13:58

A. Do we have it? 13:58

Q. Sure. There's an op report. But I have one highlighted, if you want it. I know there's one in your chart because I got one when you answered my subpoena. 13:58 13:58 13:58 13:58

A. Here we are. 13:59

Q. 00051 or so. 13:59

A. Okay. Here we are. The first thing we did was to -- let me just read this right here. 13:59

Q. Doctor, we've got plenty of time. You can read whatever you want. 13:59

A. The first thing we did was open the duodenum to visualize the ampulla. In my mind, the benign tumors are not in the bile duct for the most part but in the ampulla region in the bile duct. This is the part within the duodenum. So we didn't know from the ERCP where this tumor was. 13:59

Q. Let me stop you right now. Now, you normally don't do ERCPs; right? 13:59

A. Right. 13:59

Q. What information does an ERCP give you about the location of the mass? 13:59

A. Well, it can tell you if it's high within the bile duct or low within the bile duct. 13:59

Q. Okay. 13:59

A. So this says distal common bile duct. 14:00

Q. So you assumed that it was where? 14:00

A. Low in the bile duct, but I did not know exactly where this was until the time of surgery when I could visualize this area. 14:00

Q. Okay. 14:00

A. We visualized this area, and the ampulla appeared normal. So, therefore, in that situation, this tumor was up in the distal portion of the bile duct in an area that has a very high probability of it being a malignancy. 14:00 14:00 14:00 14:00 14:00

So to answer your question, if everything had come back negative, what I would have done was to walk over to the telephone, call Mr. Maynard and say here is the situation. My recommendation is that we proceed with surgery because we simply cannot 100 percent tell you that this is not a cancer. 14:00 14:00 14:00 14:00 14:00

Q. You didn't tell Mr. and Mrs. Maynard that before the surgery, did you? 14:01 14:01

A. I did not know where in the bile duct this was. 14:01 14:01

Q. I understand. 14:01

A. This could be in the ampulla or the distal bile duct. And what I told them, I believe, is pretty well recorded in my notes; that if it was benign -- I was trying to be very hopeful here this was a benign bile duct tumor. "We will excise the tumor and close the duodenum." 14:01 14:01 14:01 14:01 14:01

Q. Let's say two things today, in fact, we know. It was a benign tumor? 14:01 14:01

A. We know there was no cancer. 14:01

Q. Okay. Doctor, is it clear to you as you sit here and talk to me today that you never discussed with the Maynards the possibility that if all of the pathology was benign, that based on location, you would still go ahead and do this surgery? 14:01

A. Well, as I said, I would discuss it with him at the time of operation. 14:01

Q. Okay. But you didn't -- I'm just clarifying. You didn't discuss that particular suspicion that the ERCP had not defined clearly enough for you -- 14:01

A. Right. 14:02

Q. -- where it was? And maybe even based on that, even if it was benign, you were going to do it anyway? 14:02

A. I didn't have my mind made up. I didn't know what we would do. They were very, very anxious about this. I gave them a straightforward analysis about what we would do in a straightforward fashion. 14:02

Q. Prior to going in for this surgery, did you explain to Mrs. Maynard the morbidity that follows a whipple procedure? 14:02

A. I'm certain I did. 14:02
Q. Okay. You've reviewed the Cleveland 14:02
Clinic records; correct? 14:02
A. Yes. 14:02
Q. And this is not a very lawyerly 14:02
question, but you were not surprised that she has 14:02
had to undergo the surgery that she did with 14:02
Dr. Ponski? 14:02
A. I've not seen Mrs. Maynard since we had 14:02
that conference, and at that time -- according to 14:03
Dr. Rehmus who was following her -- she seemed to 14:03
be doing quite well. 14:03
Q. That wasn't the question I asked. In 14:03
terms of your knowledge, the subsequent morbidity 14:03
that follows logically from doing this rather large 14:03
operation, you're not surprised that she has 14:03
developed a problem which required yet another 14:03
corrective surgery? 14:03
A. To the contrary, I'm very surprised. 14:03
MR. EDMINISTER: Objection. 14:03
Q. You're surprised because you think 14:03
that's uncommon following a whipple? 14:03
A. It is uncommon. 14:03
Q. Do you know why she had to have the 14:03
surgery with Dr. Ponski? 14:03

A. According to his note, she had gastroparesis. 14:03

Q. Do you know what the cause of that gastroparesis was? 14:03

A. I'm not sure anyone knows what the cause was. 14:03

Q. Recently I provided to your counsel the final discharge summaries from the Cleveland Clinic. Have you seen those? Maybe Mike hasn't even seen them. He gets a lot of mail. 14:03

MR. EDMINISTER: I think what you're referring to has just arrived within days. 14:04

MS. KOLIS: It did. That's why I'm asking if he got to see it. 14:04

MR. EDMINISTER: So I think he only had an opportunity to briefly review those, and I think what you're reviewing is the discharge dates of 2/14/97 and 3/10/97. 14:04

MS. KOLIS: Right. It's the 3/10/97 following -- he doesn't have to read it. I was just asking if he had an opportunity to see it as of yet. 14:04

Q. When did you receive the final section reads on this surgery? Final section is not the right phrase for it, but -- 14:04

A. I don't know when I received it. It was -- according to the note, it was completed on 2/27/96. 14:04 14:04 14:05

Q. Okay. Did you see the actual printed copy of the pathologist's analysis at that time? 14:05 14:05

MR. EDMINISTER: You mean as opposed to on the computer? 14:05 14:05

Q. As opposed to being told what the final was. Did they actually forward you a copy of the pathology? 14:05 14:05 14:05

A. It's right here, surgical pathology report. 14:05 14:05

Q. Fine. Was there anything in the description by Dr. Mucitelli -- I can never pronounce her name -- that caused you concern that, in fact, this was not really a cancer? 14:05 14:05 14:05 14:05

A. No. 14:05

Q. All right. When did you learn that there was a possibility that there had been a misread surgically? 14:05 14:05 14:05

A. Let me see if I dictated it. 14:05

Q. That's fine. 14:05

A. In my note of 8/17/96, I say I was informed last week. 14:06 14:06

Q. Okay. Do you recall how you were 14:06

informed? It says by Scott Shorten. 14:06
A. Right. 14:06
Q. Dr. Shorten is whom? 14:06
A. He's a pathologist. 14:06
Q. And do you know if he -- well, you might not know, but is he -- does he work for Akron Pathology? 14:06
A. I don't know who he works for. 14:06
Q. He's in an office at the hospital? 14:06
A. He works there. 14:06
Q. Okay. How did he let you know what happened? 14:06
A. I think he called me, as I remember. 14:06
Q. All right. And at that point in time, he told you that he had discovered a misdiagnosis in the case of Dorothy Maynard? 14:06
A. That's what I see here. 14:06
Q. Okay. At that time, he let you know there was an internal review as well as one external review at the Cleveland Clinic suggesting that is what it says. Your note says, "Both their own internal review as well as the outside review at the Cleveland Clinic suggests strongly there was no evidence of cancer in the resected head." Is that what you meant to say? 14:06 14:07 14:07

A. Well, in the bile duct, within the head of the pancreas, so -- 14:07

Q. Okay. I just wanted to make sure we were -- that this information meant what I thought it meant. That wasn't just a different way of stating it; right? 14:07

A. (No response.)

Q. All right. You then discuss this with Dr. Rehmus; correct? 14:07

A. I did. 14:07

Q. And the two of you -- at least your note indicates -- decided to have a meeting with Mr. and Mrs. Maynard; right? 14:07

A. Correct. 14:07

Q. Okay. And, in fact -- now, this note is dictated 8/27/96, and it says, "There's a third outside opinion being sought." Am I right that that's what it says? 14:07

A. Yes. 14:07

Q. Okay. Did you know that that was already out for review at the Mayo Clinic? 14:08

A. I believe I asked Dr. Shorten to send it out to the Mayo Clinic. 14:08

Q. You think you suggested that? 14:08

A. I'm fairly certain I did. 14:08

Q. Do you know pathologists at the Mayo Clinic? 14:08

A. No, I didn't, but I wanted experienced -- 14:08

Q. You wanted a good facility that you would feel confident about the read? 14:08

A. I wanted to be certain this is what this was. 14:08

Q. Okay. To make it clear to you that Dorothy Maynard never needed chemotherapy or radiation treatment? 14:08

MR. EDMINISTER: Objection. 14:08

THE WITNESS: On the basis of the final pathology from the operation -- 14:08

Q. Right. 14:08

A. -- we were dealing with an invasive bile duct tumor. I'm not an expert in chemotherapy or radiation. 14:08

Q. All right. Well, let me ask this. At the time that you dictated this note back in August of 1996, basically what you say is as follows. And I want to talk to you about what you contemporaneously wrote with your discovery at the situation. 14:09

"I'm extremely upset with this. 14:09

Review of everything shows that indeed the surgical indications were clearly there, i.e., the intraluminal obstruction of the bile duct, frozen section, report positive for adenocarcinoma." I'm reading what you put in your chart; correct? 14:09

A. Right. 14:09

Q. And that tells me you believe that the surgical indications were the obstruction and the report being positive; right? 14:09

A. Well, the indications for the operation were the laboratory tests, the ERCP, the CAT scan. The whole picture pointed to a tumor, not just what I said here. 14:09

Q. Then you went on to write, "However, the upsetting factor here is that this patient suffered a great deal due to her chemotherapy and radiation." 14:10

A. Correct. 14:10

Q. All right. Did Dr. Rehmus tell you she was upset because if she had known the correct pathology, she would not have had the patient undergo chemo and radiation? 14:10

A. I can't remember most certainly what Dr. Rehmus' comments were. 14:10

Q. To be fair for the record, are you 14:10

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

after --

MR. EDMINISTER: What kind of meeting? 14:11

MS. KOLIS: with Mrs. Maynard. 14:11

MR. EDMINISTER: Between Dr. Guyton and Mrs. Maynard? 14:11

Q. You were in attendance at a meeting with Mrs. Maynard; correct? 14:11

A. At Akron General Hospital with Dr. Rehmus and Dr. Fromm from radiation and, I believe, Dr. Button. 14:11

Q. Who is he? 14:12

A. The chief of pathology. 14:12

Q. So the chief came, not Dr. Shorten? 14:12

A. That's correct. 14:12

Q. Okay. Because there's another note we can refer to that Dr. Rehmus wrote. That's how I knew who was there. You didn't dictate a note about the meeting; right? 14:12

A. (Witness shakes head from side to side.) 14:12

Q. Dorothy was there without her husband, wasn't she? 14:12

A. Yes. 14:12

Q. You were surprised by that? 14:12

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

Dr. Rehmus' suggestion. We set this up to get all of her doctors involved and explain to her what had happened. 14:13

Q. Okay. I agree that that's what the notes reflect, of course. But, I guess, what my question was, do you remember if -- because there's nothing in your chart that a meeting was set up. 14:13

I'm asking if you remember happening to get called to a meeting saying, gee, Mrs. Maynard is here. Let's meet with her. 14:13

A. No. I'm sure it would have been scheduled. 14:13

Q. What if I told you it wasn't scheduled? 14:14

MR. EDMINISTER: Objection. 14:14

MS. KOLIS: I'll withdraw that. 14:14

Q. Do you recall what you told Mrs. Maynard at this meeting, if anything? 14:14

A. As I remember the meeting, I didn't say much. The others did most of the talking. 14:14

Q. Well, did Mrs. Maynard ask you any questions that you can recall today at that meeting? 14:14

A. No. I can't recall that she said a word. She was very shocked and surprised. 14:14

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

right? 14:14

A. Right. 14:14

Q Do you recall Mr. Maynard asking you if she could have avoided the surgery? 14:14

A No I don't think she did 14:14

Q Have you seen Easter Rehaus chart? 14:14

A No 14:14

MS KOLIS: Okay I will be deposing Esther Rehaus in the not too distant future, so I'm going to ask you to assume this is what she has written. In fact, it is what I have in writing Mike may request it 14:14 14:15 14:15 14:15

MR EDMINISTER: What are you referring to? 14:15 14:15

MS KOLIS: It's date stamp 00028 14:15 14:15

MR EDMINISTER: I don't have the dates stamp That doesn't help me 14:15 14:15

MS. KOLIS: I sent you guys all these records that's why I -- 14:15 14:15

MR EDMINISTER: Oh, you did. 14:15

MS BARKER: It's a document dated -- 14:15 14:15

MR EDMINISTER: With date stamps on it? 14:15 14:15

MS. KOLIS: Yes. I got everything from records depositions and copied it in that order and gave it to everyone. 14:15

MR. EDMINISTER: What are you looking at? 14:15

MS. KOLIS: It is in Dr. Rehmus' dictated notes dated 8/30/96; okay? It's close to the bottom of the page, the impression. 14:15

Q. We'll start close to the bottom one-third where it says "Impression. No evidence of cancer. I discussed this with her at length and again in the presence of Dr. Guyton, Fromm and Button. We all assured her that her surgery would have been the same whether or not the frozen section would have been read as equivocal for cancer." 14:16

Does that refresh your memory of what was told to her at that meeting? 14:16

A. I'm sorry. I wasn't looking at that. 14:16

Q. I'm sorry. It's approximately at the bottom one-third of the page. 14:16

A. And what did you read here? I did read this second paragraph from the bottom here. 14:16

Q. Yeah. The indication from Dr. Rehmus in her note is that, "We all assured her that her 14:16

surgery would have been the same whether or not the frozen section would have been read as equivocal for cancer." 14:17 14:17 14:17

Does that refresh your memory as to whether you discussed this issue with her at that meeting? 14:17 14:17 14:17

A. I did not say a lot at that meeting, as I remember, and she did not ask me many questions. But equivocal here should be replaced by positive for cancer because that's what the frozen section was. 14:17 14:17 14:17 14:17 14:17

Q. All right. Yeah, I don't want to dispute what she wrote. I'm asking if that at all helped refresh your memory that you made some representations to Mrs. Maynard at that meeting or not. 14:17 14:17 14:17 14:17 14:17

A. I might have explained to her, Mrs. Maynard, given everything here, we would have done the same operation, but I can't recall that specifically. 14:17 14:17 14:17 14:17

Q. Okay. Had you seen the corrected pathology readings as well as the outside evaluations prior to that meeting? 14:18 14:18 14:18

A. Let's see. That meeting was 8/30? 14:18

Q. Yeah. I can assure you it was August 14:18

30.

A. I'm sorry. August 28 is when the report came back from Mayo Clinic.

Q. I'm asking you if you know if you saw their pathology and interpretations prior to that meeting?

A. I can't remember.

Q. You don't know?

A. I can't remember.

Q. If Dr. Rehmus testifies that had she had the correct final reading, Mrs. Maynard would not have had to have undergone chemotherapy and radiation, will you personally be disputing that at trial?

MR. EDMINISTER: Objection. He's told you he's not an expert in that field. He has no opinion.

Q. I just thought I would ask. Let's talk a little bit more about the actual operation that you did on Dorothy. Why did you do a vagotomy?

A. So that there's no ulceration that forms between the stomach and the intestine.

Q. Okay. Let's talk about that. Under whose training did you learn you should do a vagotomy as part of a whipple?

A. Well, Dr. S. Arthur Localio was the professor of surgery. 14:19

Q. Was that at NYU? 14:19

A. That's correct. 14:19

Q. Okay. Have you read literature subsequent to graduation from NYU's program that indicates that a vagotomy is not a good idea? 14:19

A. There have been papers published that raise the issue of vagotomy. However, in this particular case, we were dealing with a bile duct cancer which has a much longer survival than the more common pancreatic cancer. 14:19 14:20

The reason there's an issue with the vagotomy and hepatic cancer is most people don't live that long. Bile duct cancer, on the other hand, the longevity is much greater. 14:20

Q. Okay. Once again, the reason you did the vagotomy was to -- I don't like to use the phrase "head off at the pass," but to avoid the potential complication of ulcerations; is that right? 14:20

A. That's correct. 14:20

Q. Okay. Do all people who have a whipple without a vagotomy get ulcers? 14:20

A. I'm certain there are a number that 14:20

don't.
Q. When was the last time you reviewed the literature as to what that incidence of complication really is?
A. I can't give you an incidence.
Q. Okay. Let me just look through a couple of note cards I have. Do you have any recollection from your own office notes or your own memory of Mrs. Maynard's general state of health at the time you examined her other than the problem with the obstructive jaundice?
A. You mean when I initially saw her?
Q. Yes.
A. She had some weight loss, but other than that, it seemed to be --
Q. It seemed to be a person in relatively good health?
A. Pretty good health.
Q. Do you happen to know -- of course, preoperatively -- that there was an anesthesia assessment done for your patient; right?
A. Well, I have not seen one, but --
Q. Okay. It's been a while. As we sit here today, you don't know her ASA, how they --
A. No, I don't.

Q. Okay. Did you discuss this case with Dr. Mucitelli after you found out the pathology readings were wrong? 14:22

MR. EDMINISTER: Who? 14:22

MS. KOLIS: Diane Mucitelli. I can never pronounce her name. 14:22

THE WITNESS: No, I did not. 14:22

Q. Okay. Had you worked with her as a pathologist before in your surgery cases? 14:22

A. Yes, I have. 14:23

Q. Are you still working with her? 14:23

A. No, I'm not. 14:23

Q. She's no longer at Akron General or at least temporarily perhaps; is that right? 14:23

MR. EDMINISTER: Objection. I'm not sure he knows what Dr. Mucitelli's status is. 14:23

Q. I was just curious if you did know. 14:23

A. I no longer work with her. 14:23

Q. And why is that? 14:23

A. I haven't seen her. 14:23

Q. Okay. It isn't that you requested not to work with her? 14:23

A. No. 14:23

Q. Okay. Are any of the opinions which you are rendering today regarding what you would 14:23

have done had you had the correct readings on the basis of or in an effort to assist a colleague? Do you know what I'm asking you? 14:23

A. No. 14:23

Q. I don't usually ask rude questions, but sometimes I feel like I have to. I'm asking you if any of the opinions that you are rendering today about what you would have done had you known the correct reading, are any of those opinions based on a desire on your part to help the pathologist who misread the pathology in this case? 14:23 14:24 14:24

A. No. 14:24

MS. KOLIS: Okay. Doctor, I don't have any further questions for you, and I appreciate the time that you gave me today. 14:24 14:24 14:24

THE WITNESS: Okay. 14:24

MS. BARKER: No questions. Thank you, Doctor. 14:24 14:24

MR. EDMINISTER: He'll read and sign. Thanks. 14:24 14:24

MS. KOLIS: That's fine. 14:24

(Thereupon, deposition concluded at 2:24 p.m.)

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CERTIFICATE

STATE OF OHIO)
)
COUNTY OF SUMMIT)

I, Amie R. First, Registered Professional Reporter and Notary Public in and for the County of Summit and State of Ohio, do hereby certify that DANIEL P. GUYTON, M.D. was by me first duly sworn to testify the truth, the whole truth, and nothing but the truth, and that the above deposition, was recorded stenographically by me and reduced to typewriting by me.

I FURTHER CERTIFY that the foregoing transcript of the said deposition is a true and correct transcript of the testimony given by said witness at the time and place specified hereinbefore.

I FURTHER CERTIFY that I am not a relative or employee or attorney or counsel of any of the parties, nor a relative or employee of such attorney or counsel, financially interested directly or indirectly in this action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office at Akron, Ohio, this 22nd day of July, 1997.

Amie R. First

Amie R. First,
Registered Professional Reporter
and Notary Public in and for the
State of Ohio.

My notary commission expires August 21, 1997.

CROSS EXAMINATION OF DANIEL P. GUYTON, M.D.

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-E-

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-G-

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