STATE OF OHIO)
) SS:
COUNTY OF LORAIN)

IN THE LORAIN COUNTY COURT OF COMMON PLEAS

KATHRYN L. WEEKLEY, Administratrix, et al.,	)	
Plaintiffs,	)	
vs.	)	CAUSE NO. 90CV105471
Liwanag A. Asuncion,	)	
Defendant.	)	

The deposition upon oral examination of DR. GLEN LEHMAN, a witness produced and sworn to before me, Dana S. Miller, RPR, a Notary Public at large in and for the State of Indiana, taken on behalf of the Plaintiff at University Hospital, Room 2300, 926 West Michigan Street, Indianapolis, Indiana, on September 24, 1992 at 10:00 a.m. pursuant to the Ohio Rules of Trial Procedure and pursuant to Agreement as to time and place thereof.

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APPEARANCES

FOR THE PLAINTIFF:

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INDEX OF EXAMINATION

DR. GLEN LEHMAN,

having been first duly sworn to tell the truth, the whole truth and nothing but the truth, relating to said matter, was examined and testified as follows:

DIRECT EXAMINATION,

QUESTIONS BY MR. MICHAEL BECKER:

Q Doctor, would you state your full name for me?

A Glen Arthur Lehman.

Q And can you tell me approximately what year you started doing medical legal reviews?

A Approximately 1980.

Q Okay. And how many do you do a year?

A Approximately four.

Q All right. And have you done any previously for the law firm of Jacobson, Maynard, Tuschman & Kalur?

A No.

Q What would be the percentage breakdown between plaintiffs' cases and defendants' cases?

A Approximately half and half.

Q Okay. And in any of those cases that you've reviewed, whether for the patient or for the medical provider, had to do with the subject matter that we're dealing with today?

A Several have had to do with esophageal perforations, but I'm not -- I don't believe any have had to do with cancer, esophageal cancer.

Q Have any of them had to do with when an endoscopy is indicated?

A Relatively, yes.

Q Do you remember the names of those cases, Doctor, or the names of the counsel, whether plaintiffs or defendants?

A Not right off, but I could get that information if required.

Q Okay. I'd appreciate that if you would do that?

MR. DJORDJEVIC: We'll see what we can find.

Q Have you given any opinions relative to the subject matter of Barrett's esophagus?

A Not specifically.

Q Or adenocarcinoma of the esophagus?
A Not specifically.
Q Doctor, have you ever lectured to internists or dental practitioners relative to when an endoscopy is indicated?
A Hundreds of times.
Q Did you say hundreds?
A Yes.
Q Do you have a standard lecture format on that area?
A More or less, but it's always adjusted to the audience.
Q All right. Do you have like outlines available from those lectures, or have any of them been reduced to video tape?
A None to video tape, I certainly have notes. I'm not sure I have a concise handout, however.
Q Would you check on that one as well?
MR. DJORDJEVIC: If we can find something.
A Yes.
Q Okay. And I assume that you lecture to

medical students on the subject of when an endoscopy is indicated, as well?

A Yes.

Q The same question, if you can find anything that's been reduced to writing, any standard outlines or text on that area, I'd appreciate it.

A All right.

Q Doctor, I notice in your vitae that Mr. Djordjevic's office was kind enough to send me that you have a practice of speaking or at least presenting oral presentation of the posters of the American Society of Gastrointestinal Endoscopy?

MR. DJORDJEVIC: Michael, just a moment, the court reporter had a bit of a problem in understanding the first part of your question. So if you could repeat it, I think it would be helpful to the court reporter.

MR. BECKER: I'd be happy to.

Q Doctor, I have a copy of your vitae, and it

appears on there that you have given multiple oral presentations and actual poster presentations at the American Society of Gastrointestinal Endoscopy --

A Yes.

Q -- is that accurate?

A Yes.

Q Do any of those have to do with when an endoscopy is indicated?

A I don't believe so.

Q Okay. Doctor, I'm not sure how current this vitae is that I have at hand, and there's no date on it. I can tell you that the last bib. article is No. 73 entitled, "Prolonged Ambulatory pH Monitoring." Is that the most current vitae available?

MR. DJORDJEVIC: I think we have one with 78 publications now, Mike.

MR. BECKER: Okay.

Q Well, I just want to call your attention, Doctor, to the last five publications.

A Yes.

Q Do you have that at hand?

A Now, are you talking about the last five abstracts or the last five full publications? Those are separate.

Q Let me just cut it short, Doctor. Let me ask this another way. I've got four articles that deal with the subject of screening and use of gastrointestinal endoscopy, one from 1985, "Annals of Internal Medicine"; one of '79 from "Gastrointernology"; one of '82 "Gastrointestinal Endoscopy"; and one from "Annals of Internal Medicine," 1976. Have you written anything other than those regarding that subject matter? Have you written any other journal articles that I'm not aware of?

A We always have journal articles in various stages of preparation and publication that have not reached full publication to the public; and so there's another -- there are some more in progress, if I've answered your question.

Q All right. And when do you anticipate that they might be published?

A They're in various stages of publication pending versus not yet even submitted for publication.

Q Okay. Well, do you have any problem in turning those over to Mr. Djordjevic so I can take a look at them if they're relevant to the subject matter here today?

MR. DJORDJEVIC: Well, Mike, I think it's inappropriate to turn over unpublished reports for a number of proprietary reasons.

MR. BECKER: Well, I gathered that, but I thought I'd ask anyway.

MR. DJORDJEVIC: Yes, we'll object to that.

Q Okay. Doctor, let's move on, then. Do you consider yourself an expert in the field of esophageal cancer?

A In the diagnosis of it, yes.

Q What about in the treatment of it?

A Moderately to the treatment, but certainly I'm not a chemotherapist, I'm not a surgeon to resect, so the treatment is relative.

Q Have you met Dr. Rosenberg of Detroit?
A I don't believe so.
Q Have you heard of Dr. Rosenberg of Detroit?
A Not prior to this deposition.
Q Okay. So you don't know whether or not he's written extensively in the field of esophageal cancer?
A I do not.
Q And you don't know whether or not he's a nationally recognized authority in the field of esophageal cancer?
A I do not. I do know that he's not an authority in the diagnosis of cancer, because I'm very familiar with that literature.
Q Tell me what you reviewed in preparation for this deposition, Doctor?
A Just did my daily work that I do every day and --
Q Well, specifically in this case, did you look at any charts, did you look at any depos, any reports, that kind of thing?
A Yes.
MR. DJORDJEVIC: I'm handing

him the materials, Mike.

A Yes, I've reviewed the office chart of Dr. Asuncion; the Cleveland Clinic records; the, I guess they're multiple parts of the Cleveland Clinic record; and a deposition from Dr. Asuncion.

Q Have you looked at Dr. Rosenberg's deposition?

A I don't believe I've had access to that.

MR. DJORDJEVIC: No, he hasn't, Michael.

Q And have you looked at Dr. Rosenberg's report?

A I've read a one to two-page report from him, yes.

Q And I believe I have a report from a Dr. Lanza in Texas. Have you looked at that report?

A I just briefly looked at that this morning, yes.

Q Do you know Dr. Lanza?

A I know him, yes. Yes, I know him.

Q Okay. Doctor, on this case, before you

reached your final opinion, was there any additional information you needed after looking at that from the attending Dr. Asuncion where you made contact with Mr. Djordjevic and said, for example, I need to know this or I need to know that? Was there any additional information you needed prior to writing your report directly from the doctor that was not contained in the records?

A No, I sought no additional information.

Q Okay. Doctor, can you explain to me what the difference is between an EGD and an endoscopy, or are they one and the same?

A Well, an EGD means an endoscopy of the esophagus, G stomach, D duodenum; and endoscopy could refer to a telescopic exam of virtually any orifice, mouth, colon, etc. The implication is they're the same for this case.

Q Okay. What are the risk factors for Barrett's esophagus?

A Well, the only real risk factor -- the major

risk factor is gastroesophageal reflux of prolonged duration; and that's really the only way Barrett's comes along.

Q Do you agree that many times Barrett's esophagus is a precursor to adenocarcinoma of the esophagus?

A Occasionally it is, yes.

Q Can you give me a real brief idea of what your working week is like, Doctor? I'm particularly interested in your actual hands-on patient contact. I read this part of your vitae on patient care service, but it's not real clear to me; so I'm just interested in how often you have hands-on care contact with patients.

A Nearly all of my daily work is hands-on with patients in the sense that an average day would be a teaching conference from 7 a.m. to 8 a.m. 8 a.m. to 8:15 would be a patient planning conference where we go over the cases of the day; then the rest of the day, virtually all day long, involves direct office visits or telescoping of patients or

phone calls to patients. And then almost all our research is centered around taking care of the patients, and then most of our writing is done in the evening. Perhaps one day every other week, on the average, I'm out of the office giving a speech at some national or other organization.

Q Doctor, how is it that you're familiar with the standard of care of an ~~insurance~~ internist when treating a patient with a history of gastroesophageal reflux?

A Well, first, I am an internist, I'm board certified in internal medicine; and then a high percent of my patients come from internists having previously been evaluated by them, I talk with them almost daily about some aspect of GI patient care.

Q These internists that refer you cases, are they within the university structure, are they within the community or both?

A Approximately 50/50 each.

Q Doctor, I'm gathering from your report that if an internist treats a patient that has a

history of gastroesophageal reflux with Pepcid, and as long as there's good control an endoscopy is not indicated; is that correct?

A In general that is correct if there are not additional symptoms of dysphagia, bleeding, weight loss or some unusual chest pain, as long as there's not something extra going on.

Q Well, I guess whether or not someone is treating --

MR. DJORDJEVIC: Michael, the doctor's beeper just went off.

THE WITNESS: One second.

(A discussion was held off the record.)

Q Doctor, that general statement about treating people as long as they're in good control with Pepcid with a history of gastroesophageal reflux, that applies whether someone's on Pepcid for six weeks, six months, or six years; is that accurate?

A Six weeks, six months, yes; six years, probably a little long. After maybe a couple

years, what I usually do is evaluate the patient initially with barium or scoping, either being good, and then probably reevaluate in two or three years even if they're under good control.

Q Well, you indicated when a patient becomes refractory to management via Pepcid that endoscopy is indicated; and I guess that's where the health comes here on this case is what do you mean by refractory, and can you give me some examples?

A Refractory meaning that one of these new complications or new features, swallowing trouble, bleeding, weight loss, one of those new things occurs while on treatment, or while taking treatment the patient still has bad pain or bad routine daily symptoms.

Q Okay. So if the patient still has symptoms even though he's taking Pepcid, then it would be refractory in your mind?

A If the patient has bad symptoms.

Q Well, that's kind of vague. How do you distinguish as the treating physician what's

good, bad, fair and --

MR. DJORDJEVIC: Other than by clinical judgment, Mike?

Q Yes, I mean, can you help me appreciate that any better, Doctor?

A Well, usually it's a matter of the patient has a certain amount of discomfort, we give a medication, and we ask the patient, are you better, better enough that you're happy and generally satisfied, or are you not better, not better enough that we need to do more. And it's a combination decision between the patient and the doctor, and usually it's pretty obvious that the person either is or isn't better.

Q Let me just give you a hypothetical. If someone has severe gastroesophageal reflux problems, took Pepcid and their symptoms went from severe to moderate, would you say that that was still a refractory scenario which would require an endoscopy?

A Well, moderate is relative. If moderate was a happy medium, then probably I'd be happy.

If moderate the patient was still clearly dissatisfied and complaining a lot, then I would not be satisfied either.

Q Doctor, you ultimately find in this case that there was no substandard care by Dr. Asuncion based on your assumptions and your inferences that there was good control of Mr. Weekley's symptoms; is that fair?

MR. DJORDJEVIC: Well, we contend the chart maintains that, Michael, but I'm not going to argue with you over the phone. Doctor, you can answer the question.

A Yes, my review of the chart would -- I extract that the patient's symptoms were under control.

Q Can you be more specific? What are you referring to on the chart that causes you to have that impression?

A Just that with follow-up visits, some of the visits say, "stomach doing fine," implying that, yes, indeed symptoms were under control; and many of the visits focused on blood pressure and other things implying that

if the patient was complaining about the stomach, the stomach would have been mentioned again.

Q Okay. So you're making an assumption that the absence of anything implies that there was no complaint?

MR. DJORDJEVIC: Well, again, the doctor knows that on some occasions there are specific notations, "stomach doing fine" or "ulcer better"; but in addition to that, the doctor is making some extrapolation from the chart. Is that fair, Doctor?

THE WITNESS: That's correct.

Q Doctor, did you look at Dr. Asuncion's deposition?

A Yes, I did.

Q So the difference between refractory and nonrefractory or good and bad control is if the patient was satisfied with the result?

A If the patient is satisfied and the doctor is satisfied.

Q If you were treating a patient with Pepcid and you learned that while you were treating them with Pepcid they were still taking additional drugs like Maalox and Tagamet and other drugs like that, would that concern you?

A Most of the time when we put people on Pepcid or one of those type drugs, we ask them to take additional Mylanta or Maalox for any additional pain. And if they're taking an average amount, that's okay, that's still under good control, yes.

Q Well, to me, if you're still having pain and still on Pepcid, that means that you don't have good control; is that an unfair conclusion or --

A We would obviously like the patient to have 100 percent pain relief from the medication, that usually does not occur or often does not occur. Oftentimes some additional antacid is required, and that would still qualify for good control.

Q Doctor, if Mr. Weekly had persistent

esophagitis during the approximate two-and-a-half years while he was under Dr. Asuncion's care and while she prescribed Pepcid during most of that period, don't you feel that an endoscopy somewhere along the line would have been indicated?

MR. DJORDJEVIC: And you're assuming that Mr. Weekley makes Dr. Asuncion aware of that, I take it?

A You've said he has esophagitis continuously for two-and-a-half years, we have no proof of that.

Q Doctor, didn't you tell me that you looked at Dr. Asuncion's deposition?

A Yes.

Q Did you note on around Page 56 where she admitted that in essence that he had persistent esophagitis to some type and degree throughout that whole course?

A She's using the term esophagitis there to mean gastroesophageal reflux. Without actually looking in the esophagus or having a biopsy or something, one doesn't know whether

it's actually esophagitis or just acid irritation, symptoms without esophagitis; there's no way to tell. So we certainly agree he had reflux during the whole time, yes.

Q Persistent?

A Yes, it lasted, yes.

Q And you're saying that even though it persisted notwithstanding Pepcid, throughout the course of that two-and-a-half years you feel that an endoscopy was not indicated?

A An endoscopy was not necessary for the degree of symptoms he was having.

Q Doctor, I want to talk a little bit about the responsibility of a physician to elicit information from the patient as to how they are progressing while under the care and treatment of them. Do you agree that the physician has a responsibility to elicit or ask the patient about the present signs and symptoms a patient is having if the doctor is giving drug therapy?

A In general, yes.

Q And if the physician failed to elicit information along those lines, would you agree with me that would be substandard care?

MR. DJORDJEVIC: I'm going to object to the general nature of the question, Mike. You know, I think the doctor needs more information in terms of where the drug therapy is, how long the doctor's been seeing the patient, so on and so forth. You're asking him a question in the vacuum that I think can't fairly be addressed by this physician.

MR. BECKER: The question's before you, Doctor.

MR. DJORDJEVIC: Doctor, can you answer that?

A In general, yes, one should quiz the patient about diseases for which one is giving a drug. Now, in a patient with multiple problems, five or six problems, such as this patient, to quiz about each problem each visit is not necessary; but over the year, one should quiz, yes, on certain visits.

Q Doctor, do you agree with me that it would be imprudent and even dangerous sometimes to assume that a sign or symptom has been eliminated if the patient didn't specifically complain about it?

A At times, yes, that would be possible.

Q And that would be particularly so, Doctor, in a patient who is not known to be a complainer, correct?

A A patient who complains less may voice their complaints less, yes.

Q And a patient that has no medical background, correct?

A In general, yes.

Q And a patient that has a less than a high school graduate education?

A Education may not have anything to do with native intelligence, so I'm not sure about that.

Q Okay. Do you agree, Doctor, that the patient's specific reaction to drug therapy should be charted in the physician's record particularly if she's going to continue the

prescribed medication on a chronic or long-term basis?

MR. DJORDJEVIC: You mean should she say improved or stomach doing fine, like she did in this case?

A Yes, one would expect some notes over the year of how a given drug or symptoms were progressing, as was noted in this case.

Q Well, you say over the year, you mean each time that she prescribes it there should be some indication along those lines, shouldn't there?

A No, absolutely not.

Q Doctor, if the physician who prescribed a course of drug treatment failed to specifically ask the patient whether or not the medication she was given was eliminating or merely subsiding the symptoms, would that be substandard care?

A Sometime during the course of care that question should be raised, yes; that question need not be raised at each visit.

Q I'm going to refer you now, Doctor, to the

second page of your report dated March 30th, 1992; and before I speak directly about that report, is that the only report you've generated for this case?

A Yes.

Q And have you had a chance to review that report recently?

A Yes.

Q Do you want to stand on that report or make any corrections or additions?

A In general, I agree with it. As I reviewed it last night, I didn't find anything I disagreed.

Q Okay. Turning to Page 2, Doctor, last paragraph on Page 2, we talk about Dr. Rosenberg's statement being a, quote, hindsight call, end of quote. What do you mean by that?

A That means he's saying had something been done in this -- in 1987, he's saying, that the outcome would be probably different and that a cancer would have been found at a, he implied, curable stage. Cancers grow at

variable rates, and that cancer may have popped up and metastasized in six months. We just don't know how fast his cancer grew, it's impossible to tell.

Q Maybe I'm trying to read something into that hindsight call that really isn't there. I mean, were you offended by the way that Dr. Rosenberg opined along those lines?

A Not offended, just I -- he's drawing a firm conclusion in a very vague area that is inappropriate, I believe.

Q You state that it's impossible to determine when the cancer started or when it became incurable. Do you have an opinion more likely than not, Doctor, that's not certainty, it's more likely than not probability in Ohio, whether the cancer was present in March or April of '87?

A Again, it's impossible to say; but the fact that the X-ray showed no sign of cancer, I would say it -- well, you just can't say. Some of these cancers are metastatic when they're just tiny, tiny, and others -- well,

you just can't say.

Q When do you feel esophageal cancer is curable?

MR. DJORDJEVIC: If at all.

A Well, it's curable when it's at its smallest size.

Q What stage would that be or stages?

A Well, it depends whose staging grades you're using, it's when it's confined to the esophageal wall and not spread beyond the wall.

Q What do you base that on, Doctor?

A Just surgery data or laser data where patients have been treated with very early cancer and then they've lived a long time, so presumably they're cured. Unfortunately, we don't find patients like that very often.

Q Doctor, you don't feel that a cancer expert can state in terms of probability that cancer a few years earlier would have been in an earlier in situ stage?

MR. DJORDJEVIC: Well, that's another question. What do you mean an

earlier in situ stage? Dr. Rosenberg doesn't even say that, he says it's stage 1 or in situ.

Q Okay, stage 1 or in situ. Do you feel that a cancer expert can state that in terms of probability here?

But not treatment!

A No, you can't. I'm a cancer expert in the diagnosis of cancer, and people who -- cancer treating experts have no extra information that I don't have; and one just can't tell.

Q You state that five years survival rate of patients with gastroesophageal cancers are less than 20 percent. What do you base that on, Doctor?

A That's mostly from surgical series where cancers in this area are removed, and then the patients are followed to see if they survive.

Q Can you cite me those theories?

A I'll have to get them out of a textbook for you, but I don't have them. That's just standard textbook knowledge, but I don't have that page in front of me.

Q Have you authored or co-authored any articles in any of the gastrointernology textbooks?
A Several textbooks have my chapters in, yes.
Q Do any of them have to do with the subject matter of endoscopy?
A Almost all.
Q I don't know how we missed that. Let's go back to your vitae a moment, Doctor.
MR. DJORDJEVIC: We're looking for it right now, Mike.
A Okay, got it.
Q Which of these chapters in books, Doctor? Apparently you have contributed to seven textbooks; is that accurate?
A Mine has eight here in front of it, and we have some more in progress.
Q What is the eighth one, Doctor?
A Eighth one has to do with cancers of the -- excuse me, of diseases of the anus and rectum, a German publication from last year.
Q Okay. Do any of these articles in these seminary textbooks deal with the subject matter of gastroesophageal reflux and when

endoscopy is indicated?

A None of the book chapters have to do with that. Several of the articles have to do with gastroesophageal reflux detection or gastroesophageal reflux treatment, none have specifically to do with indications for endoscopy.

Q Okay. I just want to make sure, then, going back to your articles, now, Doctor, that I have all of them. I think we went through this once before, to make you understand where I'm coming from, I want to make sure that I have any new ones.

MR. DJORDJEVIC: We'll give you a copy of the latest CV, Mike, and you can confirm it for yourself.

Q Doctor, I wonder if you could quickly go through the publications and just give me the number that is relevant to gastroesophageal reflux?

MR. DJORDJEVIC: You want to go through both the abstracts and the peer review journal articles, Mike?

MR. BECKER: Yes.

THE WITNESS: We'll go through all 150 of them, if you'd like.

MR. BECKER: I tell you what, Doctor, you don't have to do it on the phone to me, you can just give that information to Mr. Djordjevic, and I trust him.

MR. DJORDJEVIC: Okay.

THE WITNESS: All right, thank you.

MR. BECKER: And I trust you, too, Doctor, so we'll save time on the phone.

MR. DJORDJEVIC: Very good.

THE WITNESS: Thank you.

MR. BECKER: I forgot where I was now.

MR. DJORDJEVIC: I think you were asking about book chapters, and before that you were talking about curability for stage of cancer.

Q Doctor, do you recognize as a mode of

treatment for esophageal cancer has changed in approximately 1987 and the new mode of treatment with multi-modality approach has been more successful?

A Over the last five plus years, yes, the multi-modality treatment has become more popular.

Q Doctor, do you agree that if esophageal cancer is detected at an earlier stage before dysphagia is evident that the chances are improved of attaining a five-year survival?

MR. DJORDJEVIC: Well, Michael, again, I'd like to caution the doctor, and I'd like a more specific question in terms you're saying at an earlier stage and improved, I mean, that's so vague.

MR. BECKER: Let me read the question again, Doctor, and for the benefit of your counsel, I'm not sure he understood it. Let me read it again.

MR. DJORDJEVIC: Okay.

Q Do you agree that if esophageal cancer is detected in an early stage and before

dysphagia is evident that the chances are improved to obtain a five-year survival?

A Well, we certainly hope so; but, actually, at the present time, we unfortunately don't have any proof of that.

Q Doctor, what do you feel in retrospect was actually causing Mr. Weekley's symptoms of this gastroesophageal reflux back in '87 and '88?

MR. DJORDJEVIC: Well, are you talking about the symptoms, or are you talking about the esophageal reflux, Mike?

MR. BECKER: I use that synonymously, that's what I mean.

MR. DJORDJEVIC: I don't think they are synonymous.

Q Well, gastroesophageal reflux just means you have food or burning acids coming up into your throat, doesn't it, Doctor?

A One may have those symptoms from reflux, yes.

Q What other symptoms may you have?

A Oh, many others, cough, hiccups, ear pain.

Q Let me be more specific to Mr. Weekley. What

symptoms that he complained about, to your knowledge, do you feel -- strike that. What do you feel was responsible for Mr. Weekley's symptoms back in '87 or '88?

A His gastroesophageal reflux.

Q What do you feel that was secondary to?

A To an incompetent valve between the esophagus and the stomach which permitted the reflux to occur.

Q What is the relationship between incompetent valve, the sphincter valve and something called the small sliding hiatal hernia?

A The hernia probably helps to make the valve incompetent.

Q What's the surgical procedure to repair the incompetent valve, what's that called, Doctor, repair of hiatal hernia?

A Yes.

Q The Nissen procedure?

A The Nissen's fundoplication is the most common hiatal hernia repair operation.

Q And that was developed back in the '70s?

A I believe that's correct.

Q Was that, in your opinion, recommended for Mr. Weekley?
A No.
Q When do you feel that's indicated?
A When symptoms are refractory to medical therapy or some major complication is occurring that's refractory to medical therapy.
Q Can cancer itself cause these symptoms or the appearance of esophageal reflux?
A Essentially never.
Q Can cancer cause this burning acid-like sensation in your throat?
A No.
Q Dr. Rosenberg implied that when one is treating a patient with a history of gastroesophageal reflux and treating that patient with Pepcid and after a six-week course or so you can't totally eliminate the symptoms, then one is obliged to be sure that those symptoms are not being caused by cancer. Do you agree with that philosophy?
A That's an overstatement. As long as symptoms

are reasonably controlled during that six-week interval or the follow-up interval, then scoping is not mandatory.

Q Doctor, looking back retrospectively again, had Mr. Weekley been subjected to an endoscopy in mid-1987 do you have an opinion more likely than not whether Barrett's esophagus and/or adenocarcinoma would have been discovered at that time?

A Probably Barrett's esophagus would have been seen, but the cancer is virtually impossible to say.

Q Let's talk a little bit about Barrett's esophagus. You've not written specifically on Barrett's, have you? I guess you did in the familial studies?

A Right, we published an article on that with a family that many members had it.

Q Right. I've got that in my hand here. Talking about Barrett's esophagus a minute, had that been diagnosed, you would agree with me that the standard of care would have required at least annual surveillance via

endoscopy with that condition, correct?
A No, the one suggested appropriate management for Barrett's esophagus is annual endoscopy, but that's not the all accepted standard of care.
Q Well, that's what you've written, haven't you, Doctor?
A Well, that's one accepted standard, but that's not the only standard.
Q All right, what's the other one, Doctor?
A The other standard is to say if you've diagnosed Barrett's and biopsy it, let's say, in '87, and the biopsies are perfectly okay, then to not repeat the scoping for two to five years is the other standard.
Q Okay. You're saying you can do one or the other?
A There's more than one correct standard, yes.
Q When you reviewed cases on behalf of the patient, on behalf of the plaintiff, how many times would that be, approximately 45 or 50 cases you've looked at?
A That's probably a little too many, four or

five, three or four a year now, and ten years ago I probably only did one every year or two.

Q Okay. So maybe you've looked at a total of 25 cases?

A Twenty, maybe.

Q Out of the 20 cases, you say half of those have been for plaintiff?

A Approximately.

Q And how many of those did you review that you actually found negligent to substandard care?

A Probably a couple, I'd have to think back hard exactly which cases and what was done; but I'd say a couple.

Q A couple out of ten?

A Probably a couple out of maybe eight.

Q Two out of eight? And what was the subject matter that you found substandard care on?

MR. DJORDJEVIC: If you can recall, Doctor.

A Yes, I'm not -- a recent case was a colon case where a colonoscopy was done, and eventually a perforation occurred; and I

thought that the colonoscopy was done excessively aggressively and recommended -- I'm not sure I'm at liberty to say what I've recommended, because it hasn't gone to court yet.

MR. DJORDJEVIC: Yes, he found for the plaintiff, how's that, Mike?

MR. BECKER: That's fine.

Q Doctor, assuming that Mr. Weekley's Barrett's esophagus would have been diagnosed back in mid-1987, and assume that the attending physician chose the route of regular surveillance, at least annually if not every six months, would you agree with me that it is more likely than not that his adenocarcinoma would have been discovered in an earlier stage than when it was actually discovered?

A That may have improved the staging, but we unfortunately don't have the proof yet that that's the case. That's why we don't --

Q Tell me why you think it may have improved?

MR. DJORDJEVIC: Well, he

was going to do that until you cut him off.

MR. BECKER: I didn't mean to cut you off, Doctor.

A Because more than half the cancers found in Barrett's esophagus are already incurable right when they're first found, so --

Q That's because dysphagia -- strike that. Isn't dysphagia already present, then, too?

A Part of the time.

Q So isn't it most of the time, Doctor?

A Probably in the majority, but certainly not all.

Q Okay. I didn't mean to cut you off, you want to continue with your explanation?

A Well, that was just it, we covered it.

Q I didn't follow you. I think you gave me a maybe that had the scope been done, Barrett's esophagus more likely than not would have been discovered. And had the physician chose the course of surveillance endoscopy for six months or every six months or every year whether or not the cancer would have been detected at an earlier stage than what it was

detected at, and you gave me a maybe on that, and I wanted to know why you felt that way?

A Well, just like we said, because many of these cancers when first detected are already --

Q Okay, but --

MR. DJORDJEVIC: Mike, let him finish, I mean, you keep asking the question, and he tries to answer it and you cut him off.

Q Go ahead, Doctor.

A Many times when cancer is detected it's already spread. Even though the cancer's very small, it's already spread outside the wall. We had a case like that just here in the last couple of years, very small cancer already spread to the mediastinum and uncurable.

Q Doctor, do you have an opinion if Mr. Weekley's cancer would have been diagnosed at an earlier stage whether or not it would have improved his chances of survival at least five years?

MR. DJORDJEVIC: I'm going to object to that question, again, for the same reasons, and why don't you talk about whether it's diagnosed in situ or at stage 1 and define stage 1 as the doctor did as not penetrating the mucosa of the esophagus.

MR. BECKER: Okay.

A Well, for all cancers, whether of the esophagus or anywhere, the earlier -- if one catches them very early the chances of cure is better, that's a given.

Q Doctor, I want to go back to the chart, if you have that handy?

A Yes.

MR. BECKER: Dr. Asuncion's records.

MR. DJORDJEVIC: Right.

A Yes.

Q I just want to know, maybe I'm overlooking something here, how many times did doctor describe a good control, that you deem good control? I see evidence of his ulcer scems, S-C-E-M-S, to be doing better on 2-29-88, I

see that; and I don't see any other indication of assessment of condition the balance of the year.

A On 3-87, she appropriately says, "Still complaining of gastric acid in throat despite Tagamet," therefore she makes the next move to a stronger medicine or full-dose medication.

Q Do you believe Pepcid is stronger than Tagamet?

A In full dose, I assume he was not taking a full dose of Tagamet, I'm assuming, I don't absolutely know that; because he was borrowing at that point from his wife, I believe, and therefore I assume he was not taking a full dose.

Q Okay.

A And let me find the other cites.

MR. DJORDJEVIC: All right, 7-22-87, "His stomach is doing fine."

A Yes, and --

Q Hold on, Doctor, let me look at that one a minute.

MR. DJORDJEVIC: Sure.

MR. BECKER: Go ahead.

MR. DJORDJEVIC: Did you find it, Mike?

A And 2-88, "Ulcer seems to be doing better," and it's very appropriate to call esophagitis an ulcer, they're interchangable, because esophagitis involves erosions or ulcers usually.

Q I thought the word ulcer connotes a lesion within the stomach cavity?

A Oh, no, can be anywhere from the tongue to the anus, anywhere along the GI tract.

Q Okay.

A And actually even out of the GI tract.

Q Doctor, are you aware of what the PDR says relative to the description of Pepcid?

MR. DJORDJEVIC: Well, I'm going to object, again, unless the doctor acknowledges the PDR to be authoritative, you can't cross-examine him with that.

MR. BECKER: Well, I can ask him questions, but you can object to the way

they're phrased.

MR. DJORDJEVIC: I'm going to object to them all, Mike; but it's an academic exercise at this point, we're not before a jury. If you want to go through it, let's do it.

Q Doctor, I just want to know if you feel that the PDR says that Pepcid should be prescribed for chronic long-term use such as two years or two-and-a-half years?

A No, the PDR does not say that one should do that.

Q If the PDR doesn't say that, what authority do you have that's appropriate to treat someone with Pepcid for such a long term?

A Numerous articles in the current literature on long-term treatment of gastroesophageal reflux and numerous authorities who have done that research who stand up at meetings and say, the only way to control long-term reflux is with long-term medication or surgery.

MR. BECKER: I think I'm done here, one minute.

MR. DJORDJEVIC: Okay.

Q Doctor, have you looked at Mrs. Weekley's deposition?

A No, I have not.

Q Okay, one second. Mrs. Weekley said under oath that with all the medication he was on, including the Maalox, he was slightly better, but he still had the heartburn and it was persistent. Now, Doctor, would that fall in the category of refractory?

MR. DJORDJEVIC: I think that's a simplification of her testimony. I think it requires the doctor to make two assumptions that that testimony is true and that that was something that the patient made Dr. Asuncion aware of. But based on those assumptions, if you can answer the question, Doctor, go ahead.

A If indeed medication is given and the patient is not better, yes, then the patient is not responding.

Q Not significantly better. Do you agree with the report of Dr. Lanza?

A If a patient takes standard medications and does not respond, then further studies are needed, yes, I agree if that is what happens.

Q Well, let's take a look at Dr. Lanza's report, since you have that at hand, and tell me if you disagree with it then?

MR. DJORDJEVIC: He does not have it in hand, Mike, but I will provide him with a copy. And I would suggest that the only thing he's going to disagree with is probably the assumptions that you asked Dr. Lanza to make.

A Yes, you say -- well, he says, "You have asked me to assume that there was no significant response to the long-term use of Pepcid in this case," and as I read the chart, that is not the case. Now, if in another case where indeed a patient does not respond, then further diagnostic work would be in order.

Q Assuming that assumption to be true, do you agree with Dr. Lanza's statement?

A In general, but not in this case.

Q Thank you, Doctor. Doctor, have we covered all your opinions here today?
A Well, I have many other opinions about lots of things that we haven't talked about.
MR. DJORDJEVIC: We haven't talked about the upcoming election, I think the doctor has some opinions on that, but I think we've covered them for purposes of this case.
Q Have we covered all your opinions relative to your medical legal review on this case?
A I believe so.
Q Doctor, in the event you develop new opinions or change any of those opinions, I trust you would kindly advise Mr. Djordjevic so he can kindly advise me?
MR. DJORDJEVIC: You know I will, Michael.
THE WITNESS: Yes.
Q Okay, Doctor, thank you very much. We've taken up about an hour of your time, what do you charge per hour in depositions, Doctor?
A For this I hadn't decided, let me decide.

Q If you haven't decided, that's fine.

MR. BECKER: That's all I have, and at the moment this deposition will not be ordered. Maybe you can explain waiver or he'll read it, whatever, but this deposition will not be ordered.

MR. DJORDJEVIC: All right. Thank you, Michael, and we'll see you next week.

AND FURTHER THE DEPONENT SAITH NOT.

(The reading, examination and signature by the witness are hereby waived by the witness and by the parties.)

I do further certify that I am a disinterested person in this cause of action; that I am not a relative or attorney of any of the parties, or otherwise interested in the event of this cause of action, and am not in the employ of the attorneys for any of the parties.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal this _____ day of _____, 1993.

_____

Dana S. Miller, RPR,

Notary Public

My Commission Expires:

January 17, 1994