DOC 208

IN THE DISTRICT COURT OF BOWIE COUNTY, TEXAS
102ND JUDICIAL DISTRICT

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ELIZABETH ANN DYKES AND
JOE G. DYKES, JR.

Plaintiffs,

-against-

COLLOM & CARNEY CLINC,
JOHN D. FISHER, M.D., AND
ERIC HALL, M.D.,

Defendants.

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VIDEOTAPE DEPOSITION of ALVIN KAHN, M.D., taken by Plaintiff, at Brookdale Hospital, Linden Boulevard, Brookdale, New York 11212, pursuant to Notice, on Monday, September 27, 1993, commencing at 9:55 o'clock a.m., before Claudette Cumbs, a Shorthand (Stenotype) Reporter and Notary Public within and for the State of New York.

A P P E A R A N C E S:

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BY: DEBORAH NOVICK, Esq., of Counsel

THE VIDEOGRAPHER: on the record. The date is September 27, 1993.. The time is 9:55. This is the videotaped deposition of Dr. Alvin Kahn, taken by the plaintiffs in the matter of Elizabeth Dykes, et al., versus Collom & Carney Clinic et al, docket number D-102 CV 921651, pending in the Bowie County, Texas District Court, held in the offices of Dr. Alvin Kahn, M.D., at Brookdale Hospital in Brooklyn, New York, on this date, September 27, 1993 at the time indicated on the video screen.

My name is Glenn Kauffman. I am the videographer from the firm of Fink & Carney Court Reporting Services located at 24 West 40th Street in New York City. The court reporter today is Claudette Gumbs, also from the firm of Fink & Carney Reporting Services.

Can counsel please introduce themselves for the record?

MR. ONSTAD: My name is Rockne

Onstad, I represent Ann Dykes and her husband.

MS. NOVICK: Debra Novick representing Dr John Fisher.

MR. WRIGHT: Edwin Wright and I represent Dr. Eric Hall & Collom & Carney Clinic.

THE VIDEOGRAPHER: Will the court reporter please swear in the witness.

ALVIN KAHN, called as a witness, having been first duly sworn by Claudette Gumbs, a Notary Public within and for the State of New York, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. ONSTAD:

Q Good morning, Dr. Kahn. My name is Rockne Onstad and as you just heard I represent Dykes.

Would you tell us your name please, sir?

A Alvin Kahn.

Q Dr. Kahn, are you a physician?

A Yes.

Q Are you a specialist?

A Yes.

Q What is your speciality?

A Internal medicine.

Q How are you employed at this time?

A I am employed by the Brookdale Hospital Medical Center as its medical director.

Q As the medical director, what do you do?

A I take care of all matters, professional matters concerning both the resident staff, the fellows and the attending staff at the hospital. That means taking care of the credentialing process of these physicians, adjudicating any conflicts on the staff, and reviewing the policies of the institution.

I also chair the quality assurance committee of the medical staff and the risk management committee of the entire hospital.

I am also a member of the Board of Trustees of the institution.

Q Dr. Kahn, we are here at the Brookdale Medical Center now taking your deposition.

Would you tell us a little bit about

this medical center?

A Brookdale is a 1,000 bed voluntary hospital, it is an acute hospital for the most part. It has 800 acute beds and 200 extended care beds. It is a teaching hospital in that it is a major affiliate of the State University of New York Health Science Center at Brooklyn.

Q Do you have responsibility over the physicians here?

A Yes.

Q Tell us approximately how many physicians and the types of specialties and whether they are interns, residents, practitioners --

A There are approximately 250 interns and residents, and approximately 600 attending physicians covering all of the major specialties and anesthesiology, surgery, internal medicine, obstetrics/gynecology, radiology, pediatrics, urology, opthalmology, orthopedics, I don't think there are any specialties that are not represented within the institution.

Q You indicated that as the medical director here you have responsibilities for policies.

Would you tell us a little about what you mean as responsibility for policy?

A An institution has to develop certain standards under which it operates and these change from time to time based on changes in medical practice, or changes within the law of the -- laws of the State of New York, sometimes even Federal laws. So new policies are developed as necessary, particularly concerning investigational drugs, old policies like do not resuscitate and policies relating to the Health Care Proxy Act have to be revamped or actually developed fresh, and from time to time, all of the policies, actually annually, all of the policies of each department, including nursing have to be reviewed by my office and by my staff and sometimes with the hospital attorneys.

Q You indicated as medical director you have responsibilities in the area of quality assurance.

Would you tell us a little more about that area and what it involves?

A The Joint Commission on the Accreditation of Hospitals and the Department of Health of the State of New York set up standards

that actually place a mandate on the attending staff of the institution to monitor the quality of care within the institution, to find areas of -- based on comparison with local and national standards that can be improved, to improve the quality of care and also, to monitor that, once it is improved, that the quality of care is maintained at the higher level.

Q Dr. Kahn, I have a copy of your curriculum vitae or resume. I have marked it as Plaintiff's Exhibit 25 and I will ask you a few things about what is on it.

I see that societies that you belong to include the American College of Physician Executives and the American Academy of Medical Directors.

What is that organization?

A The College of Physician Executives is specifically constituted for people like myself, who not only have clinical but have managerial responsibilities and it is to provide us with a format for learning different principles of management and things that go beyond what we probably learned at an earlier phase in our medical education.

Q Are you Board-certified?

A Yes.

Q In what area are you Board-certified?

A Internal medicine.

Q Dr. Kahn, I note here on your desk I see a book called, "Bedside Medicine" by Snapper and Kahn second edition. I picked it up.

Are you one of the authors of that book?

A Yes.

Q Here on your curriculum vitae does it set forth the other publications and books that you have either authored or participated in?

A Yes.

Q Dr. Kahn, are you a licensed practicing physician at this time?

A Yes.

Q In addition to your managerial and executive duties, do you also see patients?

A Yes.

Q Do you supervise other physicians and physicians in training, in the delivery of medical care?

A Yes. That is in particularly with my role as an attending in the department of medicine

and I am also director of medical education.

Q I note from the letterhead, your stationery, that you're the clinical associate dean for the State University of New York Health Science Center at Brooklyn. Is that correct?

A Yes.

Q Would you tell us what your responsibilities are in that regard?

A As I mentioned to you before, I -- we are affiliated with the Health Science Center of Brooklyn and we accept their medical students and I represent on the Council of Dean6 all matters of medical education, pertaining to the students that rotate through our institution from Downstate.

Q Dr. Kahn, I want to focus now a little bit on this case, Ann Dykes. At my request, did you review medical records that pertain to Ann Dykes and depositions of Dr. Fisher, Dr. Hall, and Wr. Thom Simmons, the administrator for the Collom & Carney Clinic?

A Yes.

Q Did you review some of the medical records that pertain to Ann Dykes?

A Yes.

Q All the materials that you reviewed, are they in that black three-ring looseleaf notebook that is laying just to your left on your desk?

A Yes.

Q What I am going to do is, I am going to mark that as Plaintiff's Exhibit 25-A and attach it to the deposition, so that if anybody wants to know what it is you have looked at, what you have reviewed and what you have relied upon, we will have it.

With that little predicate, are the materials that you have reviewed at my request all contained in that notebook?

A Yes.

(A black three-ring looseleaf notebook was marked as Plaintiff's Exhibit 25-A for identification, as of this date.)

BY MR. ONSTAD:

Q Dr. Kahn, I want to focus you now a little bit on the particular issue that I asked you to look at and that has to do with communication between various departments in a multi-specialty medical organization and as far as communication

goes, it has to do with if one department or one physician in this multi-specialty clinic believes they see signs of cancer in a patient, how it should be responded with and that's the basic focus that I asked to you address. Is that correct?

A Yes.

Q In that regard, I want to talk about your experience generally in overseeing or managing groups of doctors in joint practice, where communication about evidence of cancer is important.

What is your experience in that regard?

A The experience relates mainly to the departments of clinical laboratories and I would say the department of pathology and the department of radiology, the technical support services, particularly in the diagnostic area of physician practice and that's where I would focus my attention.

Q Is it generally true that when you have a group of doctors practicing together, either at a multi-specialty clinic or in a hospital, that it is important that if one of them sees signs of cancer in a patient, that there be a mechanism for clear communication to the attending physician or to the

patient?

MR. WRIGHT: Objection.

Q Let me go at that and try to ask it in a non-leading way.

Has it been your experience that groups of doctors practicing together are on the lookout for signs of cancer?

A Yes.

Q Are you familiar with cancer?

A Yes.

Q And generally speaking, what is cancer?

A It's a -- one can describe it as a malignancy which is a destructive growth process, where tumors are formed beyond normal growth within the body, and when we use the word cancer, it means that these tumors have the potential to spread beyond their borders and also to disseminate in the body as a whole.

Q Are there many tests that are designed primarily to detect or pick up evidence of cancer?

A Yes.

Q Does it happen from time to time that in the course of a routine physical or when a patient is being treated for something other than

cancer, that a physician may discover evidence of cancer?

A Most testing involves what we call screening, which really encompasses the field of preventive medicine, where the doctors are looking for illnesses beyond the scope of the physical and the verbal part of the examination and taking of a history. In other words, to pick up disease at a very early phase before even the patient is aware of it.

Q Do you know if mammograms are one of those types of screening tools that you just talked about?

A Yes. Very much so.

Q Are there other types of screening tests or tools that might pick up cancer?

A A chest x-ray would be another one and there are many blood tests to pick up cancers in different organ systems of the body.

Q Before I get into this next line of questions, I want to ask you some technical questions about standard of care.

Do you have knowledge of accepted standards of medical care for communication of

evidence of cancer within multi-specialty clinics in hospitals where you have groups of doctors practicing together and maybe seeing the same patient?

A Yes. My experience is particularly in this hospital, but in my work with other medical directors and through my organizations, I am aware of standards in other institutions as well.

Q Are there standards that are national in your opinion, that pertain to communication between multi-specialty groups whenever a physician sees evidence of cancer on some screening test?

MR. WRIGHT: Objection. Leading.

Q Let me ask that question again in a non-leading fashion.

Can you state whether or not there are any standards of care that are applicable to groups of doctors practicing together that deal with communication whenever one doctor sees evidence of cancer?

A I would say that it goes even beyond cancer and that is, that we -- there are national standards that indicate that there are things called panic values, which means technical --

technologically developed parameters that indicate that a patient has a problem that the physician must respond to and once identified, either by pathology, clinical laboratories or radiology, this has to be communicated in some effective way to the physician that is actually taking care of the patient.

MR. WRIGHT: Objection, not responsive. Further object because it uses alleged standards that were not in force and effect at the time or times pertinent to the litigation at issue.

Q Doctor, he is making technical objections, so I will reask the question. I am really asking you basically almost a yes or no question, whether there are standards and then, if there are standards that you have knowledge about, I am going to go in and ask you about what they are. So I am going to try this question again.

Are there national standards that are applicable to communication of signs of cancer between doctors that practice together, whenever one of these doctors sees evidence of cancer?

MR. WRIGHT: Object. Leading, vague and general.

Q I will keep on doing it until I get it right.

Can you state whether or not there are any national standards of care that are applicable to a situation where you have multiple specialty doctors practicing together as a group and when one of those doctors sees evidence of cancer in a patient, such standards that would apply to communication of that cancer?

HR. WRIGHT: Object.

Multifarious, vague and general.

Q You can go ahead and answer.

A Yes.

Q Are you familiar with those standards?

A Yes.

Q Would you tell us what those standards are?

A I would say the best example of it are the standards promulgated by the Joint Commission on Accreditation of Hospitals.

Q Would you tell us what the standards are, kind of in lay terms about communication?

A It comes up very early in the Joint Commission manual, where they state that there has

to be an effective mechanism of communication between the governing body, the administration and the medical staff to allow for safe environment to exist for the patients that are cared €or in the institution.

Q If one physician in a multi-specialty group of doctors sees evidence of cancer in some sort of a screening test, what does the standard call for with respect to communication of that suspicion of cancer?

MR. WRIGHT: Objection. Leading.

A There was an objection.

Q That's okay, you can go ahead and answer it.

A That that information be communicated to the physician who ordered the test on the patient.

Q Now, when it comes to communication between doctors on the subject when one doctor is of the opinion that the patient has cancer, is there any kind of standard practice on the type of wording or the manner in which the communication takes place?

MR. WRIGHT: Are you finished,

Kahn

Mr. Onstad?

MR. ONSTAD: Yes.

MR. WRIGHT: I must object. It requires the doctor to give opinions regarding standards that were not in force and effect regarding all matters pertinent to this litigation.

MS. NOVICK: Same objection.

Q Let me go at it a little differently. Doctor, what is your understanding of Ann Dykes' situation with the Collom & Carney Clinic between the period when she had her first mammogram in July of '89 up until December of '90 when she had her surgery?

A My understanding is that a mammogram was taken in '89; that was suspicious for the presence of a tumor, and that a follow-up mammogram was done about a year-and-a-half later which indicated that a tumor was present of a definite degree of malignancy. The degree of malignancy was established by a biopsy and resection.

Q And you read Dr. Fisher's report where he reported his findings on the 1989 mammogram?

A Yes.

Q Have you read his deposition where he gave testimony what his opinion was after reviewing the mammogram?

A Yes.

Q Have you read Dr. Hall's deposition where he expressed what he understood the report of the mammogram to mean to him, that being the mammogram of 1989?

A Yes.

Q Have you read Mr. Simmons' deposition where he discussed what policies or procedures existed at the Collom & Carney Clinic with respect to communication?

A Yes.

Q Did you form any opinions based on your education, training, background and experience about the conduct of the Collom & Carney Clinic with respect to policy on communication of evidence of cancer between its various doctors?

A Yes.

Q What is your opinion?

A There was no policy that existed that required panic values to be acknowledged or dealt with in any specific way with respect to diagnosis

of those situations, including cancer, that would require a specific action on the part of a physician.

MR. WRIGHT: I must object to the question and the response, because it relies upon standards and other terminology that was not in force and effect at all times relevant to this lawsuit.

MS. NOVICK: Same objection.

Q What is your understanding of Mr. Simmons' testimony on the issue of whether or not the Collom & Carney Clinic ever had any policies whatsoever about communication of evidence of cancer on patients between doctors?

A I didn't see in his testimony any evidence that there was a policy.

Q Let me show you some legal definitions from Texas.

I have marked as Plaintiff's Exhibit 36 and I believe that these are the definitions that the court will probably give the jury on the matter of negligence and the matter of gross negligence as it relates to the Collom & Carney Clinic and have

you reviewed that in the materials that I have sent you before?

A Yes.

Q Now, using those definitions that are set forth in Plaintiff's Exhibit 36, do you have an opinion, based upon the materials that you have reviewed, your education, your training and experience, on the issue of whether or not the conduct of the Collom & Carney Clinic as it relates to policy on communication of evidence of cancer among its doctors was negligent?

A Yes.

Q What is your opinion?

A I believe that with the notation of previous cases, and I believe that the cases were the Anderson and Propps cases, both where there were communication problems, communicating a diagnosis of cancer or the suspicion of cancer on the part of radiologists to physicians that -- with these cases as warnings, the hospital not having -- the clinic not having a policy on panic values represents gross negligence.

MR. WRIGHT: I must object. Both to the question and to the response

because it relies upon terminology or conduct and standards which were not in force and effect at the time of all matters pertinent to this lawsuit..

MS. NOVICX: Same objection.

Q Let me just lay some more background. Doctor, you told us about panic value and communication that uses panic value.

Would you explain what you mean by that?

A A panic value is a finding on a test that has a specific meaning and requires a specific action. For example, a low blood sugar requires further diagnostic tests but also that a patient be given a certain amount of sugar to prevent them from losing consciousness.

The suspicion of cancer requires pursuit, identification by some objective means of the presence of cancer or further diagnostic tests. These are findings that cannot be ignored. They are not in the same category as certain abnormalities that could be deferred for a period of time because you're looking for trends more than actual exclusion of very serious problems and that is what the

meaning of panic values are.

Q How does that relate to findings on mammograms?

A A suspicious finding on a mammogram must be pursued, because that is actually the reason why we take a mammogram. It is to find something, like a malignancy in its earliest possible phases, where it can be removed easily without extensive surgery and, of course, at best, prior to the point that it has metastasized and presented itself in other organ systems of the body.

Q Dr. Kahn, in your work as an administrator and medical director and dean of a medical -- assistant dean of a medical school and in your work with the American College of Physician Executives, have you come to know if there is national standards on communicating of evidence of cancer that is found on mammograms?

HR. WRIGHT: Objection. Leading.

MS. NOVICK: Same objection.

A Yes.

Q How long have there been standards of care applicable to hospitals and multi-specialty clinics, that deal with reporting of findings on

mammograms that are suspicious of cancer?

A Concepts relating to the early diagnosis of cancer and the communication of this to physicians that were involved were already made known to me when I started medical school in 1950.

MR. WRIGHT: Object. Not responsive.

MS. NOVICK: Same objection.

Q Dr. Kahn, let me keep asking this until we get either no objection or whatever.

Have there been any changes in the standard of care on the issue of reporting evidence of cancer between doctors for as long as you have been practicing medicine?

MR. WRIGHT: Objection. Vague and general.

A There have been changes.

Q Let me ask the question a little differently.

Doctor, is it important that if more than one doctor is either conducting tests or diagnosing or treating the same patient, that if one of the doctors finds something suspicious for cancer, that it be reported to the other doctors

that also are treating the patient?

A Yes.

Q why is that important?

A The importance stems.from the very reason why the test was ordered in the first place. The tests are ordered in the interests of the patient's health to find illness at an early phase before it can actually destroy the patient and for this reason, the findings of the test must be reported clearly to the physician who ordered the test, again, in the best interests of the patient.

MR. WRIGHT: Objection. Not responsive.

Q How long has that been so?

A That has always been the case.

Q Were you taught that when you went to medical school?

A Yes.

Q Are they still teaching medical students today in medical school, the importance of clear communication of evidence of cancer to the other doctors dealing with the patient?

A Yes.

Q Has that always been important as long

as you have been a doctor?

A Yes.

Q Is it still important?

A Yes.

Q With regard to this clear communication of evidence of cancer between doctors who have joint concern for the patient, is there a national standard of care on that issue?

MR. WRIGHT: Objection. Leading.

MS. NOVICK: Same objection.

BY HR. ONSTAD:

Q In the review of the materials that I have provided you that are in the book, did you take note of the petition and the settlements in there on the Anderson case and on the Propps case?

A Yes.

Q When you have a multi-specialty clinic and they have a situation like the Anderson case, where the radiologist reported evidence of cancer but the opinion on the evidence of cancer never got to the clinicians, and time is lost, what would something like that in your experience, prompt the organization to do with respect to its policies?

MR. WRIGHT: Objection.

Misstates the evidence.

Q Let me go at it this way:

What is your understanding of the nature of the Catherine Anderson case?

A That -- the case involved a failure on the part of the ordering physician to understand the nature of the report of a malignancy, presence of a malignancy on the mammogram of a patient who was being screened.

Q Do you know what clinic was involved?

A The same clinic as in our case, Collom & Carney Clinic.

Q And when you have a -- when a clinic like the Collom & Carney Clinic has a situation like the Anderson case, in your opinion, what would a reasonably prudent clinic like the Collom & Carney Clinic do with respect to its policies?

A A solution would be to develop a system of panic values which involve the development of clear reports, verbal communication, and a meeting between radiologist and patient's attending physician to plan out a response to the initial finding.

Q From your review of the depositions of

Dr. Hall and Tom Simmons, were you able to determine if the Collom & Carney Clinic ever had such a policy review following the Anderson review case?

A I see no evidence that they did.

Q Based upon your education, training and experience and the materials that you have reviewed in this case, do you have an opinion that you hold on the issue of whether or not the Collom & Carney Clinic, in not having such a policy, amounted to negligence?

A Yes, I have an opinion.

Q What is your opinion?

A There was gross negligence involved.

MR. WRIGHT: Object. Not responsive.

Q Do you have an opinion based on your review of the materials, your educational experience, the facts that you told us about on the issue of whether or not the Collom & Carney's failure to develop any kind of policy of communication of evidence of cancer with panic values, as to whether or not such conduct amounted to gross negligence?

A Yes, I do.

MR. WRIGHT: Excuse me, Doctor, I have to interject, because of our rules down in Texas, I must object to the multifarious nature of the question, the leading nature of the question and the fact that the question subjects my client to standards that were not in force and effect at all times relevant to this lawsuit.

BY MR. ONSTAD:

Q Now, the standards of care that you have told us about and that you believe in your opinion are applicable to the Collom & Carney Clinic, have they been applicable since 1986?

A Yes.

Q And are they still applicable today?

A Yes.

Q Bearing in mind those standards, and your education, training and experience and the facts of this case, as you learned from the materials that you told us you reviewed, do you have an opinion, based on such, on the issue of whether or not the Collom & Carney Clinic's conduct amounted to gross negligence?

Kahn

MR. WRIGHT: Objection. Leading and multifarious, vague and general.

Q You can go ahead and answer.

A Yes, I do.

Q What is your opinion?

MR. WRIGHT: Same objection.

A That the situation involving communication of vital material between physicians, failure to have an effective policy amounted to gross negligence on the part of the Collom & Carney Clinic.

MR. ONSTAD: That is all the questions I have, doctor. We will take a break.

THE VIDEOCRAPHER: Off the record.

The time is 10:33.

(Discussion off the record.)

THE VIDEOGRAPHER: Back on the record.

The time is 10:37.

CROSS-EXAMINATION

BY MR. WRIGHT:

Q Dr. Kahn, my name is Ed Wright. I

represent Dr. Eric Hall and the Collom & Carney Clinic. I have no desire to trick you or fool you. Therefore, if you don't understand a question that ask you, would you tell me that sir, where I can repeat or rephrase my question to make sure you understand what you're answering.

A Yes.

Q Doctor, have you ever been licensed to practice in the State of Texas?

A No.

Q Have you ever practiced medicine in Texarkana, Texas?

A No.

Q What is your understanding as to how many doctors worked at the Collom & Carney Clinic back in July of 1989?

A I don't know.

Q You would certainly agree with me, would you not, sir, that the Collom & Carney Clinic did not have the hundreds of doctors working in July of 1989 that you have here at this facility?

A I would assume that as a clinic, it would have fewer doctors than we as an institution, large institution would have.

Q Doctor, would you agree with the general proposition that the larger the number of doctors on staff, the greater the reason to have written reports and other procedures in place to ensure effective communication between the doctors?

A No. I can't agree with that.

Q Doctor, are you aware that the Collom & Carney Clinic is not a hospital?

A Yes.

Q Are you aware, doctor, that the Collom & Carney Clinic is small enough that the doctors see one another normally on a daily basis?

A That may or may not be.

Q If they see one another on a -- normally on a daily basis, wouldn't you expect those doctors to discuss their care and treatment of the patient as well as the interpretation of tests made on the patient?

A I would expect doctors in general to communicate with each other on the results of tests.

Q That certainly wouldn't be unusual would it, sir, in a small clinic type of practice?

A Even in a large clinic or hospital.

Q Is most of your time here sir, spent on

administrative matters, such as having meetings with the trustees, the board of which you're a member, counseling residents and interns and otherwise ensuring that the quality of this institution remains high?

A No. I also spend time teaching, making rounds with residents and seeing private patients.

Q Is the majority of your time, however, and I mean by that, more than 50 percent, spent on administrative matters, sir?

A It's about 50 percent.

Q What is a mammogram, Doctor?

A It's basically -- it's a soft tissue x-ray of the breast. It is an x-ray that is designed to indicate whether there are masses within the soft tissue of the breast structure.

Q Is it always an accurate test to determine whether or not a woman has breast cancer?

A There are cancers that are too small to be detected on mammograms.

Q Therefore, a mammogram can never totally rule out that a woman has breast cancer, correct?

A It is not a test that's used in that

way. It can rule it in more often than it can rule it out.

Q Now, doctor, have you in this past year ordered mammograms on your patients?

A I have ordered mammograms on 'my patients, yes.

Q When you ordered mammograms on your patients, did you have a radiologist read and interpret those mammograms?

A Xes.

Q Did you rely upon the radiologist being a specialist in reading and interpreting those mammograms?

A Not exclusively. There are times when I have indicated to the radiologist myself certain areas to focus on and it's -- I view it more as a combined venture between the radiologist and myself.

Q Let's go at it this way: you're an internist are you not, sir?

A Yes.

Q What is an internist so the ladies and gentlemen will understand what you do and what your functions are.

A An internist is for the most part a

diagnostician to evaluate the presence of disease in the major organs of the body of a non-surgical nature or someone who may pick up surgical problems that have to be referred on for surgical treatment. But in essence, it deals with the internal organ systems of the body, the heart, the lungs, the gastrointestinal tract, the endocrine system. It's a very broad based specialty, primary care.

Q And what is a radiologist, doctor?

A That is a specialist in what we call imaging today, using radiographic or nuclear medicine or ultrasound techniques. In other words, its diagnostic production of images in the internal systems of the human body.

Q And some of those images that the radiologist reads and interprets are mammograms, correct?

A Yes.

Q You would expect a radiologist here at your institution to read many more and interpret many more mammograms during a day or a week or a month than you, would you not, sir?

A I always have radiologists interpret my mammograms. I don't do this myself.

Q And do you do that because they were specially trained in reading and interpreting mammograms?

A Yes.

Q You would expect that the radiologist at Collom & Carney to be specially trained in that very same fashion, that is, to have special expertise in reading and interpreting mammograms?

A Yes.

Q You would certainly expect the radiologist to have much more expertise in that area than the internist or even obstetricians and gynecologists practicing in the same clinic, would you?

A Yes.

Q Now, would it be correct to say that the radiologist in this case gave a written report?

A Would it be correct, to say that --

Q Yes, sir. Is that your understanding?

A Yes.

Q So this was communication in this case, was there not?

A Yes.

Q Have you ever reviewed any other report

that Dr. Fisher, the radiologist in this case, prepared regarding mammograms?

A Are you asking whether I saw reports of other patients that --

Q Well, let me go at it this way to make sure you and I are understanding one another.

Other than the mammogram report that Dr. Fisher prepared in this case, have you ever reviewed any other mammogram report that he prepared while he was in the -- working at the Collom & Carney Clinic?

A No, I don't believe that I did.

Q Were you familiar with his standard language or disclaimer language that he used or used to use in those reports?

A No, I only reviewed this -- this report.

Q Doctor, is it correct that dysplasia is not cancer?

A Dysplasia is not cancer.

Q Is it also true, sir, that fibrocystic changes are not unusual in many women?

A It is not an unusual finding.

Q Doctor, if you received a report from a

radiologist, that one of your patients upon mammogram may have had dysplasia and certain fibrocystic changes, would you be inclined to operate or refer that person or that patient to an operative procedure?

A Not the use of those terms, specifically.

Q Now, let's focus upon the specific term. If you want to look at your report, I believe in your report, you quote Dr. Fisher as saying "mass lesion cannot be excluded." Is that true?

A Yes.

Q That is not a definitive interpretation that Ms. Dykes had cancer, is it?

A No.

Q Let's now focus please, sir, upon your patients.

I take it that you still do clinical practice in which you examine and treat ladies.

A Yes.

Q Do you still have mammograms performed upon them?

A Yes.

Q Do you advise your patients to

follow-up and come back for further visits and further mammograms?

A Yes.

Q If those patients fail to follow your advice, to come back and keep their appointments and have those mammograms performed, would you agree, sir, that they are not acting prudently and properly?

A That is correct.

Q They would be negligent, wouldn't they?

A Yes.

Q So the ladies and gentlemen of the jury will understand, you are not saying that the Collom & Carney Clinic, Dr. Hall, or even Dr. Fisher caused this lady to have cancer, are you?

A They did not cause her to have cancer.

Q That was a a disease process that was in her body, was it not?

A That's correct.

Q Do you know what caused this lady to have cancer?

A The cause of cancer, although many areas are suspicious, is virtually unknown definitively today.

Q Is there a general concensus, Dr. Kahn, as to what are some of the suspected causes of breast cancer in women such as Ms. Dykes?

A There are suspected causes of cancer, yes.

Q Please tell me what those are, sir.

A Hereditary, obesity, prolonged exposure to -- without rest, estrogens, estrogen stimulation, high fat diet and environmental factors that are somewhat nondescript but limited to certain areas of the country.

Q You mentioned earlier the Joint Commission on Accreditation. Isn't it true, sir, that that Joint Commission on Accreditation refers to accreditation of hospitals?

A Yes.

Q It does not refer to accreditation of clinics like the Collom & Carney Clinic, does it?

A It refers to standards of practice that can apply anyplace. It is just one of the organizations that has has verbally and in written form established standards for -- by which physicians, nurses, administrators, function in the health care system.

Q I must object as nonresponsive.

The Joint Commission does not accredit clinics, does it, sir?

A That is correct.

Q One second, I need to get one note, please excuse me.

Excuse me for the delay, Doctor, I forgot one paper that I had.

Is it correct that the American College of Radiology promulgated certain words to use to denote the risk of cancer after July of 1989?

A I can't comment on that. If I saw what you're referring to, I --

Q You just don't know one way or another?

A That's right.

Q Doctor, have you ever been a party to a lawsuit?

A Yes.

Q Medical negligence lawsuit?

A Yes.

Q On how many different occasions, sir?

A Once.

Q Was that lawsuit tried or what was the disposition of that?

case or sued in this state?

A Which hospital?

Q This hospital for which you practice, sir?

A No. What was your question?

Q I am sorry to be -- has the Brookdale Hospital medical Center ever be a party to a lawsuit?

A Yes.

Q On more than one occasion?

A Yes.

Q On more than ten occasions?

A Yes.

Q Has it ever been sued for failing to have proper standards in the communication between doctors?

A Not that I am aware of.

Q It could have? You just don't know?

A I'm not aware of anything like that.

Q In the Anderson case, did you review anything other than the plaintiff's petition and the settlement agreement?

A I would say I didn't review anything else other than that.

A Settled.

Q In that settlement, sir, did yau or your counsel on your behalf state that you were not at fault and were not admitting liability?

A .Yes.

Q You certainly weren't judicially determined that you were at fault, were you?

A No.

Q Now, in the Anderson case that Mr. Onstad referred to you, were you aware that that case was settled?

A Yes.

Q And do you recall what the amount of the settlement was?

A I don't recall right now, but I think I was told. I just don't remember at this moment.

Q Was it less than $10,000?

A It was more than 510,000.

Q Do you recall an estimate of it, sir?

A It was probably over a million dollars.

Q Do you know what portion that the clinic paid as opposed to the other defendants?

A No, that was not discussed with me.

Q Has the hospital ever been sued in this

Q You certainly weren't given enough information to determine whether or not effective communications did take place in that case, were you?

A There didn't appear to be effective communication. That is all that I could say.

Q You just didn't -- you didn't have time and you were not furnished the materials to get the clinic's side of the story, were you?

A I don't know the clinic's side of the story.

Q Doctor, in the past five years, how many cases have you served as a consulting expert or as a testifying expert for Mr. Onstad and his firm?

A Twice.

Q Is this the second case, sir or is this the third case?

A The third case.

Q What was the first case?

A Brain damaged baby case.

Q Do you recall the clients' names or the people's names?

A Yes. Stout.

Q Stout?

A Yes. S-t-u-o-t.

Q In what area did you render opinions in that case, sir?

A The administrative aspect of the -- several aspects, credentialing aspects of the physician and also the response of the hospital for -- in the patient who had fetal -- showed signs of fetal distress and did not adequately develop a system of responding to the fetal distress.

Q And the other case?

A The second case, the name I believe was Cole and it had to do with a -- do you want to know what?

Q Yes, sir, please.

A It had to do with a -- an operative procedure in a patient who a physician suspected a disease called achalasia, which is a failure of the esophagus to open properly and allow food to enter the stomach.

Q What were your opinions in that case, please?

A That the operation was not called for.

Q In the past five years, have you always been a consulting expert or a testifying expert for

the plaintiffs or the people bringing the medical negligence case?

A No.

Q In every case that you have had for Mr. Onstad, have you been on rhe side of the patient bringing the case?

A In the two -- in the three cases he represented the plaintiff.

Q Do you know how he came all the way to Brooklyn to have you as his expert, sir?

A Yes.

Q Please tell me.

A Through a law firm called Med-Quest.

Q Explain to me what Med-Quest is, sir.

A Med-Quest is a firm that recommends experts to attorneys who are looking €or specific experts in certain areas.

Q Do you pay them a fee or do they pay you a fee for being on their list of doctors to whom they refer attorneys in medical negligence cases?

A I don't pay them a fee.

Q Do they pay you a fee to be there?

A They don't pay me a fee to be on the list, but they facilitate the payment of a fee of

the attorney -- that I bill to the attorney.

Q And how do they do that? Do they, before they match up you and the attorney, do they require the attorney to send you a referral or retainer fee?

A No.

Q How do they facilitate that, then? I don't understand.

A What I believe is that the attorney interested in an expert consults them, tells them a little bit about the case and says do you have anybody who might be able to act as an expert. Then, in my case, they will call me and say that there -- there is an attorney who has such and such a case from such and such an area, do you know the attorney, do you know the individual -- individuals involved; this is the nature of the case, could you act as an expert in this type of case, would you be available. They will give me the time constraints and then either the attorney or Med-Quest, depending on -- the attorney might send me the documents directly, otherwise they will transmit the documents to me. From that point on I work with the attorney.

Q Is it your understanding that Med-Quest

advertises in legal periodicals to advise attorneys about their services?

A That I don't know.

Q Would it surprise to you learn that Med-Quest advertises?

MR. ONSTAD: I object as misleading.

A I really don't know how they get their referrals.

Q Are you charging a fee in this matter, sir?

A Yes.

Q How much are you charging?

A $250 an hour.

Q Is that true whether or not you're reviewing records or giving testimony?

A That is correct.

Q Doctor, would it be correct to say in the past five years, the majority of the time you have served as a consulting or testifying expert on behalf of plaintiffs?

A No.

Q What percentage is it?

A About 50 percent.

Q Have you in the past five years served as an expert stating or opinioning that a clinic or hospital had proper procedures in force and effect regarding communications amongst its doctors?

A I don't think I really understand your question.

Q Have -- as I understand your testimony here today, you're critizing one of my clients for failing to have procedures in place to ensure adequate and proper communication amongst doctors.

A Yes.

Q Have you ever been on the opposite side of the fence, when you have given an opinion that the proper procedures were in force and effect?

A In other words, you're asking whether, in the 50 percent of the time that I testified for the defense, whether any of these cases represented cases where I would have to have said whether there was good communication between physicians. That's what --

Q That's correct.

A I am not certain.

Q Do you keep your files here in your office regarding cases?

A Yes.

Q These cases that are here to your right and my left, are those your current cases?

A Not necessarily, no.

Q Are those the cases that go back to when you first started consulting on matters such as this, sir?

A There are a certain number of cases there, that are cases that have either been settled or disposed of, that I am not aware that they -- that the attorneys have not told me, so from time to time, we have to make a lor. of telephone calls, but they don't represent necessarily current cases, no.

Q In the past five years, how many cases have you served as a consulting and testifying expert?

A Maybe about 70 to 80.

Q Doctor, if a radiologist suspected cancer in a patient, would you want that radiologist here at the medical center ko so state in explicit terms?

A At my medical center, yes.

Q Yes, sir.

A I don't think -- in most instances, a

radiologist can merely define a suspicion or a need for some type of follow-up, but I would expect him to indicate in some way that this was not a normal finding. That the mammogram itself was not a normal mammogram.

Q Would you expect him to act upon a suspicious mammogram report?

A Yes.

Q And how would you expect him to account upon it?

A By informing me of the nature of his concern.

Q You being the primary treating --

A Referring physician, yes.

Q Would the failure to act upon that be negligence, in your opinion, on the part of the radiologist?

A Would the failure to inform me of a suspicious finding -- yes.

MR. WRIGHT: I pass the witness.

THE VIDEOGRAPHER: Off the record, the time is 11:05.

(Discussion off the record.)

THE VIDEOGRAPHER: Back on the

record. The time is 11:07.

CROSS-EXAMINATION

BY MS. NOVICK:

Q Dr. Kahn, my name is Debra Novick and I represent Dr. John Fisher, the radiologist, in this case.

You discussed earlier some of the medical records and depositions and that sort of thing that you had reviewed in preparation of your report and deposition.

Is there anything that has been taken out of your file?

A No.

Q So everything that you have looked at in this case is here with you today in your file?

A That's correct.

Q And that is the black binder that we have here?

A Plus my own personal records.

Q And what records are those?

A I don't believe it's -- I will just read it off. It is my report to Mr. Onstad.

Q Dated September 1, '93?

A Yes.

Then, Mr. Onstad's letter to me of August 23rd. That was what actually led to my being involved in the case.

Q Can I see it?

Thank you. I didn't mean to interrupt you.

A My rough notes, which is actually a duplicate in my own handwriting of the record. The subpoena. And the letter to -- from Mr. Onstad dated September 15th, dealing with the deposition of Tom Simmons.

MS. NOVICK: Have those been marked already?

MR. ONSTAD: No.

MS. NOVICK: Can we mark that, I guess as Defendant's Exhibit 1.

MR. ONSTAD: Sure.

(Notes were marked as Defendant's Exhibit 1 for identification, as of this date.)

BY MS. NOVICK:

Q Is it fair to say that when you were asked to serve as an expert in this case, your role was to discuss whether or not there was quality

assurance problems?

A It could be designated as a quality assurance problem, yes.

Q It is your opinion, is it not, that Dr. Fisher's report was an abnormal finding report?

A Yes.

Q And it is also your opinion, is it not, that by preparing that report, Dr. Fisher was indicating that he had a suspicion of cancer?

A Yes.

Q Is it also your opinion that Dr. Fisher, by preparing his report which indicated a suspicion of cancer was communication to the clinician or the primary treater in this case?

A It was a written communication, yes.

Q Dr. Fisher, being a radiologist, is not a clinician or a treating physician with the patient. Isn't that true?

A He is functioning purely as one who interprets the images.

Q As we know a traditional physician / patient relationship, Dr. Fisher does not have a traditional patient/physician relationship with somebody who comes in for a diagnostic test. Isn't

that true?

A He functions as a radiologist, not as a treating physician.

Q His job is to review films or in this case, mammograms and prepare a report which then goes on to the clinician outlining what his findings are?

A Yes.

MS. NOVICK: That's all of the questions that I have.

MR. ONSTAD: I have a few. These are just little, formal, follow-up questions.

REDIRECT EXAMINATION

BY MR. ONSTAD:

Q Dr. Xahn, let's me hand you what has been marked as Plaintiff's Exhibit 25 entitled your curriculum vitae.

Is that a true and correct copy of your Curriculum vitae?

A Yes.

Q In lay terms, that's a resume; is that correct?

A Yes.

Q It sets forth your education, your training, your experience, your positions, your publication, your licensure and things of that nature; is that correct?

A Yes.

Q Dr. Kahn, let me show you Plaintiff's Exhibit 24. You were asked about it and it is in the folder Ms. Novick was just asking you about.

Is that the original of the report you prepared following your review of the materials I sent you?

A Yes.

Q Does that report set forth your findings and your opinions?

A Yes.

Q Are the opinions set forth in your report, are they based on reasonable medical probability?

A Yes.

Q Now, the materials that are in the manila envelope, they included my letters to you and that letter from me to you that is contained in Defendant's Exhibit 1, was that the communication between me and you that described the scope of what

I asked you to you do?

A Yes.

Q Is that would you what you tried to respond to in your review?

A Yes.

Q And then, as I think the record would show, we didn't have Mr. Simmons' deposition at the time that you gave -- made your report and the letter that you talked about that is in the manila folder from me dated September 15, 1993, was that the letter that sent to you Mr. Simmons' deposition, asking to you review and consider it as well?

A Yes.

Q Did you do that?

A Yes.

Q Just to be sure, if I have not already done this, the three-ring binder that we have marked Plaintiffs Exhibit 25, let me hand it back to you, is that what I sent to you with my letter, my first letter, September 1, 1993, transmitting materials pertaining to this case for you to review and look at?

A Yes.

Q And those materials within Plaintiff's

Exhibits 25-A, does that set forth the factual basis from this case that you rely upon in expressing your opinions that along with Dr. -- along with Tom Simmons' deposition?

A Yes.

Q Dt. Kahn, that is all the questions that I have. I thank you for your time.

MR. WRIGHT: Just a few here, sir.

CROSS-EXAMINATION

BY MR. WRIGHT:

Q In the case against you, what was the nature of the patient's complaint or the lawsuit some?

A It was a failure to diagnose cancer.

Q Was it a failure to diagnose breast cancer or what type of cancer?

A Yes, breast cancer.

Q And what was the allegation as to what you did wrong?

A There was -- the allegation was that I was the patient's attending physician. I was not the patient's attending physician. I was her friend and I had requested a mammogram because she said she

needed one and the basic case centered on whether that made me her attending physician, because I requested the mammogram. The rest of the case involved a failure of the radiologist to diagnose cancer and he felt that the mammogram was negative and that is the initial report that he gave.

Q Was that case filed here in New York, sir?

A That -- that is a Brooklyn case, Kings County.

Q Kings County?

A Yes.

Q Do you recall if that was settled on your behalf?

A Yes.

Q And for how much was it settled, please?

A I don't remember.

Q Do you recall what year it was settled in?

A No.

Q Could you estimate it being in the '60's, '70's, '80's or '90's?

A Late '70's, early '80's.

Kahn

Q Now, regarding the Propps and Anderson cases that are referred to in your file, did you ever review any depositions taken in that case?

MR. ONSTAD: Objection. That is misleading. There were none.

Q Did you review anything in -- from those cases, other than correspondence between the attorneys and the petitions themselves?

A I think that was all.

HR. ONSTAD: I think it is fair to he say he reviewed what is in that folder, that's why we marked it.

Q Doctor, will you agree with me that the statement "mass lesion cannot be definitely excluded from either breast", is not a definitive diagnosis or impression of cancer?

A It is not a definitive diagnosis of cancer.

Q Assuming that this was normal disclaimer language used by Dr. Fisher, would you find that to be unhelpful to the referring physician?

A That could not be normal disclaimer language.

Q Have you read any other report from Dr. Fisher?

A No.

MR. WRIGHT: I pass the witness.

MR. ONSTAD: No further questions.

Any more?

MS. NOVICK: I am thinking. Just a second. I have one further question, Dr. Kahn.

RECROSS-EXAMINATION

BY MS. NOVICK:

Q You agreed with me that Dr. Fisher's report conveyed a suspicion of cancer, right?

A Yes.

Q Since Dr. Fisher's report conveyed a suspicion of cancer, would you agree that if a clinician receiving that report was unsure, that it would be up to the clinician to notify Dr. Fisher if he was unsure of what the report meant?

A Yes.

MS. NOVICK: Pass the witness.

MR. ONSTAD: No further questions.

Kahn

Dr. Kahn, thanks again. I will keep you posted.

THE VIDEOGRAPHER: Off the record. The time is 11:21, this concludes this deposition.

(Whereupon, at 11:21 o'clock a.m., the deposition was concluded.)

I N D E X

Witness:	Direct	*Cross*	Redirect	Recross
Alvin Kahn, M.D.	4	31	56	62

EXHIBITS

Plaintiff's For Ident.	Description	Page
25-A	A black three-ring binder	11

Defendant's For ident.		
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C E R T I F I C A T E

STATE OF NEW YORK)
) ss.
COUNTY OF NEW YORK)

I, CLAUDETTE GUHBS, a Shorthand (Stenotype) Reporter and Notary Public of the State of New York, do hereby certify that the foregoing Videotaped Deposition, of the witness, ALVIN KAHN, M.D., taken at the time and place aforesaid, is a true and correct transcription of my shorthand notes.

I further certify that I am neither counsel for nor related to any party to said action, nor in any wise interested in the result or outcome thereof.

IN WITNESS WHEREOF, I have hereunto set my hand this 11th day of October, 1993.

CLAUDETTE GUMBS