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IN THE COURT OF COMMON PLEAS

OF SUMMIT COUNTY, OHIO

DOROTHY S. MAYNARD, et al.,

Plaintiffs,

vs.

AKRON GENERAL MEDICAL

Case No.

CENTER, et al.,

CV 97 01 0228

Defendants.

Judge Whitmore

- - - - -

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.

- - - - -

Computer-aided Transcription and
Litigation Support Services by:
KALAPODIS REPORTING SERVICES, INC.

926 First National Tower

Akron, Ohio 44308

ORIGINAL

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25 - - - -

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

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

7 BY MS. KOLIS:

13:10

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

13:10

13:10

13:10

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

13:10

13:10

13:10

13:10

15 If at any point I ask a question that
16 doesn't seemingly make any good common sense to
17 you, you'll let me know if you don't understand my
18 question?

13:10

13:10

13:10

13:10

19 A. I will.

13:10

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

13:10

13:10

13:10

13:10

13:10

25 If at any time you want to take a break

13:11

1 -- perhaps you have a surgical page -- that's 13:11
2 acceptable. If at any time you want to confer with 13:11
3 Michael, unlike some lawyers, I don't object to
4 that. You need to indicate that for the record. 13:11

5 with that in mind, also, you have to 13:11
6 answer all questions verbally. We try not to put 13:11
7 the court reporter in the duty of interpreting 13:11
8 anyone's body language. Do you understand? 13:11

9 A. Yes, I do. 13:11

10 Q. Starting with an easy issue, can you 13:11
11 tell me briefly about the education which led you 13:11
12 to your current profession? 13:11

13 A. Well, I went to college and medical 13:11
14 school at Case Western Reserve and then completed a 13:11
15 surgical residency at New York University Medical 13:11
16 Center in Manhattan. 13:11

17 Q. Okay. When did you graduate from Case? 13:11

18 A. 1975. 13:11

19 Q. At a time other than today, if you 13:11
20 would, provide a copy of your CV to your counsel. 13:11
21 He'll forward it to me. 13:11

22 A. I will. 13:11

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? 13:12

1 A. Correct. 13:12

2 Q. Okay. What kind of surgical residency 13:12
3 program was it? Number of years and specialty, I 13:12
4 guess is what I'm asking. 13:12

5 A. Well, it was five years, and it was a 13:12
6 specialty in surgery. 13:12

7 Q. Okay. Just general surgery? 13:12

8 A. Right. 13:12

9 Q. All right. During your last year, were 13:12
10 you the chief resident? 13:12

11 A. Yes, I was. 13:12

12 Q. Okay. Did you publish any articles or 13:12
13 have any area of interest during that five-year 13:12
14 residency program? 13:12

15 A. During that five-year residency, I did 13:12
16 not publish any articles. 13:12

17 Q. Okay. When you finished that program, 13:12
18 did you undertake another surgical residency at 13:12
19 another hospital? 13:12

20 A. No, I did not. 13:12

21 Q. Okay. Following that, what did you 13:12
22 then do? 13:12

23 A. I entered private practice. 13:12

24 Q. Okay. Where did you enter private 13:12
25 practice? 13:12

1	A. Akron, Ohio.	13 : 12
---	-----------------	---------

2	0. Okay. What year would that have been?	13:12
---	--	-------

3	A. 1980.	13 : 12
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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
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21	Q. Solo practice. How long were <i>you</i> 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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1 never met you before, and I don't have your CV, so 13:13
2 I have to ask these kinds of questions. 13:13

3 From 1980 to the present, which is 13:13
4 1997, you've maintained a surgical practice on your 13:13
5 own. You have no partners; correct? 13:13

6 A. Correct. 13:13

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

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

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

19 A. Correct. 13:14

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

22 A. What four-year period? 13:14

23 Q. '83 to '87. 13:14

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

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

1 practice?

2 A. Yes, I did. 13:14

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

6 A. Dr. Helmet Schreiber. 13:15

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

9 A. Yes, he was. 13:15

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

12 A. That's correct. 13:15

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

15 A. I believe it was 1991. 13:15

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

18 A. Correct. 13:15

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

22 A. Yes, I am. 13:15

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

1 surgeries do you regularly perform? 13:15

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

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

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

16 A. Correct. 13:16

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

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

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

25 A. That's fine. 13:15

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

5 A. 1975, probably. 13:17

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

8 A. That's correct. 13:17

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

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

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

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

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

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

23 Q. Okay. At Akron General, as part of the 13:17
24 doctors who have privileges in general surgery, is 13:17
25 there anyone who you would consider to be a 13:18

1 specialist in hepatic biliary surgery? 13:18
 2 A No 13:18
 3 Q Okay Is preparation for today's 13:18
 4 deposition, can you tell me what medical documents 13:18
 5 you've reviewed? 13:18
 6 A Well, I've reviewed my office notes 13:18
 7 Q Okay 13:18
 8 A The X-ray reports 13:18
 9 Q Oh, X-ray reports Okay 13:18
 10 A The pathology reports, and that's it 13:18
 11 Q Have you had an occasion since I filed 13:18
 12 this lawsuit to re-review the hospital chart 13:18
 13 itself? 13:18
 14 A No. I did not look at the hospital 13:18
 15 chart 13:18
 16 Q Okay Well, I have some pages paper 13:18
 17 clipped. We'll probably look at them. But I was 13:18
 18 just curious if you had looked at it 13:18
 19 Have you been provided with 13:18
 20 Mrs Maynard's subsequent care records from the 13:19
 21 Cleveland Clinic? 13:19
 22 A. Regarding? 13:19
 23 Q Any care and treatment that she 13:19
 24 received from the department of gastroenterology 13:19
 25 and the department of surgery after she was told 13:19

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

3 A. Most recently, yes. 13:19

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

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

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

15 A. The reason Mrs. Maynard had her 13:19
16 procedure was because she presented with signs of 13:19
17 obstructive jaundice as well as radiographic 13:20
18 evidence of a lesion in the distal common bile 13:20
19 duct. 13:20

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

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

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

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

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

5 A. Maseelall. 13:21

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

8 A. On rare occasions, yes. 13:21

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

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

11 Q. Okay. It's my understanding that he 13:21
12 examined her on that date and sent her directly 13:21

13 across the street to see you. Do you know if 13:21
14 that's accurate or not? 13:21

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

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

19 A. I see here, "The patient states that 13:22
20 since August she has had the following 13:22
21 constellation of symptoms. Whenever she eats, she 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
25 other doctor to send Mrs. Maynard to you? I'm not 13:22

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

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

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

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

13 A. I believed I could. 13:23

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

15 A. Right. 13:23

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

20 A. That's correct. 13:23

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

23 A. Correct. 13:24

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

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

1 A. Sure. 13:25

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

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

7 (Discussion had off the record.)

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

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

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

15 A. Yes. 13:25

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

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

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

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

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

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

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

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

6 A. Yes. 13:26

7 Q. Okay. I probably have labs in a 13:26

8 section marked labs, I would guess. What kind of 13:26

9 blood work were you going to do for Mrs. Maynard? 13:26

10 A. Well, we were going to get a liver 13:26

11 profile which would tell us indeed the degree of 13:26

12 the obstructive jaundice. 13:26

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

14 blood studies? 13:26

15 MR. EDMINISTER: Which ones? 13:26

16 MS. KOLIS: The ones that he's 13:27

17 indicating he initially ordered to do the liver 13:27

18 profile to see how much obstruction there was, I 13:27

19 suppose, if I'm paraphrasing. 13:27

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

22 Q. You don't see them in here. All 13:27

23 right. Well, let me just represent to you that -- 13:27

24 maybe we should have counsel for Akron General get 13:27

25 her records. What's in that notebook is everything 13:27

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

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

6 MR. EDMINISTER: Donna -- 13:28

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

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

11 MS. KOLIS: Right. 13:28

12 MR. EDMINISTER: But in the 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. 13:28

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

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

20 THE WITNESS: No. 13:29

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

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

1 you to keep a copy in your office chart? 13:29

2 A. Not as an inpatient. 13:29

3 Q. Not as an inpatient. Okay. Because I 13:29

4 didn't see any labs. Do you have any way of 13:29

5 telling from looking at the chart what the result 13:29

6 of that blood work was? 13:29

7 A. Well, it's not readily available. 13:30

8 Q. Okay. For the moment, I think we're 13:30

9 going to let that go. 13:30

10 A. I would say they were consistent with 13:30

11 obstructive jaundice. 13:30

12 Q. Okay. And I suspect that would be true 13:30

13 since she had a polypoid lesion, correct, in the 13:30

14 bile duct; is that right? 13:30

15 A. We did not know that at the time. 13:30

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

18 what you told me? 13:30

19 A. Yes, that's correct. 13:30

20 Q. You and I cannot locate those results; 13:30

21 right? 13:30

22 A. (Witness nods head up and down.) 13:30

23 MR. EDMINISTER: At present. 13:30

24 Q. At present. That doesn't mean they 13:30

25 don't exist. It just means we don't have them. 13:30

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

6 MR. EDMINISTER: Off the record. 13:30

7 (Discussion had off the record.)

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

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

12 A. 000460. 13:31

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

15 A. Yes, I have. 13:32

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

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

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

23 A. Correct. 13:32

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

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

13 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

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

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

6 Q. Okay. Now, at that point, based upon 13:33
7 this examination, are you aware that there is a 13:33
8 polypoid mass? 13:34

9 A. No. 13:34

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

15 A. Still obstructive jaundice. 13:34

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

19 A. Correct. 13:34

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

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

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

24 A. Pretty much. 13:34

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

1 A. No, I do not. 13:34

2 Q. That's his thing; right? 13:34

3 A. Correct. 13:34

4 Q. All right. You ordered that, I 13:34

5 believe, for the following day. I think that was 13:34

6 the 20th. Let's take a look at the results that 13:34

7 you got from the ERCP. 13:34

8 A. Okay. 13:34

9 Q. Okay. Are we at the same page? You've 13:34

10 got one -- oh, I'm looking at the radiology 13:34

11 report. You're looking at Dr. Maxwell's report; 13:35

12 right? 13:35

13 A. Right. 13:35

14 Q. Tell me what Dr. Maxwell revealed to 13:35

15 you based on the ERCP. 13:35

16 A. Polypoid lesion distal common bile 13:35

17 duct, biliary tumor. 13:35

18 Q. Now, at that point, he doesn't know 13:35

19 what, this mass represents; is that right? 13:35

20 A. He says it's a biliary tumor. 13:35

21 Q. Okay. Were you convinced that it was a 13:35

22 biliary tumor at that point? 13:35

23 A. Yes, I was. 13:35

24 Q. Okay. What would be the basis upon 13:35

25 which you were convinced it was a biliary tumor? 13:35

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

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

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

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

16 A. Correct. 13:36

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

18 A. That is correct. 13:36

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

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

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

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?

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

1 brushed the mass. 13:37

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

4 A. That's correct.

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

7 A. Right. 13:37

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

11 A. Both have signed this. 13:38

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

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

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

20 A. Correct. 13:38

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

22 A. Correct. 13:38

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

1 A. Reactive glandular cells, correct. 13:38

2 Q. So those do exist in nonmalignant 13:38

3 growth? 13:38

4 A. Right. 13:38

5 Q. What did you make of the acute and 13:38

6 chronic inflammatory cell description? 13:38

7 A. This is cytology. This is a surface 13:38

8 brushing. 13:38

9 Q. Right. 13:38

10 A. I don't place much evidence in that. 13:39

11 Q. All right. So it's just one additional 13:39

12 piece of information that you had, and it didn't 13:39

13 necessarily change your impression that it was more 13:39

14 likely than not that a malignancy existed; right? 13:39

15 A. Correct. 13:39

16 Q. Okay. I want to do this nice and 13:39

17 sequentially. All right. You've got the CT 13:39

18 results, blood results. You know what the ERCP 13:39

19 says, and now you know the cytology; right? 13:39

20 A. Right. 13:39

21 Q. Okay. At this point, what decision **do** 13:39

22 you make? 13:39

23 A. Well, we talked it over, Dr. Maxwell 13:39

24 and I, and we both agreed that the patient needed 13:39

25 exploration. 13:39

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 13:40
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

1 February 21, 1996? 13:40

2 A. According to my note here, I already 13:40
3 had met with them. 13:40

4 Q. All right. I'm assuming you had met 13:40
5 with them after you had all the test results back. 13:40

6 A. That's correct.

7 Q. Okay. At that point, you indicate in
8 your note -- and by the way, her daughter was also 13:40
9 there; right? 13:40

10 A. I can't remember. 13:40

11 Q. Your note says she was there. 13:40

12 A. Fine, fine. 13:40

13 Q. Okay. Your note says, "We will open 13:41
14 the bile duct and excise the tumor"; correct? I'm 13:41
15 reading that with no problem? 13:41

16 A. Correct. 13:41

17 Q. "We will send this for frozen section 13:41
18 analysis." 13:41

19 A. Correct. 13:41

20 Q. "If it is returned as a cancer, we will 13:41
21 proceed with a" -- I can never say the word -- a 13:41
22 whipple, but it obviously says the correct name of E3:41
23 the procedure. "I've informed them we will take 13:41
24 out part of the stomach, pancreas and some of the 13:41
25 intestines, et cetera. I've informed them this is 13:41

1 a large operation, dot, dot, dot I we informed 13:41
2 them, however, is this is benign, what we will do 13:41
3 is just excise the tumor and close the Nuodenum'; 13:41
4 correct? 13:41

5 A Correct 13:41

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

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

14 A This is a summary of a very long 13:41
15 meeting we had where we outlined all of this, where 13:42
16 I believe I reviewed several pictures of things -- 13:42

17 Q. I think that you did. 13:42

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

20 Q. Okay. Now, in your decision with them, 13:42
21 your note makes it clear -- and I think there's 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 based upon positive or negative 13:42
25 pathology That's what I'm going to call it 13:42

1 Malignant or benign pathology; correct? 13:42

2 A Correct 13:42

3 Q And as your memory serves to me pretty 13:42
4 good -- Your lawyer will find that out -- You did 13:42
5 have a very lengthy conversation with the Maynards 13:42
6 about it; right? 13:42

7 A As I recall, I believe it was lengthy, 13:42
8 right 13:42

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

11 A. Uh-huh. 13:42

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

15 MR EXHIBITIONER: Objection to the 13:43
16 form of the question. Go ahead 13:43

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

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

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

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

1 MR. EDMINISTER: Objection.

2 THE WITNESS: I guess the 13:46
3 pathologist just says I can't tell one way or the 13:46
4 other. 13:46

5 Q. Are you and I discussing the pathology 13:46
6 call of defer? I'm trying to -- 13:46

7 A. They would have to defer to permanent 13:46
8 sections. 13:46

9 Q. Okay. If you had received a pathology 13:46
10 reading during this particular surgery from frozen 13:46
11 section that indicated from the pathologist that 13:46
12 the pathologist would need to defer because it was 13:46
13 not clear evidence of malignancy, what would you 13:46
14 have done? 13:46

15 A. I would have done the same thing after 13:47
16 discussing it with the Maynards. 13:47

17 Q. Now, you added "after discussing it 13:47
18 with the Maynards." 13:47

19 A. Right. 13:47

20 Q. Let's talk about that for a second. 13:47
21 First, I need to ask you why you would have gone 13:47
22 ahead and done the surgery if you would have 13:47
23 received an interoperative pathology read of 13:47
24 defer. 13:47

25 A. Well, because of the age of the

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

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

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

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

23 A. Yes. 13:48

24 MR. EDMINISTER: Objection. 13:48

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

1 statistics are? 13:48

2 MR. EDMINISTER: Objection. 13:48

3 MS. KOLIS: He says that he's 13:48

4 aware of them. 13:48

5 MR. EDMINISTER: Correct. 13:48

6 THE WITNESS: In pancreatic 13:48

7 cancers that can be resected without lymphatic 13:49

8 spread that are confined to the pancreas that are 13:49

9 under two centimeters in size, as many as 40 13:49

10 percent of those patients can live five years. 13:49

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

12 A. Even higher percent. 13:49

13 Q. Okay. Can you tell me what studies or 13:49

14 literature you rely upon in making that assertion? 13:49

15 A. Any number of standard textbooks. 13:49

16 Q. Can you tell me which textbooks you 13:49

17 relied on for those statistics? 13:49

18 A. Schwartz Principles of Surgery, 13:43

19 Sabiston Biological Basis of Modern Surgical 13:49

20 Practice, Cameron's Current Surgical Therapy. 13:49

21 Q. Okay. If you are uncertain if there is 13:50

22 a malignancy, do you believe that you have an 13:50

23 obligation to advise the patient that there is 13:50

24 uncertainty as to whether or not there's a 13:50

25 malignancy? 13:50

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.

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

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

9 A. Well, from an oncologic point of view, 13:51
10 you would be worried about contamination of the 13:51
11 operative field with potential tumor cells. I 13:51
12 would be personally worried about leaving a 13:51
13 residual tumor behind in that situation. 13:52

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

17 MR. EDMINISTER: If you know. 13:52

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

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

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

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

1 was, you could close and wait for a final section 13:52
2 reading and then go back in and do this procedure 13:52
3 if there was found to be a true malignancy in the 13:52
4 final reading; correct? 13:52
5 A You could I would not advocate that. 13:52
6 aut -- 13:52

7 Q Okay Let's go through this we might 13:52
8 as well get everything out on the table Why 13:52
9 wouldn't you advocate that if a family did not want 13:52
10 a person to undergo a surgery such as this and 13:52
11 wanted to wait for the final read? 13:52

12 A Well, first of all, I would never go 13:52
13 against a family's wishes -- 13:53

14 Q. I understand that. 13:53

15 A -- number one Number two, I would try 13:53
16 my best to educate the family as to the 13:53
17 probabilities of a malignancy versus a benign 13:53
18 tumor. 13:53

19 Q. Right. 13:53

20 A. And I would stress to them sometimes we 13:53
21 just don't know and you have to go ahead and do a 13:53
22 resection even though on a final report it may be 13:53
23 benign. 13:53

24 Q. Okay What I'm asking is this. I'm 13:53
25 just trying to listen and write, and that's always 13:53

1 hard.

2 There is no medical standard or no 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
5 the final came out that it was actually a 13:53
6 malignancy? 13:53

7 MR. EDMINISTER: Objection. 13:53

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

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

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

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

22 A. It was fairly small. 13:54

23 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
25 five. So I just rounded it and said that it's 13:54

1 five. Does that seem accurate? 13:54

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

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

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

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

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

16 A. That's correct. 13:55

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

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

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

1 missed the lesion? 13:55

2 A. What point was I worried in this case? 13:55

3 When our initial biopsies came back as benign 13:55

4 tissue. 13:55

5 Q. When they came back as benign tissue, 13:55

6 were you inclined to disbelieve those other areas 13:55

7 were benign? I'm paraphrasing what I thought I 13:55

8 heard you say. 13:55

9 A. I was very concerned -- because a 13:55

10 biopsy is a superficial sampling -- that there was 13:56

11 a tumor deeper to our biopsies. 13:56

12 Q. If you had that concern that there was 13:56

13 a tumor, as you're phrasing it, "deeper to your 13:56

14 biopsies" -- I think I know what you mean -- what 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 13:56

18 as you can in other areas. 13:56

19 Q. And you did, in fact, do some 13:56

20 additional biopsying, didn't you, at the time of 13:56

21 the surgery? 13:56

22 A. Well, I think we were very persistent 13:56

23 in attempting to delineate exactly what the problem 13:56

24 was here. 13:56

25 Q. Right. 13:56

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

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

7 A. No, I have not. 13:56

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

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

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

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

23 A. Yes. 13:57

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

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

1 Q. 00051 or so. 13:59

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

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

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

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

14 A. Right. 13:59

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

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

19 Q. Okay. 13:59

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

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

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

25 Q. Okay. 14:00

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
25 know. It was a benign tumor? 14:01

1 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 14:02
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

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. 14:03

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

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

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

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

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

11 MR. EDMINISTER: I think what 14:03
12 you're referring to has just arrived within days. 14:04

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

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

19 MS. KOLIS: Right. It's the 14:04
20 3/10/97 following -- he doesn't have to read it. I 14:04
21 was just asking if he had an opportunity to see it 14:04
22 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
25 right phrase for it, but -- 14:04

1	A. I don't know when I received it. It	14:04
2	was -- according to the note, it was completed on	14:04
3	2/27/96.	14:05

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

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

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

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

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

17	A. No.	14:05
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18	Q. All right. When did you learn that	14:05
19	there was a possibility that there had been a	14:05
20	misread surgically?	14:05

21	A. Let me see if I dictated it.	14:05
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22 Q. That's fine. 14:05

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

25	Q. Okay. Do you recall how you were	14:06
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1 informed? It says by Scott Shorten. 14:06

2 A. Right. 14:06

3 Q. Dr. Shorten is whom? 14:06

4 A. He's a pathologist. 14:06

5 Q. And do you know if he -- well, you 14:06

6 might not know, but is he -- does he work for Akron 14:06

7 Pathology? 14:06

8 A. I don't know who he works for. 14:06

9 Q. He's in an office at the hospital? 14:06

10 A. He works there. 14:06

11 Q. Okay. How did he let you know what 14:06

12 happened? 14:06

13 A. I think he called me, as I remember. 14:06

14 Q. All right. And at that point in time, 14:06

15 he told you that he had discovered a misdiagnosis 14:06

16 in the case of Dorothy Maynard? 14:06

17 A. That's what I see here. 14:06

18 Q. Okay. At that time, he let you know 14:06

19 there was an internal review as well as one 14:06

20 external review at the Cleveland Clinic suggesting 14:06

21 that is what it says. Your note says, "Both their 14:07

22 own internal review as well as the outside review 14:07

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?

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

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

7 A. (No response.)

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

10 A. I did. 14:07

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

14 A. Correct. 14:07

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

19 A. Yes. 14:07

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

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

24 Q. You think you suggested that? 14:08

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

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

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

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

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

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

12 MR. EDMINISTER: Objection. 14:08

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

15 Q. Right. 14:08

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

19 Q. All right. Well, let me ask this. At 14:08
20 the time that you dictated this note back in August 14:08
21 of 1996, basically what you say is as follows. And 14:09
22 I want to talk to you about what you 14:09
23 contemporaneously wrote with your discovery at the 14:09
24 situation. 14:09

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

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
17 radiation." 14:10

18 A. Correct. 14:10

19 Q. All right. Did Dr. Rehms 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. Rehms' comments were. 14:10

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

1 telling me you don't remember her saying that?

2 A. She might very well have, but a lot of 14:10
3 people were very upset with this. I can't remember 14:10
4 her specific comments. 14:10

5 Q. Doctor, let me ask you a question. Why 14:10
6 was everyone so upset if all this was indicated 14:10
7 anyway, irrespective of the misread? 14:10

8 A. As I said, I was upset here because she 14:10
9 had had complications from the chemotherapy and the 14:10
10 radiation. She had been hospitalized several times 14:10
11 for this. I had seen her once or twice actually in 14:11
12 the hospital. 14:11

13 Q. So that's what you were upset about? 14:11

14 A. I was upset that she had suffered from 14:11
15 the chemotherapy and the radiation. 14:11

16 Q. You weren't upset because you thought 14:11
17 that she had received needless medical treatment 14:11
18 for a condition she didn't have? 14:11

19 MR. EDMINISTER: Objection. 14:11

20 THE WITNESS: That's not my 14:11
21 decision on the chemotherapy and the radiation. 14:11

22 Q. I know it's not your decision. That 14:11
23 wasn't what I asked you. But there was a meeting 14:11
24 approximately August 30. I don't see a note, but 14:11
25 does that sound right to you, a couple days

1 after -- 14:11

2 MR. EDMINISTER: What kind of 14:11

3 meeting? 14:11

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

5 MR. EDMINISTER: Between 14:11

6 Dr. Guyton and Mrs. Maynard? 14:11

7 Q. You were in attendance at a meeting 14:11

8 with Mrs. Maynard; correct? 14:11

9 A. At Akron General Hospital with 14:11

10 Dr. Rehmus and Dr. Fromm from radiation and, I 14:11

11 believe, Dr. Button. 14:11

12 Q. Who is he? 14:12

13 A. The chief of pathology. 14:12

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

15 A. That's correct. 14:12

16 Q. Okay. Because there's another note we 14:12

17 can refer to that Dr. Rehmus wrote. That's how I 14:12

18 knew who was there. You didn't dictate a note 14:12

19 about the meeting; right? 14:12

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

21 side.)

22 Q. Dorothy was there without her husband, 14:12

23 wasn't she? 14:12

24 A. Yes. 14:12

25 Q. You were surprised by that? 14:12

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 14:12
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

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

4 Q. Okay. I agree that that's what the
5 notes reflect, of course. But, I guess, what my
6 question was, do you remember if -- because there's
7 nothing in your chart that a meeting was set up. 14:13
8 I'm asking if you remember happening to get called 14:13
9 to a meeting saying, gee, Mrs. Maynard is here. 14:13
10 Let's meet with her. 14:13

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

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

14 MR. EDMINISTER: Objection. 14:14

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

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

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

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

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

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

1 right? 14:14

2 A. Right. 14:14

3 Q Do You recall Mr# Maynard asking you 14:14

4 if she could have avoided the surgery? 14:14

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

6 Q Have you seen Esther R#hus. cart? 14:14

7 A No 14:14

8 MS KOLIS: Okay I will be 14:14

9 deposing Esther R#hus in the not too distant 14:15

10 future. So I'm going to ask you to assume this is 14:15

11 what # has written. In fact, it is what I have 14:15

12 in writing Mike may re#ut# it 14:15

13 MR #DMINISMER: What are you 14:15

14 re#erring to? 14:15

15 MS KOLIS: It's #ates stamp 14:15

16 00028 14:15

17 MR #DMINISMER: I don't have the 14:15

18 #ates stamp That doesn't help me 14:15

19 MS. KOLIS: I sent you guys all 14:15

20 these records What's why I -- 14:15

21 MR EDMINISMER: Oh, you did. 14:15

22 MS BARKER: It's a document 14:15

23 dated -- 14:15

24 MR EDMINISMER: With #ates stamp 14:15

25 on it? 14:15

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

1 30.

14:18

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

14:18

14:18

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

14:18

14:18

14:18

7 A. I can't remember.

14:18

8 Q. You don't know?

14:18

9 A. I can't remember.

14:18

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

14:18

14:18

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

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

14:19

14:19

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

14:19

14:19

23 Q. Okay. Let's talk about that. Under
24 whose training did you learn you should do a
2s vagotomy as part of a whipple?

14:19

14:19

14:19

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. 14:20

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

1 don't. 14:20

2 Q. When was the last time you reviewed the 14:20
3 literature as to what that incidence of 14:20
4 complication really is? 14:20

5 A. I can't give you an incidence. 14:20

6 Q. Okay. Let me just look through a 14:21
7 couple of note cards I have. Do you have any 14:21
8 recollection from your own office notes or your own 14:21
9 memory of Mrs. Maynard's general state of health at 14:21
10 the time you examined her other than the problem 14:21
11 with the obstructive jaundice? 14:21

12 A. You mean when I initially saw her? 14:21

13 Q. Yes. 14:21

14 A. She had some weight loss, but other 14:21
15 than that, it seemed to be -- 14:21

16 Q. It seemed to be a person in relatively 14:21
17 good health? 14:21

18 A. Pretty good health. 14:21

19 Q. Do you happen to know -- of course, 14:21
20 preoperatively -- that there was an anesthesia 14:21
21 assessment done for your patient; right? 14:21

22 A. Well, I have not seen one, but -- 14:22

23 Q. Okay. It's been a while. As we sit 14:22
24 here today, you don't know her ASA, how they -- 14:22

25 A. No, I don't. 14:22

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

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

21 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

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

4 A. No. 14:23

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

12 A. No. 14:24

13 MS. KOLIS: Okay. Doctor, I don't 14:24
14 have any further questions for you, and I 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
18 you, Doctor. 14:24

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

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

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

23 - - - - -
24
25

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

1 IN WITNESS WHEREOF, I have
2 hereunto set my hand and seal of office at Akron,
3 Ohio, this 22nd day of July, 1997.
4
5
6
7
8

9
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.
18
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CROSS EXAMINATION OF DANIEL P. GUYTON,

M.D.

BY MS. KOLIS..... 3 6

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