IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

BONNIE WEISS, Administratrix of the Estate of Edith James,	)	
Plaintiff,	)	
vs.	)	Case No. 326275
HENRY W. EISENBERG, M.D., et al.,	)	
Defendants.	)	

VIDEOTAPED DEPOSITION OF KEVIN W. OLDEN, M.D.

Scottsdale, Arizona
Thursday, September 10, 1998
7:00 p.m.

ORIGINAL

REPORTED BY: Carole A. Yelton

NICHOLS CERTIFIED COURT REPORTERS
602/991-7666 • Fax 602/998-7228 • 800/227-0577
8300 North Hayden Road, Suite 207 • Scottsdale, Arizona 85258
110 West "C" Street, Suite 1300 • San Diego, California 92101
7825 Fay Avenue, Suite 200 • LaJolla, California 92037
1801 Avenue of the Stars, Suite 640 • Los Angeles, California 90067

APPEARANCES:

MARK W. RUF, ESQUIRE
Hoyt Block Suite 300
700 West St. Clair Avenue
Cleveland, Ohio 44113-1230
Appearing on Behalf of Plaintiff

REMINGER & REMINGER
(BY: GARY H. GOLWASSER, ESQUIRE)
The 113 St. Clair Building
Cleveland, Ohio 44114-1273
Appearing Telephonically on Behalf of
Defendant Henry W. Eisenberg, M.D.

ALSO PRESENT:

Ms. Naomi Valadez, Videographer

I N D E X KEVIN W. OLDEN, M.D.

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E X H I B I T S

(Exhibits retained by Mr. Ruf.)

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The deposition of KEVIN W. OLDEN, M.D., a Witness herein, taken pursuant to Notice of Videotape Deposition, before Carole A. Yelton, court reporter, at Scottsdale Marriott Suites, 7325 East Third Avenue, Scottsdale, Arizona, on Thursday, September 10, 1998, commencing at or about 7:00 p.m. in the evening.

* * *

Scottsdale, Arizona

Thursday, September 10, 1998

7:24 p.m

* * *

PROCEEDINGS

MR. RUF: This is Mark Ruf. I am counsel for the plaintiff along with David Malik. It is September 11 [sic], 1998.

First, I would like to put on the record that there has been a stipulation between counsel that Plaintiff's Exhibits 1 and 2 are admissible into evidence.

Is that correct, Mr. Golwasser?

MR. GOLWASSER: That is correct.

MR. RUF: I would also like to put on the record that this deposition is taking place by agreement of counsel; is that correct?

MR. GOLWASSER: That is correct.

MR. RUF: And that there is no objection to any formalities or the manner in which this deposition is being taken; is that correct?

MR. GOLWASSER: I waive all formalities. Obviously, I reserve my right to object to any questions which I deem inappropriate.

MR. RUF: Okay. Let's proceed with the deposition then.

Would you swear in the witness, please.

THE VIDEOGRAPHER: This is the videotape deposition of Dr. Kevin Olden, taken by the plaintiff in the matter of Weiss versus Eisenberg, Case No. 326275, held at the Marriott Suites, 7325 East Third Avenue in Scottsdale, Arizona, on September 10, 1998, at the time indicated on the video screen of 7:26 p.m.

The court reporter is Carole Yelton from the firm of A.A. Nichols, Inc., Phoenix, Arizona.

The legal video specialist is Naomi Valadez in association with A.A. Nichols, Inc.

Counsel will now please introduce themselves.

MR. RUF: This is Mark Ruf. I am co-counsel for the plaintiff, along with Dave Malik.

Mr. Golwasser, could you please introduce yourself? Gary, are you there?

Let's go off the record.

THE VIDEOGRAPHER: We will go off the record at 7:27 p.m.

(Interruption of the proceedings.)

THE VIDEOGRAPHER: We're back on the record at 7:30 p.m.

MR. GOLWASSER: All right. This is Gary Golwasser from Cleveland, Ohio, representing the defendant Dr. Eisenberg.

MR. RUF: Could you please swear in the witness?

KEVIN W. OLDEN, M.D.,

a Witness herein, after having been first duly sworn, testified as follows:

EXAMINATION

BY MR. RUF:

Q. Could you please introduce yourself to the jury?

A. My name is Kevin Olden. The last name is spelled O-l-d-e-n.

Q. What is your profession?

A. I'm a physician.

Q. How long have you been a physician?

A. I graduated from medical school in 1976, and I've been licensed since 1977.

Q. What areas of medicine are you trained in?

A. I completed training in internal medicine and the subspecialty of gastroenterology and internal medicine. I also trained in psychiatry and did a fellowship in addiction psychiatry.

Q. What is gastroenterology?

A. It's the study and treatment of diseases of the gastrointestinal tract and liver.

Q. Is more than 50 percent of your professional time spent in the active clinical practice of medicine?

A. Yes, it is.

Q. Where are we now?

A. We are at the Marriott in Oldtown, in Phoenix, Arizona

Q. Is that where you're currently practicing medicine?

A. That's correct.

Q. What is the name of the hospital

that you're currently practicing at?

A. I recently joined the staff of Mayo Clinic Arizona, here in Scottsdale.

Q. What hospitals were you on staff at prior to joining the Mayo Clinic?

A. Prior to coming to Arizona, I was in San Francisco, and I was on the staff of St. Mary's Medical Center in San Francisco, California Pacific Medical Center in San Francisco, University of California Hospital and the Veterans Administration Hospital in San Francisco.

And I also had a psychiatric practice, which was at Sequoia Hospital which was south of San Francisco.

Q. Which is a priority for you, patient scheduling and meeting your patient obligations or testifying as an expert in a legal case?

A. Well, obviously, patient demands come first, which is why we're doing this in the evening.

Q. Does your patient schedule permit you to be present for the trial in Cleveland, Ohio?

A. Unfortunately, it does not.

Q. Could you tell us about your

educational background?

A. I received my M.D. in 1976 from the State University of New York, College of Medicine, New York City; completed a medical -- straight medical internship and two years of medical residency at the U.C.L.A.,San Fernando Valley, medical residency.

From there, I went to Boston and completed two years of psychiatric residency at the Massachusetts General Hospital.

After leaving Boston, I returned to Stanford, where I completed a two-year fellowship in substance abuse and gastroenterology at Stanford.

From 1983 to ‘88, I was in practice of internal medicine and psychiatry in San Francisco.

In 1988, I returned to complete my training in gastroenterology at the Martinez VA Medical Center in the Bay area.

Q. Have you also described your postgraduate training for us?

A. Yes.

Q. Could you tell us about your certification and licenses?

A. I’m licensed in California, licensed in Arizona. I am board certified in internal medicine,

in gastroenterology, in psychiatry, and in addiction psychiatry.

Q. What does it mean to be board certified?

A. Physicians, after medical school, complete a -- a period of training, from one to five years, sometimes it's longer, in an area of specialty in a teaching hospital setting.

After they obtain their license and upon completing that program with the recommendations of the director of training at their training program, they are then deemed board eligible, which means that they are intellectually and trainingwise and competencywise felt to be fit to take a specialty board examination, which then, once completed, leads to a -- a certificate of board certification in that particular specialty.

Q. Is board certification the highest level of certification a physician can receive in a specific area of medicine?

A. In terms of -- of certification, yes.

Q. Could you tell us about your experience as a physician?

A. My practice, for approximately the

last 10 years, has been devoted to gastroenterology, by and large. About 25 percent of the practice are pure general gastroenterology problems.

My research interest is the area of -- of stress-induced gastrointestinal disease. So about half of my gastroenterology practice is -- consists of that.

I also, for about the last 10 years, have maintained a psychiatric practice, but in 1998 that practice was phased out in preparation for my move.

Q. How long have you been practicing gastroenterology?

A. Well, full time, since 1988.

Q. Have you told us about all of your hospital appointments or do you have additional appointments we haven't discussed?

A. I think we've covered it.

Q. Could you tell us about your academic appointments?

A. I, until recently, was Associate Clinical Professor of Medicine and Psychiatry at the University of California, San Francisco School of Medicine.

I'm in the process of transferring

my appointment to the medical school here in Arizona.

Q. Could you tell us about your medical teaching experience?

A. Teaching is an interest of mine, and I've been actively involved in teaching, both gastroenterology fellows, residents in internal medicine and psychiatry residents for the last 10 years or so on a -- on a clinical part-time basis until recently.

Q. So you've been involved in training and teaching other physicians?

A. Correct.

Q. Could you tell us the professional societies or memberships that you have in gastroenterology?

A. I'm a member of the American Gastroenterological Association, member of the American College of Gastroenterology, a member of the American Society of Gastroenterological Endoscopy, and those are the major GI societies I belong to.

Q. Have you performed research in gastrology?

A. Yes.

Q. Have you been a reviewer to medical journals involving publications on gastroenterology?

A. I have.

Q. Have you published chapters in books on gastroenterology?

A. I have.

Q. Have you published medical articles and abstracts on gastroenterology?

A. I have.

Q. I'm handing you what's been marked as Plaintiff's Exhibit 4.

Could you please identify that document?

A. It's a copy of my curriculum vitae, which is dated 1/6/98, and is essentially correct except for my -- my recent appointment here in Arizona.

Q. Is Plaintiff's Exhibit 4 a true and accurate copy of your CV?

A. Yes, except for the recent move.

Q. Does the CV discuss your credentials in detail?

A. Yes.

Q. Have you served as an expert in medical malpractice cases before?

A. I have.

Q. Have you served as an expert --

expert for both the plaintiff patient and the defendant doctor?

A. I have.

Q. Have you given testimony on behalf of a plaintiff patient and a defendant doctor?

A. I have.

Q. Could you break down by percentage the amount of time that you've been an expert for the plaintiff patient as opposed to the defendant doctor?

A. It -- it runs about 50 over the last 10 or 12 years or so.

Q. Do you charge for being a medical expert?

A. Until recently, yes.

Q. What is your charge for being a medical expert in a case?

A. Until recently, it was -- it was $250 an hour for review of records and discussion with counsel and $450 an hour per deposition.

Q. Okay. How has that changed?

A. I'm currently on -- on -- on salary, and any -- any income from medical-legal work goes in to support my salary.

Q. Could you tell us the difference

between gastroenterology and general surgery?

A. Gastroenterology is the study and medical treatment of diseases of the liver and gastrointestinal tract, including endoscopic treatment, that is, the use of fiberoptic endoscopes to diagnose and treat.

Gastroenterology does not involve the -- the practice of surgery, that is, performing major surgery, opening up the abdominal cavity. That is the purview of the general surgeon.

Q. Are all general surgeons endoscopists or do they perform endoscopy?

A. No. Some surgeons certainly are, but most surgeons are not.

Q. Could you tell us a little bit more about endoscopy? What is endoscopy?

A. Endoscopy is a field which evolved with the invention of what we call the fiberoptic endoscopes.

And a fiberoptic endoscope is a flexible rubber tube, which is waterproof, and, because of advances in technology is able to have a fiberoptic television cable, a fiberoptic light source that goes through it, as well as small channels to suction water

out, to apply water to the colon, and also to insert small instruments, such as biopsy forceps and smears.

The major advantage of flexible fiberoptic endoscopy is that these instruments can twist and turn, which allows large segments of the gastrointestinal tract to be intubated and approached for both diagnostic and therapeutic purposes.

Q. Are you able to view the inside of the colon or the lumen of the colon with an endoscope?

A. Yes.

Q. What is the difference between sigmoidoscope and a colonoscope?

A. A flexible sigmoidoscope is, basically, a smaller version of the colonoscope. The flexible sigmoidoscope is usually 60 centimeters in length, and the colonoscope tends to be about three to four times that length.

Q. What is the total length of the colon?

A. It varies, but it -- between individuals, but it tends to be, plus or minus, about 9 to 12 feet.

Q. Are you able to view the entire length of the colon with the sigmoidoscope?

A. No.

Q. Are you able to view the entire length of the colon with a colonoscope?

A. Yes.

Q. Do you have anatomy pictures that you can use to explain to the jury the anatomy of the intestine?

A. We do have some pictures and diagrams here, yes.

Q. Okay. Cou d we hold those up and could you explain the anatomy of the colon? First of all, why don't we use Plaintiff's Exhibit 5.

Would you hold that up for the jury, please, Doctor? Why don't you hold on one second until she gets this in focus.

Okay. Doctor, please proceed.

A. If I may borrow a pen just to use as a pointer?

Q. Certainly, Doctor.

A. Thanks. This is, basically, an -- an open view of -- of the abdominal cavity just for the sake of demonstrating various anatomic organs in the colon and, down at the right lower part of the picture here, you can see the beginning of the colon, which goes

up through here.

And this is what is called the sigmoid colon, which, on the larger picture above, is this area here. That goes up to approximately here, and then, going further up on the left side of the abdomen, that is the descending colon. This is what is called a splenic flexure or the turn which occurs at the spleen.

The colon then shoots across; that's called a transverse colon, makes another turn over on the right side at the liver, which is called the hepatic flexure, and then it comes down on the right side.

This is the ascending colon, which, in turn, connects to the small bowel with the direction of flow being from here, from the small bowel, up across and down to the anus.

Q. Okay. Where is the anus located on that diagram?

A. Well, it's not completely visible because this is a view from the front. But, basically, it goes down through here, and it would be right on the other side of this -- this pubic bone here.

Q. Could you explain the lengths involved with each portion of the colon?

A. Well, the first thing to point out

is that the colon, as you can see by this large, yellow structure here, is held up. It has a supporting structure, which is called the mesentery, and it tends to float just like -- a rough analogy would be a hose being held up by a string dangling from a bar above it.

So when you go in with your scope to look, this colon will move up and down, will move back and forth, and the -- the distances tend to be somewhat approximate --

Q. Excuse me, Doctor. Do you have an illustration to show the different positions of the colon?

A. Yeah. We have another picture here, which may work better. Yeah, this is better.

Actually, I prefer to use this one if I may --

Q. Okay.

A. -- just 'cause it has a better view. This is a bigger view.

Is this okay?

THE VIDEOGRAPHER: (Nonverbal response.)

This is coming up from the anus. This is the -- this is the --

Q. BY MR. RUF: Excuse me, Doctor. Try

and hold it square with the camera.

A. How is that?

THE VIDEOGRAPHER: Up a little bit.

THE WITNESS: This is the anus. This is the rectum. Up here, you'll notice a very sharp turn, which usually occurs at about 19 centimeters, although certainly it can vary in various directions, and that's called the rectosigmoid junction.

And then the colon turns up this way to go into the sigmoid colon, and then, once it begins a straight shot to go up, that is the beginning of the descending colon.

And this, from here down, is approximately 60 centimeters, but, again, how far you can actually get in with a 60-centimeter scope varies with patients.

Q. Where is the splenic flexure?

A. Right up here.

Q. And how far is the splenic flexure from the anus?

A. Again, it varies in distance, but it can be anywhere from -- from as little as about 65 to 70 centimeters to as much as 110.

Q. And when you do endoscopy, where do

you insert the scope?

A. It goes up through the anus, and then we just follow the course of the colon, going up this way.

Q. Okay. So when you use a sigmoidoscope, how far can you go into the intestine?

A. Usually, with a sigmoidoscope, barring any unusual anatomic aspects, we can usually get to right about here, below the splenic flexure.

Q. Okay. With a colonoscope, how far can you go?

A. Well, by definition, a colonoscope can go through the entire length of the colon over to the cecum, which is the end over on the right side.

Q. Could you show us Plaintiff's Exhibits 7 and what that depicts?

A. This is, basically, four pictures that demonstrate some of the various positions a colon can assume, normally, in a normal individual, which can make flexible sigmoidoscopy and/or colonoscopy either easier or more difficult.

Q. Now, when the colon is in different positions when you take measurements, do you reach different locations when the colon is in different

locations?

A. Right, exactly right.

Q. So if you perform an endoscopic procedure and you go to 30 centimeters one day, and the position of the colon changes, will it necessarily be 30 centimeters the next day?

A. No.

MR. GOLWASSER: Excuse me. Mark, could you try to avoid leading the witness? I need to object to all these questions, and it messes up the transcription here.

Q. BY MR. RUF: Doctor, do you have an illustration that shows us the inside or lumen of the colon?

A. Well, this is -- this will do it. This sheet here shows at the bottom in the rectosigmoid the colon being cut away to demonstrate what it looks like and also to demonstrate some lesions you might find in this area.

Q. Now, when we're talking about the lumen of the colon, what are we talking about, Doctor?

A. Well, if you consider the colon a hose, the inside of the hose, the empty space, is what we call the lumen.

Q. How thick is the wall of the colon?

A. It -- it varies. It is thickest in -- in the part on the left side just before the end of the colon because it requires more muscles to force the stool out. As you go further back, it tends to get thinner. Here, it can be as much as -- as 3, 4 centimeters.

MR. GGLWASSER: Doctor, where is here?

THE WITNESS: I'm sorry. In the rectosigmoid and rectal area.

MR. GOLWASSER: Thank you.

Q. BY MR. RUF: Doctor, could you tell us the number of endoscopic procedures that you perform per year?

A. It varies. In the last year, I've been performing about 40 procedures per month.

Q. So, over the course of a year, approximately how many procedures do you perform?

A. In '96 and '97, about 600, between 450 and 600.

Q. Over your professional lifetime, how many endoscopic procedures have you performed?

A. It's tough to say because we don't, obviously, keep exact counts. It -- it is fair to say

I've performed somewhere between 3 and 5,000.

Q. When you perform a sigmoidoscopy or a colonoscopy, what are you looking for?

A. Well, it -- a lot of things. It depends why you're doing the sigmoidoscopy in the first place. If somebody has ulcerative colitis or an inflammatory process like ulcerative colitis of the bowel, you, many times, will do it just to see how that known disease is doing.

The most common indication for doing flexible sigmoidoscopy is for screening for colorectal cancer.

Q. When you're performing either a sigmoidoscopy or colonoscopy, do you only examine the inside of the bowel when you're going in or do you also look coming out?

A. You do both.

Q. Is one better for examining the colon than the other?

A. Well, in general, when you do a colonoscopy or a flexible sigmoidoscopy, the going-in part is just that.

Your major goal is to get the scope through to where you need to go, and you're not paying

attention, per se, to look at every part of the lumen or the mucosa, the lining of the lumen, and most of the looking, if you will, is done on the way out.

Q. What qualifications does a physician need to have to perform either a sigmoidoscopy or colonoscopy?

A. Well, it's generic. I mean, certainly, any physician can be trained to do flexible sigmoidoscopy and colonoscopy.

It is not something which is the purview of gastroenterologists or surgeons, and, to deal with this, the professional societies have set up guidelines for training in endoscopy.

And what is generally accepted as being necessary for competence is one taking a course to understand the cognitive aspects of it and the safety aspects, and, secondly, is to do it under supervision.

For flexible sigmoidoscopy, it's recommended that 20 to 25 procedures be done as a minimum with supervision before a person attempts them on their own, and, for colonoscopy, it tends to be about 100.

Q. Are you familiar with the Olympus brand sigmoidoscope colonoscope -- and colonoscope?

A. It's -- it's a leading brand.

Q. Have you used an Olympus sigmoidoscope or colonoscope?

A. Yes.

Q. Are you familiar with its capabilities?

A. Yes.

Q. What size of an abnormality are you capable of viewing inside the colon with the Olympus sigmoidoscope or colonoscope?

A. The scopes have the advantage of going towards or away from a lesion. It's, basically, like -- like bending forward with your eyeglasses to get a better look or something.

And, by doing that, you -- you can see something which is actually quite small, down to a millimeter or half a millimeter.

Q. Doctor, I'm handing you a ruler.

Could you show the jury the size of a millimeter?

A. I don't know if I can because it's kind of small. Basically, on the ruler here --

Can you see that?

THE VIDEOGRAPHER: (Nonverbal response.)

THE WITNESS: -- at the bottom, there's a metric scale and the -- there is a line that goes to the end of the ruler. Basically, the space between these two lines is a millimeter if I'm not mistaken. Right.

Q. BY MR. RUF: What types of abnormalities can you view with a sigmoidoscope or colonoscope?

A. Basically, anything that's in the colon you can see. You can see inflammation of the colon; you can see strictures; you can see polyps; you can see diverticula or out pouchings from the colon.

Again, it's a direct view; so anything that's there, you'll see.

Q. Are you able to see redness in the colon?

A. Yes.

Q. Are you able to see edema or swelling in the colon?

A. Yes

Q. Doctor, what is an exophytic tumor?

A. Basically, it's a tumor which -- which grows. It has mass effect. It grows into the lumen of -- of the bowel.

Q. If someone has an exophytic tumor,

can evidence of that exophytic tumor be seen inside the lumen or inside the bowel?

A. Yes.

Q. Are you able to view changes or abnormalities in the mucosa of the bowl?

A. Yes.

Q. What is the mucosa of the bowel?

A. It's, basically, the lining of the wall. Again, thinking of the colon as a hose and the lumen being the empty space on the inside, the wall *of* that -- that tube is the mucosa.

Q. In performing either sigmoidoscopy or colonoscopy, can you distinguish between diverticulosis and a polyp or cancer?

A. They look very different, yes.

Q. What is diverticulosis?

A. Well, diverticulosis is a condition which occurs with age. It's a very common condition which occurs with age, where there is an out pouching of the colon. Actually, this diagram shows one.

And, for reasons that we don't fully understand, the muscles of the wall of the colon get weak, and where the weakness forms, which is right here --

Can you see that?

THE VIDEOGRAPHER: (Nonverbal response.)

THE WITNESS: -- it causes the -- the outside of the colon to bulge out, forming a little bubble as you can see.

When you do colonoscopy or flexible sigmoidoscopy, what you will see is something which looks very close to Swiss cheese. It's on this diagram, but it's hard to see. Basically, you see little holes, which -- which disappear into the wall of the colon.

If you look from the outside, what you would see are these little out pouches on the outside. But, again, using the scope, where we can only see on the inside, the only thing we see are these little holes coming out.

Q. BY MR. RUF: Does that diagram also illustrate colonic polyps?

A. It does. There is one over here, and there's -- there's one down here, which actually may be a cancer. I'm not sure what they are calling it.

But, basically, a polyp, which you can see here, is a mass which hangs down into the colon, and here is either a polyp or -- or a frank cancer, which also appears as a lumpy, bumpy mass in the colon.

So it's the exact opposite of a diverticula, which appears as a hole.

Q. How does cancer look different than a polyp, if it does look different?

A. You really can't tell. All cancers develop in the colon from polyps unless it's a -- all adenocarcinomas in the colon develop from polyps, to be exact.

And what happens is a polyp is a group of cells that has lost their control. They're growing much faster and much more erratically than the surrounding mucosa. And, because of that, they begin to form a mass, and that mass is called a polyp.

As polyps continue to grow, the natural tendency of the cells to produce in a regular manner goes down, and, as they keep reproducing, they get more and more bizarre.

And, at some point, that bizarreness turns from a normal cell which is reproducing too fast to a cell which doesn't look right, but is, basically, not a cancer, and then it drifts into cancer.

So a long -- a long answer, basically, what I'm saying, is that endoscopically many times you can't tell, and when you see a polyp, you need

to take it out and have the biologist look and see if there is any cancer or -- or very erratic. Viz are calls in there which could be seeing a cancer

Q. Is a polyp an abnormality of the colon?

A. Oh, yeah. Adenomatous polyps are not a -- a normal part of the colon.

Q. What do you mean by adenomatous polyps?

A. Well, there -- there are a number of different kinds of polyps in the colon. There is a thing called juvenile polyp, which is benign and it's seen in young people.

There are very small polyps which are called hyperplastic polyps, and those are polyps -- both of those polyps have no tendency to continue to grow and no tendency to turn to cancer.

Polyps which arise from the natural tissue of the colon, the adenomatous tissue, the mucosal tissue, do continue to grow, and those are the ones that, in -- in their continued growth, almost inevitably turn into a cancer.

Q. Are you able to view sessile polyps with a sigmoidoscope or colonoscope?

A. All a sessile polyp means is -- is a flat polyp. There's, basically, two kinds of adenomatous polyps by -- by appearance. One is a pedunculated polyp, which looks exactly like a mushroom. It is a stalk with a mushroomlike cap on top of it.

And the other type is a sessile polyp, which is, basically, a little mass, which appears somewhat like a lifesaver without the hole in it or sometimes it looks like a wad of gum if it's beginning to develop irregularly.

Q. What size polyps are you able to view with either a sigmoidoscope or colonoscope?

A. Well, again, the ability of the scope to go towards or away from any part of the colon allows you to get very close to something to see whether it's a shadow, whether it's a bubble or whether it's actually a polyp. So -- so anything which is visible to the naked eye on close inspection, which would be about a millimeter, you can see quite clearly.

Q. Do you have an illustration that shows the layers of the bowel wall?

A. Well, I have a couple of illustrations here. Let's see which does it best. This one probably does it best.

Can you see that okay?

THE VIDEOGRAPHER: (Non-verbal response.)

THE WITNESS: Basically, this is the lumen, the hole in here, which is cut away for the purposes of illustration, and -- and then the mucosa is the inner lining of that wall which is cut away.

The middle is what's called the muscularis, which is the muscular tissue which helps the colon contract, and then, on the outside, is the serosa or the waterproofed outer coating of the colon or this hose, as we might allude to it for illustrative purposes, which is in contact with the outside of the bowel cavity.

Q. BY MR. RUF: If you have a polyp that's growing in the colon, what part of the bowel wall does that grow out of?

A. Well, it grows out of the mucosa. It starts in the mucosa, and it moves into the -- into the lumen of the bowel, and then, as it continues to grow, it will grow into the middle of the bowel wall, the muscularis.

And, ultimately, as it gets -- gets larger still, it will break through into the outside, but, at that point, it's usually a cancer.

Q. What are the indications or reasons for performing a sigmoidoscopy for colon cancer?

A. That's an interesting question because t's a concept in evolution. For about the last 15 years or so, for colon cancer screening in people over the age of 40, 45 or 50, depending on the study you read, since most cancers of the bowel occur within -- 60 percent of cancers of the bowei occur within reach of the flexible sigmoidoscope.

Flexible sigmoidoscopy was advocated as a screening test because, one, it was easy to do; two, it was cheaper than colonoscopy for a number of reasons, and, secondly, 60 percent of cancers of the colon could be found within reach of the scope. That's the major use of flexible sigmoidoscopy.

Q. What are the indications or reasons for performing a colonoscopy?

A. Well, again, a concept in evolution. Over the last three to five years, there has been a move towards doing full colonoscopies, i.e., examining the entire colon for colon cancer because, again, the sigmoidoscopy would detect 60 percent of cancers in most studies, but, of course, then, 40 percent go undetected.

And because of the long time it

takes for a polyp to turn into a cancer, which is measured in years, the latest thinking is to do a colonoscopy every 10 years, which will clear the colon with a flexible sigmoidoscopy every five years.

Now, I'm sure those recommendations are going to change, but what is not changed and what is well established is that if someone has rectal bleeding, if somebody has a family history of colon cancer, if somebody has other cardinal signs of a colon cancer, such as anemia or weight loss or a change in bowel habits, such as constipation, which is getting worse for no understandable reason, or pain in the colon, then you would proceed with a colonoscopy as opposed to just a flexible sigmoidoscopy.

Q. What are the risks or drawbacks to using a sigmoidoscope when you're screening for colon cancer?

A. Well, the biggest risk -- the biggest risk both for colonoscopy and for sigmoidoscopy is perforation of the colon, and that is, by and large, avoidable because, again, both of these instruments are passed under what we call direct visualization, i.e., you look where you're going.

And perforation can usually be

avoided, and also perforation is quite rare in both of the procedures, fortunately.

Q. Do polyps or cancers grow outside of the reach of the sigmoidoscope?

A. Yes, they do.

Q. What are the potential complications that can result from colonoscopy or sigmoidoscopy?

A. Well, colonoscopy is a bigger exam, and you're going through more of the colon. So the risk of perforation is higher because you have a bigger scope in the patient.

Colonoscopy is done with sedation. The patient is -- is sleepy, but not completely unconscious, and, sometimes, you can get complications from that. People can get into respiratory distress and the like.

And if you do a therapeutic maneuver, if you take a polyp out, then you run the risk of bleeding after the polyp has been removed.

Q. What is the complication rate for either colonoscopy or sigmoidoscopy?

A. Well, it depends on the complication and -- and depends on the procedure. It, basically, for both of them, for both sigmoidoscopy and for

colonoscopy, simply stated it's less than 1 percent.

Q. Are sigmoidoscopies and colonoscopies safe procedures?

A. Yes.

Q. How often do you encounter diverticulosis in performing either a sigmoidoscopy or colonoscopy?

A. Well, about 30 -- 30 to 50 percent of people over the age of 50 will have some degree of diverticulosis, and that is just a natural part of the aging process in most people.

And given that most flexible sigmoidoscopies for colon cancer screening are done in people 50 years or older, it's not uncommon. I mean, I couldn't give you an exact percentage, but I would guess it would be double digits somewhere between 10 -- 10 and 30 percent.

Q. Can diverticulosis cause problems in performing a sigmoidoscopy or colonoscopy?

A. Yes, it can. Again, diverticulosis, when you're looking into the colon, gives the appearance of Swiss cheese. You have multiple holes, and the challenge is to find which is the right hole to go down.

The other thing which occurs is that

these out pouchings, which we had here before -- and you can see on the outside of the colon, this is what a diverticula looks from the outside -- they sometimes will get stuck to adjacent parts of the bowel or the mesentery.

And they act like little rubber bands tractioning the colon, making it harder to move the colon as you go through here with your scope So it sometimes makes it a more technically difficult procedure because of that.

Q. Do you automatically discontinue either sigmoidoscopy or colonoscopy if you encounter diverticulosis?

A. No. Diverticulosis, per se, the mere presence of it, is not a contraindication to colonoscopy or to sigmoidoscopy.

Q. What are the indications for stopping either a sigmoidoscopy or colonoscopy due to diverticulosis?

A. For sigmoidoscopy, where the patient is not sedated, if they have a lot of pain, certainly pain and discomfort on the part of the patient is a reason to stop the procedure because, again, this tractioning of the colon from the outside by these

little -- little out pouchings, and, secondly, sometimes the diverticula distort the lumen so much that you really cannot find which of these little Swiss cheese holes is the right one and you can't do it.

So that's an indication, because you can't, basically, pass the scope; you can't find your way through, to discontinue the procedure.

Q. Over the course of a year, how many times do you have to discontinue either a sigmoidoscopy or colonoscopy due to diverticulosis?

A. About one or two a year.

Q. And that's out of 6 or 700 procedures a year?

A. Well, of those 6 or 700, about half of those are colonoscopy or sigmoidoscopy. So it would be about one or two out of 300 plus or minus.

Q. Have you reviewed Dr. Eisenberg's records for Edith James?

A. Yes.

Q. And Dr. Eisenberg's records, in performing some of the sigmoidoscopies, he did not advance the scope any further due to spasm.

Is that an indication or a reason not to go further?

A. Well, it can be. Spasm, basically, is a clamping down of the colon, and it's usually a clamping down which occurs in response to the air which needs to be inflated into the colon to spread the colon apart so you can see what you're looking at.

If a patient is having discomfort with that and the spasm is so bad that you can't get through on sigmoidoscopy, that is usually an indication to discontinue the sigmoidoscopy and to come back and attempt colonoscopy, which can be done under sedation, and usually, when the patient is sedated and relaxed, that spasm doesn't occur.

Q. Are there techniques that can be used by qualified endoscopists to advance a scope through diverticulosis?

A. We do it all the time.

Q. Is that a skill that an endoscopist should have?

A. You have to have it because so many people have diverticulosis.

Q. Is there any evidence in Dr. Eisenberg's records that would justify not advancing the scope to the full length that the scope was capable of going?

A. Well, again, that's a decision for the endoscopist at that moment. If you can't proceed beyond a certain point because you don't know where the lumen is or because there's intense spasm, it certainly -- if you feel uncomfortable, it is prudent to discontinue the procedure at that point, but then you -- what you need to do is come back, and there are alternative strategies to overcome that.

Q. In 1993 through 1995, Dr. Eisenberg used a flexible sigmoidoscope that was capable of going to 45 centimeters.

Did the standard of care for a physician require him to advance the scope to the full 45 centimeters?

MR. GOLWASSER: Objection.

MR. RUF: Please answer, Doctor.

THE WITNESS: Okay. I'm sorry. Would you repeat the question?

Q. BY MR. RUF: Certainly.

MR. RUF: Could you please read back the question.

(Pending question read.)

THE WITNESS: Well, that question is really answered by percentages. In an individual case,

at an individual sitting, it may be prudent and reasonable not to advance to 45 centimeters, the full length of the scope.

The way we measure competence is the ability to go to the length of the scone, in this case, 45 centimeters, a percentage of the time.

And for flexible sigmoidoscopy, competence is judged to be achieving full insertion of the scope to its limit in 95 percent of the time. Anything below 90 is really a quality assurance issue.

MR. GOLWASSER: Excuse me. For the record here, I'm going to object based upon the discovery deposition of Dr. Olden in which he outlined his criticisms as to Dr. Eisenberg's standard of care and assured me on the record that for trial testimony, if there was any change or additions to that testimony, I would be advised.

There was no testimony on the subject just alluded to by the doctor. Thus, at trial, I will be objecting to this portion of the transcript.

You may proceed.

MR. RUF: Well, for the record, in his deposition, he simply responded to your questions. He could not anticipate the questions I was going to ask

in the trial deposition.

And if that is your motion, then I'm going to move in limine to preclude your witnesses from stating anything other than what they've stated in their depositions.

MR. GOLWASSER: Mark, I'm not here to argue a motion in limine. I'm here to make an objection on the record. Let's continue, please.

Q. BY MR. RUF: Does the standard of care require an endoscopist to carefully examine the bowel?

A. Yes.

Q. What are the risk factors for colon cancer?

A. One is a family history of previous colon cancer Two, in some patients, a history of ulcerative colitis, which is a chronic inflammatory disease of the bowel which can just change the DNA in the cells.

And there's a strong tendency for those cells to become cancerous after about 10 or 15 years of disease, and the most common thing in the population at large is the presence of chronic polyps.

Q. I'm sorry. Did you say age is a

risk factor?

A. Well, age is indirectly because, as we get older, we have a stronger tendency to generate polyps.

Q. What percentage of people die from colon cancer after the age of 50?

A. About half. It's a disease of mid and late life.

Q. Does the risk increase as you get older?

A. Yes.

Q. For each decade, how much does the risk increase?

A. It depends on the studies, but, basically, it goes up about 10 percent per decade or 1 percent per year over the age of 50.

Q. You said polyps are a risk factor?

A. They are.

Q. What factors of a polyp increase that polyp for being at risk for being cancer?

A. Well, again, a polyp starts as an acorn, if you will, and if it's an adenomatous polyp, it will continue to grow and its DNA, its genetic material will get increasingly distorted, and somewhere, as it

continues to grow, it will turn into a cancer.

So, again, we -- we have to evaluate this on percentages, and the number for where a polyp's size tends to be more likely than not be a cancer is at about 1 centimeter

Q. Is size the biggest risk factor for a polyp being cancer?

A. If it's an adenomatous polyp, yes

Q. What is atypia?

A. Atypia is the intermediate state between a polyp with no cancer and a frank cancer where the genetic material is starting to get increasingly erratic and bizarre.

Q. Is atypia a risk factor for a polyp being cancer?

A. Atypia in a polyp means that is a polyp headed straight for cancer, yes.

Q. What is a synchronous polyp?

A. A synchronous or, actually, what is called a synacrenous polyp in a colon -- in a person's colon to have a second polyp in another part of the colon if you find one.

Q. Is there a risk of synchronous polyps for somebody that has one polyp?

A. Yes. It runs about 30 to 50 percent.

Q. So there is a 30 to 50 percent chance that if you find a polyp, there is a polyp farther into the colon?

A. Right.

Q. Does having one polyp put somebody at increased risk for developing polyps in the future?

A. Yes.

Q. What is the percent chance of developing polyps in the future if you have grown one polyp?

A. It runs -- again, depends on the study, but it can be as little as 10 percent and as much as 30 to 40.

Q. What is the risk of a polyp 2 centimeters or greater being cancerous?

A. It's very high. It's in the 75 percent range and higher.

Q. Did Edith James have any risk factors for cancer?

A. She had a father who apparently died of colon cancer, and family history is a risk factor.

She was older. Again, the older you

are the more likely you are to form polyps, and, indeed, she was found to have a polyp, which is an independent risk factor.

Q. When was she first found to have a polyp?

A. In 1985.

Q. Was she at an increased risk after 1985 for developing either polyps or colon cancer because of that?

A. Yes,

Q. What are the methods or tests a physician can use to screen for colon cancer?

A. Flexible sigmoidoscopy, colonoscopy, barium enema, and also what's called fecal occult blood testing or checking the stool for minute amounts of blood.

Q. What is a barium enema?

A. Barium enema is a procedure where you -- you clean the colon of any extraneous material i.e., stool, and you infuse -- I'm going to use the graph -- from the rectum barium, which is forced up under pressure through the entire colon.

And, basically, if there is a -- a defect in the colon, as you would see here, this is a

Q. What is the error rate for barium enema?

A. It -- it depends on -- on the radiologist. Again, there are multiple studies, some coming out of top notch university centers where the error rate is extremely low.

Other studies, looking at large departments of radiology in general hospitals, it can be as low as 5 percent to as high as 48 percent -- 48 or 50 percent.

Q. Can barium enema produce false positives?

A. Sure.

Q. How does that occur?

A. Well, again, a barium enema *is* a picture of a shadow. If there is a defect in the colon, it creates a shadow. And a shadow can be caused by many things.

It can be caused by a tumor or polyp. It can be caused by a piece of stool which

didn't find its way out of the colon. It can be caused by a piece of the colonic wall pushing in, just because, at the time of the picture, the colon was bending in a way to create a little defect on the inside of the colon. All of those look very similar on the x-ray.

Q. Can there be problems with filling the colon with the barium?

A. Sure. People -- some people, particularly older people, don't hold the barium well They get a sense of rectal urgency and have to go to the bathroom, and, when they do that, they drain the barium out

Q. What did you say a guaiac stool test is or a fecal occult test is?

A. Basically, it's a chemical test where we take a little piece of stool, either obtained directly or a rectal exam done by the physician or the patient submits a little fleck of stool from one of their bowel movements.

And then we test it on a piece of paper which is chemically treated. And you put a drop of this developing solution on it, and if there's -- if there's hemoglobin in it, i.e., one of the components of blood, it will turn a color, usually blue, and that

suggests that you've got bleeding someplace in the GI tract.

Q. What is the error rate with a guaiac stool test or fecal occult test?

A. It's about 30 percent. The -- the test is very sensitive. That is, if you're bleeding from anything, including your gums on down through the pipe, you can -- it will be detected.

Because it detects the protein that is present in blood, it is frequently influenced by the presence of red meat because red meat has hemoglobin and iron in it.

It is frequently influenced by drugs. Certain drugs, such as aspirin, can influence it, and certain vitamins, particularly vitamin C, can influence it.

So there's a lot of -- and iron, if you're taking iron pills it can also influence it, obviously. So that's one problem with the test.

The other problem with the test is that most lesions of the gastrointestinal tract don't bleed on a regular basis. They tend to ooze, and the challenge is to pick up a drop of blood on your chemical test when it's passing through the rectum.

So, the point is, you can have a tumor which is bleeding further up the pipe a little bit because they don't bleed a lot and the blood hasn't gotten down to the bottom yet, or if the person is moving their bowels fairly quickly, the blood can be washed out very quickly. So it's easy to miss blood in the stool.

Q. Can a guaiac stool test or fecal occult test produce false positives?

A. Sure.

Q. What is the error rate for sigmoidoscopy or colonoscopy?

A. It's -- it's much lower, again, because the beauty of those tests is you look directly at the colon. So you, basically go up and look at the area you're concerned about.

It's also operator dependent. Most studies would agree that the high is about 17 percent to a low of about 2 to 3 percent for sigmoidoscopy and colonoscopy.

Q. What is the most accurate and reliable test for detecting either polyps or cancer in the colon?

A. Well, speaking of the entire colon,

colonoscopy is the gold standard. No test is better because you're examining the colon inch by inch.

For a cancer in the -- in the region, which can be reached by a sigmoidoscope, that is also the gold standard for the same reason.

Q. Could you show us on the anatomy chart where 45 centimeters would be located?

A. Well, again, it -- it varies between patients because of -- of movements in the individual anatomic position of the person's colon.

But 40 centimeters would be about here, up in the descending colon above the rectosigmoid, approximately halfway between the splenic flexure up here and the beginning of the sigmoid colon down here.

Q. So what portion of the bowel would be left unexamined if you performed a sigmoidoscopy to 45 centimeters?

A. Well, again, here -- here was our cutoff in the mid descending colon. It would be anything -- I'm sorry -- it would be anything proximal to this, which would be this whole area going back through the transverse into the ascending colon and cecum.

Q. Do you know what the percent chance

of there being a polyp or cancer in the unexamined part of the colon?

A. Depends on the situation. If you -- if you have a polyp in the examined portion of the colon, on sigmoidoscopy it will be about 50 percent plus or minus.

If you -- if you are doing it de novo, we know, as I said before, that 60 percent of cancers will be within the reach of the sigmoidoscope at 60 centimeters. Most sigmoidoscopes are 60 centimeters.

And 40 percent of the cancers will not be able to be seen by that instrument.

Q. What does the standard of care require if a polyp is found on barium enema?

A. Finding a polyp in the colon, irrespective of how you detect it, is an indication for full colonoscopy, the entire colon, basically.

Q. What does the standard of care require if a polyp is found on sigmoidoscopy?

A. Same answer.

Q. What does the standard of care require if a polyp is found on colonoscopy?

A. Same answer, but it's a self-answering question because you're doing what you're

supposed to be doing, which is a colonoscopy.

Q. If you find a polyp, then what does the endoscopist do with that polyp, if anything?

A. It takes it out. Again, a polyp left untended is a polyp which will continue to grow and, basically, inevitably turns into a cancer given enough time. So what you want to do is get that thing out before it gets any bigger.

Q. Does the standard of care require a physician to remove a polyp if one is discovered on endoscopy?

A. Yes.

Q. Now, when we're talking about standard of care, is that a national standard?

A. The studies looking at the diagnosis of colon cancer, the screen for colon cancer have all been national or, in some cases, international studies So it is a national standard, yeah.

Q. Does the practice of medicine differ state by state?

A. Not in this instance, no.

Q. Do you practice medicine any differently in Arizona than you did in California?

A. No.

Q. Is the standard of care any different in Arizona than it is in California?

A. Not to my knowledge, no.

Q. If you would practice medicine in the state of Ohio, would you practice medicine any differently?

A. I don't think so.

Q. Could you tell us what the cancer polyp sequence is?

A. Well, basically, we've -- we've talked about it indirectly. It -- it is the natural tendency, indeed, the inevitable tendency of an adenomatous polyps with time to go from a polyp with no atypia, i.e., no bizarre DNA in cells to one with atypia, which means it's really starting to go awry and then it progresses on to a full-blown cancer.

Q. What medical evidence is there that cancer originates from benign polyps?

A. Well, I mean, there is a lot. Without getting into it, it is an unequivocally established fact at this point.

Q. What is the amount of time that it takes for the cancer polyp sequence to occur?

A. Again, these are hard studies to do

because we don't go in and find a polyp on day one. Usually -- it's usually been there for a while.

Our best understanding is it will take about five years for a polyp to go from nothing, you know, the beginning of a couple of cells turning into a polyp to a cancer.

Q. Do you have an opinion based on medical certainty as to whether Edith James's cancer that was diagnosed in October 1995 originated from a benign polyp?

A. Again, adenocarcinoma of the colon always arises from a polyp which sometime in its life was not a cancer.

Q. So can you say with medical certainty that her cancer originated from a polyp?

A. I can.

Q. And do you still hold that opinion even if there was no benign adenoma found on surgical pathology when pathology was performed on the colon cancer?

A. I'm sorry. Say that again.

Q. Sometimes, do you find evidence of benign adenomas when a cancer is removed?

A. Sure. Again, polyps have a life

span from normal polyp, no atypia, to increasing atypia to frank cancer.

It's not unusual as a polyp grows in size for it to be growing in different ways. One part has not reached the malignant stage yet; other parts have become frankly cancerous.

Q. If no benign adenoma is found along with the cancer, does that mean that the cancer did not originate from a polyp?

A. No. It just means the -- the polyp has reached full maturity, if you will. It's turned completely into a cancer. It's growing wildly.

Q. Do you always find evidence of a benign adenoma in cancer?

A. No. I mean, many times, you go up and find nothing but a cancer.

Q. Doctor, could you explain the concept of surveillance?

A. Well, the whole basis for colon cancer prevention is to get polyps out before they grow to any significant size and turn into cancers.

And surveillance means, basically, looking in people's colons on some sort of reasonable -- or not reasonable -- regular basis to make sure that

there - there are no polyps growing there from the last time

It is something that has to go on in timeframes and that differs for different patients depending on their personal history, depending on their age

Q What is the standard of care require of a physician in performing surveillance on a patient following removal of a benign adenoma in someone over the age of 50?

A. Again, it depends on the size of the polyp If -- if somebody has, on initial exam, a small adenomatous polyp, and that is, these days, usually defined as less than 5 millimeters.

There is some data whether you should get a colonoscopy in one year or three years or five years or, in some studies it's suggesting not at all.

If somebody has a large polyp, and that being defined as a polyp greater than 1 centimeter, which is removed at the initial colonoscopy, the medical literature is clear that follow-up colonoscopy should occur within one year.

Q. And then, after the first year, what

does the standard of care require?

A. Well, again, it's -- it's somewhat in flux. There are some studies which say you should have two negative colonoscopies, i.e., year one, you find a polyp; year two, you do a colonoscopy; it's negative and then, you do another colonoscopy the year after that. And if it's negative then you can stretch the person's surveillance out.

Other studies say you can do one follow-up colonoscopy in one year and if that's negative, you can stretch the follow-up out to three to five years.

Q. Did Edith James have a benign adenoma?

A. In 1985, she did, yes.

Q. What was the size of that adenoma?

A. It was about 2.5 centimeters, if I remember correctly.

Q. How was adenoma discovered?

A. It was discovered on colonoscopy.

Q. Was it seen on barium enema prior to the colonoscopy?

A. Prior to colonoscopy, yes.

Q. What happened to that benign

adenoma?

A. It was removed endoscopically by Dr. Eisenberg.

Q. What is the name of the procedure when you remove a polyp?

A. It's called polypectomy.

Q. What did the standard of care require Dr. Eisenberg to do following the removal of that polyp in 1985?

A. Well, one, was *to* determine the pathology, which he did, and then, given the fact that it was an adenoma, and given the fact that it was a large adenoma in the sigmoid, my understanding of the medical literature is that the standard of care dictated you do a follow-up colonoscopy in one year.

Q. And then, after the first year, what did the standard of care require of him?

A. It would depend on the findings. If the colonoscopy at one year was negative, which I will assume that it would have been, then Mrs. James, because of her history at that point, i.e., her tendency to form polyps, deserved follow-up colonoscopy between every three and every five years after that.

Q. So what's the total number of

colonoscopies that the standard of care required Dr. Eisenberg to perform between 1985 and 1995 when the cancer was discovered?

A. Well, assuming that she would have had a follow-up colonoscopy one year later in 1986, that would have been one.

Assuming that that would have been negative, that would have been '86 plus five, which would have made her due for a second colonoscopy in 1991, and, if that was negative, then she would have been due for another colonoscopy in 1996.

Q. And does the standard of care require a colonoscopy to be performed even if the patient is asymptomatic?

A. Well, that's the treacherous thing about colon cancer. Most patients are asymptomatic until the disease is quite advanced.

Q. Does the standard of care require surveillance by coionoscopy even in the absence of symptoms for somebody that has had a polyp removed?

A. Right. Precisely. Because a polyp will return and grow quite silently. There will be no symptoms except in the most unusual cases, and the only time the person will become symptomatic is when that

polyp has grown into a full-blown cancer.

Q. How many colonoscopies did Dr. Eisenberg perform between 1985 and 1995?

A. I believe he performed two, one and an attempted second one.

Q. When was the second one attempted?

A. 1995.

Q. Is barium enema a substitute for colonoscopy?

A. In -- in some settings, it can be. And it is okay, provided it's performed with flexible sigmoidoscopy because barium enema does not do a good job of identifying the very distal part of the colon.

And if the -- if the prep is good, if the patient has a very clean colon and, finally, if the person has a colon where a cancer, basically, can't hide; it's not twisting and turning and has little nooks and crannies where a cancer can hide.

Q. I'm handing you Plaintiff's Exhibit 1.

Could you take a look at Dr. Eisenberg's notes for 1987?

A. First note is August, I think, 13, 1987.

Q. Did Dr. Eisenberg schedule a colonoscopy for Edith James?

A. He did.

Q. Was the colonoscopy performed?

A. No, it was not.

Q. Why was the colonoscopy canceled?

A. Ms. James either -- I think she canceled it. Either she canceled or she no showed; I can't remember. It doesn't say. It just says, "canceled until further notice per patient request".

Q. If a patient cancels a colonoscopy, what does the standard of care require of a physician?

A. Well, again, the stakes are high in a case like this, and it's important that the physician make a reasonable attempt, I mean, to get this done or to respect the patient's informed wishes not to have it done.

And what most physicians will do is they will send a letter to the patient, if not a registered letter, basically, outlining the concern about a possible recurrent polyp, the risk of cancer and the need for an exam, which the patient can then, at that point, either accept or decline based on their own desires.

Q. Does the standard of care require a physician to reschedule a colonoscopy within a certain amount of time if it's canceled by the patient?

A. The physician has an obligation to make a good faith effort to schedule a colonoscopy or to document that good faith effort and the patient's refusal to go forward.

Q. Could you please read the note of September 8, 1987 in Dr. Eisenberg's records out loud?

A. It says -- "9/8/87, phone," which I take to mean phone call, "barium enema is negative except for diverticulosis; therefore, no need for colonoscopy".

Q. Based upon that note, would that give reassurance to a patient that they did not need a colonoscopy?

A. To a patient who wasn't sophisticated in colon cancer screening techniques, yes

Q. Would that assurance be well-founded?

A. Unfortunately, no. Again, there is a lot of subtleties in colon cancer screening, and, in my opinion, it would have not in this particular case because of -- of the diverticulosis or the presence of

significant amounts of diverticula that Ms. James had.

Again, these are the kinds of lesions that form, these little Swiss cheese-like out pouchings, in the colon, and cancers can hide in those, and it's very difficult for a barium enema, one, to pick up a cancer within diverticulosis in the colon.

And, secondly, it -- the barium enema is least effective in the distal part of the colon, which is where Mrs. James' diverticulosis was, and also that's where her previous polyp was. So it wasn't an ideal test for this particular patient.

Q. Did the standard of care require Dr. Eisenberg to reschedule the colonoscopy following September of '87?

A. It certainly wasn't an emergency. That is, it didn't have to be scheduled within the next few weeks, but certainly within a year, the year being 1987, a colonoscopy should have been performed to follow up on the original polyp of 1985.

Q. Did he perform a colonoscopy within a year?

A. No, he didn't.

Q. Is colon cancer treatable?

A. It is. It can be.

Q. What is the number one factor for survival in the patient with colon cancer?

A. Early detection.

Q. What is the most effective way to decrease the mortality rate for colon cancer?

A. Early detection and treatment, removal of the lesion.

Q. Okay. I'm handing you what's been marked as Plaintiff's Exhibit 9.

Could you please identify that document?

A. It is labeled a "Colon Cancer Fact Sheet".

Q. What information is relevant in that Colon Cancer Fact Sheet?

MR. GOLWASSER: Excuse me. Because I'm not there, what is that exhibit? What is that exhibit?

MR. RUF: It's what he said. It's a half page exhibit, Colon Cancer Fact Sheet.

MR. GOLWASSER: Where did it come from?

THE WITNESS: I can tell you because I just noticed something, Mr. Golwasser. It s -- it's from -- up in the right-hand corner of the exhibit, it has the web site address for the American College of

Gastroenterology. So I would assume it came from the American College of Gastroenterology web site.

MR. GGLWASSER: All right. For the record, I'm going to object to that exhibit. You may continue your inquiry.

Q. BY MR. RUF: Is the information listed in Plaintiff's Exhibit 9 accurate and reliable, based upon your education and experience?

A. Give me a second to read it here if I may.

MR. GGLWASSER: Show an objection again, please.

THE WITNESS: I would agree with this, yes.

Q. BY MR. RUF: Is there any statistical information in Plaintiff's Exhibit 9 that is relevant to this case?

MR. GOLWASSER: Objection.

THE WITNESS: Basically, it says, "Colorectal cancer is the number two cancer -- number two killer in the United States. Yet, it is one of the most preventable, curable. Early detection and intervention can reduce mortality from colorectal cancer by up to 90 percent."

MR. GOLWASSER: Excuse me. For the record, I move that the doctor's answer be stricken. It is clearly contrary to Ohio Rules of Evidence for any expert to read from a text or journal source in direct examination. You may proceed.

Q. BY MR. RUF: Based upon your education and experience, if there is early detection and intervention, what is the potential reduction in the mortality rate for people with colon cancer?

A. Well, it's very high. I mean, theoretically, it's 100 percent with -- with very aggressive screening.

The major impediment to screening -- aggressive screening to reduce mortality to zero is the fact, one, that it's expensive, and, two, many people will not accept the somewhat inconvenient nature of the exact, i.e., examination of their colon.

Q. What is the cure rate for colon cancer if a polyp is detected and excised or cut out of the colon?

A. Depends on the polyp. But, usually, if it's a polyp with some cancer in it or so-called carcinoma in situ, it can be cured endoscopically, taken out endoscopically, and the issue is closed.

Q. What is the cure rate for colon cancer if you have a primary lesion of 2 centimeters or less?

A. Well, again, 2 centimeters or less, going smaller, the smaller the polyp the less chance of cancer. So it continues to go up. It could approach 100 percent.

Q. What is the cure rate for colon cancer if the primary lesion has spread to the lymph nodes?

A. Again, the more the tumor spreads, the worse the prognosis. If it spreads out to the lymph nodes, that is called Duke's, D-u-k-e's B2, and that runs about a 30 to 50 percent five year survival.

Q. Do you have an illustration that shows the lymph nodes around the colon?

A. I'll give you that back. Oh, here we go. This exhibit, which is marked Plaintiff Exhibit 8, is a very nice drawing of the lymph nodes.

Here's the colon up here, and these blue dots that surround the colon towards the center of the abdominal cavity are the lymph nodes. So you can see how the colon is very closely aligned with, and it's actually drained by the lymph nodes in the abdomen.

Q. Are the lymph nodes located outside the actual wall of the colon?

A. Right.

Q. What is the cure rate for somebody that has a primary lesion plus spread to the lymph nodes and metastasis to another organ?

A. That is what is called a Duke's D carcinoma, which is, basically, a death sentence. It is somewhere between 5 and 10 percent five-year survival. It's very low.

Q. And when we talk about metastasis, what do we mean by that?

A. Well, tumors, as they grow wildly, tend to shed cells, and those cells are picked up either by the blood stream or by the lymph glands, the job of which is to remove impurities from various organs.

The problem is, when that happens, you now have cancer cells on the road, and they're traveling, and they tend to travel to organs that have very rich blood supplies.

In the case of colon cancer, it tends to be the liver, and they set up and grow there and form a whole new tumor.

Q. Based upon reasonable medical

certainty, what were the chances for cure for Edith James in October of 1995, when a tumor was found in her colon with 80 to 90 percent obstruction? She had cancer in 10 out of 10 lymph nodes and metastasis to the liver.

A. She, basically, at that point, had no prognosis. She, by the survival statistics, would be dead. All patients in that group would be dead in five years except 10 percent.

Given Mrs. James' age and overall level of health, she would have died sooner, which, indeed, was the case.

Q. Do you have an illustration that shows where the liver is with respect to the large colon?

A. This one would probably do it best. This is a diagram of the colon which we used before to show the polyps and the descending colon and diverticula, and this is the transverse colon going over, and this is the hepatic flexure and this large brown thing up here, indeed, is the liver.

So, what you would typically see, which I don't think is illustrated on this diagram, is little lumps and masses on the colon, which would be the metastatic tumor.

Q. How does a colon cancer spread or metastasize to the liver?

A. By the lymph nodes and by the blood stream.

Q. What other organs can be affected by metastasis?

A. Basically, any organ, but in the case of colon cancer, it tends to be the lymph nodes, the liver, the lungs, the bones less frequently and the brain less frequently.

Q. In October of 1995, did Edith James have an advanced stage of cancer?

A. Yes.

Q. Could you describe for the jury how the progression of the cancer would occur in her body?

A. Well, it would continue to grow and -- and spread as it did to the liver. It went from inside the lumen, through the wall of the colon, into the lymph nodes.

The lymph nodes carry it to other parts of her body. She died with tumor in her -- her liver, which is as far as it probably got. But if -- if she had survived longer, it would just have continued to grow with the sites I just named, and it could have

spread elsewhere. Basically, it would have taken over her body.

Q. What have you reviewed before rendering your opinion in this case?

A. Nothing specifically for this case. I mean, just basically, texts and books I've read over the years.

Q. Did you review any medical records?

A. Oh, I'm sorry. I thought you were talking about literature. I reviewed Mrs. James' medical records from Dr. Lerner, her primary care physician; Dr. Eisenberg, her colorectal surgeon, her records from Mt. Sinai Hospital, including her radiation therapy and chemotherapy records, her x-rays from 1995, and various depositions.

Q. Did you review Dr. Mentz's records, who is the oncologist?

A. Yes.

Q. What is an oncologist?

A. That's an internal medicine specialist who specializes in cancer treatment.

Q. Did you review any depositions?

A. Yes.

Q. What depositions did you review?

A. Dr. Lavery's, Dr. Eisenberg's, my own, Dr. Lerner's and --

Q. Did you review either Dr. McCarty's or Dr. Lash's deposition?

A. I looked at -- I looked at Dr. McCarty's somewhat briefly and Dr. Lash's very briefly.

Q. Did you review any films?

A. Just -- just her barium enema x-ray from '95.

Q. What medical facts are known to you after reviewing these materials concerning Edith James?

A. Well, that she died of colon cancer. In a cancer that arose in the sigmoid colon. And that was -- that arose in the presence of a history of having a previous significant polyp in the same area, i.e., the left side of the colon, 10 years prior.

Q. According to Plaintiff's Exhibit 2, what was the date of death for Edith James?

A. That's a death certificate, and her death was 11/3/96.

Q. And what did she die from?

A. The cause of death is metastatic colon cancer on the record here.

Q. When was the colon cancer first diagnosed?

A. In 1995.

Q. In what month?

A. October. I'm sorry.

Q. I'd like to go back to 1985, which is the date the original polyp was found.

Could you take a look at the barium enema that was performed?

A. In 1985?

Q. Correct.

A. There is a report from June 4, 1985. Sorry.

Q. What did the barium enema show?

A. It basically showed a 2-centimeter polyp in the distal sigmoid colon.

Q. Did it show any other polyps?

A. There was a report of a small polyp in the area of the splenic flexure.

Q. And what was done after the barium enema was reported?

A. Colonoscopy.

Q. Who performed the colonoscopy.

A. Dr. Eisenberg.

Q. What did Dr. Eisenberg discover on colonoscopy?

A. He found a 2.5 centimeter polyp in the sigmoid colon.

Q. What was the location of that polyp, how far from the anus?

A. Again, such measurements can be relative between different procedures, but I believe it was about 35 centimeters.

Q. Do you have his operative report?

A. It's here someplace. It's right here. That's the one from '95, '96. Just found it. 6/20/85 is the report from Mt. Sinai. And on that procedure it was listed 45 to 50 centimeters from the anal verge.

Q. Could you show us on the medical illustration where that would be located?

A. About here, sort of in the middle of the descending colon.

Q. Now, you said there was also a -- another polyp reported on barium enema?

A. Right.

Q. Where was the location of that polyp?

A. Around the splenic flexure.

Q. And could you show us on the anatomical drawing where the splenic flexure is?

A. Sure. It is right up here, this little turn up there.

Q. Did Dr. Eisenberg in his colonoscopy report make note of a polyp at the splenic flexure?

A. No.

Q. Did he make note of the absence of a polyp at the splenic flexure?

A. No.

Q. Is there any discussion about the barium enema in Dr. Eisenberg's colonoscopy report?

A. No.

Q. Did Dr. Eisenberg resect or cut out that polyp?

A. The one in the splenic flexure or the one in the sigmoid?

Q. The one in the sigmoid colon.

A. He did, yes.

Q. And was that sample sent to pathology?

A. Yes.

Q. What did the pathology show?

A. It showed a adenoma with some degree of -- it doesn't mention the degree of atypia here. It just calls it a villous adenoma.

Q. Was that polyp cancerous?

A. No.

Q. Did Dr. Eisenberg perform surveillance following that -- that polypectomy in 1985?

A. He did.

Q. How often did he perform surveillance?

A. Well, the grand total was six times between 1985 and the last procedure in '95.

Q. Did Dr. Eisenberg ever perform a colonoscopy between 1985 and 1995 when the cancer was discovered?

A. No.

Q. In the sigmoidoscopies that were performed by Dr. Eisenberg between 1985 and 1995, did he ever go to the level of the original polyp?

A. Well, again, distances can be somewhat deceptive because the colon tends to move back and forth, but the numbers would -- would suggest that he did not go that high, to the 40 or 50 centimeters. He was in the 20 to 30 centimeter range or 20 to high 30

centimeter range.

Q. During that 10-year period, how far did Dr. Eisenberg go during these sigmoidoscopic procedures?

A. Well, on -- on his report, he would go from a low in the low 20s to a high in the high 30s.

Q. How often did he go up to the 30s?

A. Can't remember exactly. I think it was two times, one or two times.

Q. Where was the cancer found ultimately in October of 1995?

A. I believe it was found in about 35, but I want to check that. Yeah. It was 30 to 35.

Q. And what is the date of that report?

A. 10/23/95.

Q. Did Dr. Eisenberg perform a sigmoidoscopy in 1995?

A. He did.

Q. How far did he go on sigmoidoscopy?

A. I believe -- well --

Q. Why don't you look at his records, Doctor?

A. This is Dr. Lerner's records.

On May 22nd, he went to

28 centimeters, and then he went on to the colonoscopy.

Q. And the cancer was ultimately found where?

A. At 30 to 35 centimeters.

Q. In Dr. Eisenberg's sigmoidoscopy of May 22, 1995, did he see a polyp or cancer?

A. No.

Q. Before May 22, 1995, when was the most recent time that Dr. Eisenberg performed a sigmoidoscopy?

A. I'm sorry. Again?

Q. Did he perform a sigmoidoscopy prior to May 22, 1995?

A. Yes. And immediate to that procedure, he had done it on April 25, 1994, and it was done to 38 centimeters.

Q. What about in 1993? Did he perform a sigmoidoscopy?

A. He did. On April 5, '93, and he went to 28 centimeters; and February 1, '92, he went to 25; and in January 31, '91 to 22 centimeters; February 6, 1990, to 22 centimeters.

And then we go back to 1985 with a follow-up colonoscopy on December 5, '85, which was the

22 -- 25 centimeters. I'm sorry.

Q. At this point in time, I'm going to ask you a number of opinions, Doctor. I'm going to ask that you render those opinions based on medical certainty and based upon your education and experience,

If you cannot render an opinion based on medical certainty, will you tell me?

A. I will.

Q. Doctor, based on medical certainty, do you have an opinion as to whether Dr. Eisenberg deviated from the acceptable standard of medical practice?

A. In my opinion, yes.

Q. Doctor, could you state all of your opinions concerning the deviation or deviations from the acceptable standard of care?

A. I alluded to these indirectly earlier. One major concern I have is the failure, after the initial colonoscopy and polypectomy in '85, for the patient to be followed up with a colonoscopy on some sort of reasonable basis.

Again, she didn't get one again until '95. Secondly, was the failure to do due -- do due diligence in terms of following up in 1987 when the

patient canceled her colonoscopy, at least, to make sure the patient understood the implications of that decision, and, three, as the patient became ill late in her course in 1994 and 1995, to not perform colonoscopy then.

MR. GOLWASSER: Just for the record, I'm going to object to the last two items of the doctor's opinions.

For the Court's reference, which we'll deal with at trial, I refer to page 28 of the doctor's discovery deposition.

You may continue.

Q. BY MR. RUF: Doctor, based -- based upon reasonable medical certainty, do you have an opinion as to whether Dr. Eisenberg's failure to go to the level of the original polyp on sigmoidoscopy during the 10-year period he followed her was below the acceptable standard of care?

MR. GOLWASSER: Objection.

THE WITNESS: Yes. And -- and it goes back to my first comment, which was the need for colonoscopy. Because of the tendency of the colon to move, it is hard to get precise meaning to the numbers 25 or 28 or whatever it is, and it's important to use a

colonoscope, which is able to get through the area on to the end of the colon to the cecum.

Q. BY MR. RUF: Would you turn to Dr. Eisenberg's note of April 25, 1994?

A. Got it.

Q. First of all, what are the signs or symptoms of colon cancer?

A. Rectal bleeding, weight loss, change in bowel habits, fatigue, occasionally pain in the -- the abdomen.

Q. Is general malaise a symptom of colon cancer?

A. Yes.

Q. What does general malaise refer to?

A. Basically, feeling lousy, feeling weak and under the weather and just feeling sickly.

Q. Did Edith James have any symptoms of colon cancer on April 25, 1994?

A. She had pain in the left lower quadrant, and that was the only thing that was documented at that particular visit.

Q. Did she have any blood at that time?

A. Not that I can see from this particular note. You just pointed to something, but

it's cut off here; so I really can't see it. I'd have to look at my other records. It's cut off right there.

Q. Doctor, assuming that says, "occasional pinkish smear"; is that a sign or symptom of colon cancer?

A. That can be, yes.

Q. Doctor, assuming that it says, "occasionally has several BMs," is that sign or symptom of colon cancer?

A. Well, it's a change in bowel habits, and that can occur in colon cancer, yes.

Q. Given that Edith James had those symptoms on April 25, 1994, what did the standard of care require Dr. Eisenberg to do?

A. Well --

MR. GOLWASSER: Objection.

THE WITNESS: -- basically, the possibility of rectal bleeding was an indication for colonoscopy itself.

The change in bowel habits is an indication for colonoscopy in itself, and given her history of colon cancer it just ups the ante, 'if you will.

Q. BY MR. RUF: Doctor, could you take

a look at Dr. Eisenberg's note of May 22, 1995?

A. I have it.

Q. According to Dr. Eisenberg's record, did Edith James have any signs or symptoms of colon cancer at that time?

A. In that note, Dr. Eisenberg has written "C.L." or complaint "of GM," which I take to mean general malaise.

And then further down in the note, it says, "occasional pinkish blood".

Q. Given that she had those signs and symptoms on May 22, 1995, what did the standard of care require of Dr. Eisenberg?

A. For the same reasons as my previous answer, a colonoscopy.

MR. GOLWASSER? Objection.

Q. BY MR. RUF: did Dr. Eisenberg perform a colonoscopy following the office visit of April 25, 1994?

A. No.

Q. Did Dr. Eisenberg perform a colonoscopy following the office visit of May 22, 1995?

A. No.

Q. Did Dr. Eisenberg perform a

colonoscopy between April 25, 1994 and October of 1995, when the cancer was ultimately discovered.

A. He did not.

Q. Based upon medical certainty, do you have an opinion as to whether the failure to perform a colonoscopy between April 25, 1994 and October of 1995 was a deviation from acceptable medical practice?

A. I do. And I feel that way because, one, we have symptoms here which are suggestive of a possible colon cancer, and they certainly could have been due to other things, but that needed to be excluded, with colonoscopy being the test that could do that.

And, secondly, it was a missed opportunity to diagnose the cancer, which, retrospectively, we have the advantage of knowing it was approximately 18 months earlier.

Q. Doctor, what is a medical history?

A. It, basically, is the physician or other caregiver taking the pertinent facts about a patient's complaints, about their medication, their lifestyle, et cetera, from the a patient him or herself.

Q. Whose obligation is it to see that the proper information is it obtained by the doctor,

considered by the doctor and recorded in the medical records?

A. It's -- it's mainly the physicians.

Q. Does the standard of care require a physician to perform a complete medical history and physical examination?

A. At least, a relevant history and physical examination, yes.

Q. What is a physical examination?

A. It's, basically, laying on of the hands to examine the body, looking for abnormalities.

Q. In taking a medical history of Edith James, what information should have been obtained?

A. One, how she was doing, how does she feel; two, did she have any specific complaints, such as pain or bleeding or weight loss. Those would be relevant things on the history.

On the physical exam, what we call vital signs, her blood pressure, heart rate and weight are standard for that.

And for a patient with colon cancer being seen in follow-up by a physician, that would involve examination of the head and neck looking for swollen lymph nodes, which could suggest spreading

cancer, listening to heart and lungs and also examination of the abdomen and the rectum.

Q. In taking a medical history for a patient that is at risk for colon cancer, should a doctor ask about family history of colon cancer?

A. Yes.

Q. All right. Did Edith James have a family history of colon cancer?

A. She did. Her father died of colon cancer.

Q. Is that reflected anywhere in Dr. Eisenberg's records?

A. Not that I could see, no.

MR. GOLWASSER: Show a continuing objection to all of this.

Q. BY MR. RUF: I want you to assume that the family is going to testify that for a year prior to October of 1995, Edith James experienced a decrease in appetite and weight loss.

Is that information reflected in Dr. Eisenberg's records?

A. No, it's not.

Q. I also want you to assume that in Dr. Raisa Lerner's records, Edith James' rate -- weight

was recorded on October 26, 1994 as 115 pounds, and that, on September 18, 1995, her weight was recorded as 105 pounds.

Is that information recorded anywhere in Dr. Eisenberg's records?

A. No, it's not.

Q. Does Dr. Eisenberg have any notation about weight loss in his records from April 25, 1994 until October of 1995 when the cancer was discovered?

A. Not that I could see.

Q. Does the standard of care require a physician to document a plaintiff's [sic] symptoms who is at -- if that patient is at risk for colon cancer?

A. Yes.

Q. Given that Edith James had a 2-centimeter polyp in 1985, was she at risk for colon cancer?

A. She was at increased risk, yes.

Q. Does the standard of care require a physician to question a patient concerning all symptoms of colon cancer?

A. It does.

Q. Doctor, do you have an opinion based upon medical certainty as to what was causing Edith

James' symptoms on April 25, 1994?

A. Well, retrospectively, it's quite clear it was from her colon cancer.

Q. Doctor, do you have an opinion based upon medical certainty as to what was causing Edith James' symptoms on May 22, 1995?

A. Same, her colon cancer.

Q. Do you have an opinion based on medical certainty as to whether diverticulosis was causing Edith James' medical symptoms on April 25, 1994?

A. Diverticulosis is, basically, an asymptomatic condition. It tends not to cause pain, and it certainly doesn't cause weight loss, and it won't cause bleeding in the majority of cases.

If diverticulum or these out pouchings become inflamed, you can develop diverticulitis, which can produce a left lower quadrant pain, but it also produces fever and sweats and some other very typical symptoms, which Ms. James did not display.

Q. So based upon medical certainty, do you have an opinion as to whether diverticulosis was causing Edith James' medical symptoms on April 25, 1994?

A. In my opinion, no.

Q. Do you have an opinion based upon medical certainty as to whether diverticulosis was causing Edith James' medical symptoms on May 22, 1995?

A. In my opinion, no, again.

Q. Was there any medical symptom that became more severe from April 25, 1994 to May 22, 1995?

A. Yes.

Q. What?

A. What are they?

Q. What symptom is that?

A. She continued to lose weight and feel weak which progressed, and she continued to have intermittent rectal bleeding.

Q. Do you have an opinion based upon medical certainty as to the size of the cancer on April 25, 1994?

A. On the size of the cancer?

Q. Yes.

A. Well, that's -- that's established in the pathology report. It was a significant cancer, which had occluded about 80 to 90 percent of the lumen of the bowel.

Q. That was in October of 1995?

A. Right.

Q. I'm asking you, a year and a half before the diagnosis on April 25, 1994, do you have an opinion based upon medical certainty as to the size of the cancer at that point?

A. It's difficult to say precisely because tumors grow at different rates, but there are boundaries with how fast or how slow a tumor will grow

And I can say, based upon my knowledge of the literature, comfortably, that that tumor was, at least, 1.5 to 2 centimeters -- well, even to give more benefit of the doubt, between 1 and 2 centimeters in April and May of 1994.

Q. Based upon medical certainty, would a 1- to 2-centimeter polyp be diagnosable by colonoscopy?

A. It would.

Q. Do you have an opinion based on medical certainty as to when the polyp or cancer was first diagnosable?

A. Again, it's hard to say precisely, but given the fact that polyps tend to form de novo over about five years, I would estimate that it probably initially could have been first detected in 1991 plus or minus.

Q. How many sigmoidoscopies did Dr. Eisenberg perform between 1991 and October of 1995?

A. I believe, three or four. Let me calculate them.

Q. Would you go through his records and count them, please, Doctor?

A. Sure. 1991, there was one; 1992, there was one; 1993, there was one; '94, there was one; and 19 -- May 22, '95, there was one. So there was five.

Q. So Dr. Eisenberg had five opportunities to diagnose this polyp or colon cancer?

A. He did.

Q. Did Dr. Eisenberg make the diagnosis of a polyp or cancer in performing those five sigmoidoscopies?

A. He did not.

Q. Based upon medical certainty, was his failure to diagnose either the polyp or colon cancer a deviation from acceptable medical practice or medical negligence?

MR. GOLWASSER: Objection.

THE WITNESS: Given the fact that the patient was symptomatic, given the fact the patient had

a history of a polyp, as we know, given the fact that, indeed, she was being seen for surveillance by Dr. Eisenberg, and he was performing surveillance, I feel there was a deviation in that proper surveillance during that period would have consisted of full colonoscopy, at least, once and possibly twice for that seven-year period.

Q. BY MR. RUF: Doctor, could you explain how Dr. Eisenberg recorded in his note of April 25, 1994 that he went to 38 centimeters and did not see a polyp or colon cancer, and the colon cancer was ultimately discovered in October of '95 at 30 to 35 centimeters?

A. Well, Dr. Eisenberg's note of April 25, '94 says, "flex sig to 38 centimeters, spasm and diverticula in sigmoid colon, no polyps".

And something else I can't see -- it says "normal". I can't read the other words, will normal or something or wall normal. And his diagnosis for diverticular disease.

Again, that's -- that's the problem of doing sigmoidoscopy in a colon with diverticular disease or diverticulosis, that the colon tends to act like an accordion, and it can open and close.

So, if you have a short scope, sometimes it can only go so far up. That is obviated by the presence of a colonoscope, which because it's so long can go through that area and visualize the entire area.

Q. So what is your explanation for his recording that he went to 38 centimeters a year and a half before the colon cancer was discovered, and the colon cancer was discovered in October of '95 at 30 to 35 centimeters?

A. The colon moves around. And 38 centimeters one day can be as much as 25 the next.

Q. Is it a possibility that Dr. Eisenberg missed either a polyp or colon cancer that was present on April 25, 1994?

A. Oh, I think -- based on what we know about the tumor in '95, I think that's exactly what happened.

MR. GOLWASSER: Reporter, did you get my objection?

THE REPORTER: Just now? No, I didn't.

MR. RUF: I want you to assume that --

MR. GOLWASSER: Wait, wait, wait. I objected to the question that was just answered. Did

you get that?

THE REPORTER: Yes.

MR RUF: Yes.

MR. GOLWASSER: Okay.

BY MR. RU Did Dr. Eisenberg perform an uaiac st test or f l occult test from 1985 to 19

A. No.

Q. I want you to assume that Dr. Raisa Lerner, the primary care physician, performed guaiac stool test or fecal occult tests that were negative.

Does that mean that Edith James did not have colon cancer?

A. No. Because tumors bleed intermittently, and, again, as I previously testified, there are difficulties with capturing a positive stool.

Q. If a fecal occult test was negative in September of 1995, that was a month before the colon cancer was discovered, does that mean she did not have colon cancer at that time?

A. Obviously *not.*

What is ur expla ion for wh can have negative f l occult t and still colon ca

A. Because tumors bleed intermittently, and that blood finds its way intermittently to the -- to the rectum.

MR. RUF: Gary, could we stop one minute? The tape is about to run out.

MR. GOLWASSER: Sure.

THE VIDEOGRAPHER: This is the end of tape number one in the continuing deposition of Dr. Kevin Olden. Today's date is September 10, 1998, and the time is now 9:21 p.m.

(Recessed from 9:21 p.m. until 9:25 p.m.)

THE VIDEOGRAPHER: This is the beginning of tape number two in the continuing deposition of Dr. Kevin Olden. Today's date is September 10, 1998; and the time is now 9:25 p.m.

Q. BY MR. RUF: Dr. Olden, do you have an opinion based upon medical certainty as to whether Dr. Eisenberg's deviations from acceptable medical practice or his medical negligence protection proximately resulted in the death of Edith James?

A. Unfortunately, I think that is the case. I think the failure to diagnose the tumor led to its continued growth to the point where it became

Q. Do you have an opinion based on medical certainty as to whether the pathology slides that were taken at the time the tumor was resected or clinic symptoms are better medical evidence to indicate whether or not the cancer was present in May of 1995 and April of 1994?

A. Pathology slides really tell you nothing about how the patient was behaving with that particular tumor. They have implications for diagnosis and implications for treatment once the tumor is discovered.

But, as I previously testified, Mrs. James had a number of symptoms which were classic for colon cancer, although, in fairness, could have represented other conditions, but, given her unique history, needed to be taken very seriously.

Q. Are the clinical symptoms that she had in May of 1995 and April of 1994 the best evidence we have as to when the colon cancer was present?

A. Clinically, yes.

Q. Do you have an opinion based on medical certainty as to whether Edith James' colon cancer took only three to four months to grow to block 80 to 90 percent of the lumen of the colon, was in 10

out of 10 lymph nodes and spread to the liver?

A. I've never seen that clinically, and that's not my understanding of the literature, no.

Q. When we're talking about 80 to *90* percent occlusion of the lumen of the colon, what do we mean?

A. Well, again, conceptualizing the colon like a hose or a pipe, it's, basically, a tumor growing around the circle of the inside of this hose, and then it grows towards the center. So 90 percent of the center is occluded by tumor from all sides.

Q. Can you see a submucosal tumor on colonoscopy?

A. No.

Q. Do you have an opinion based on medical certainty as to whether Edith James would have survived had Dr. Eisenberg met the acceptable standard of care?

A. Yes.

Q. What is your opinion?

A. Well, again, the literature is quite clear that the earlier you detect a colon cancer, the better the survival, and there were a number of lost opportunities to pick this tumor up at an earlier stage,

which were not seized upon.

Q. Do you have an opinion based on medical certainty as to whether Edith James would have to have undergone radiation and chemotherapy if Dr. Eisenberg met the acceptable standard of care?

A. Radiation, in particular, is reserved only for end stage cancer, very advanced cancers. Chemotherapy is reserved for intermediate and late stage cancers. If the tumor had been picked up in its earlier stages, there would have been no need for them.

Q. So based upon medical certainty, do you have an opinion as to whether or not Dr. Eisenberg's negligence caused Edith James to undergo chemotherapy and radiation?

A. In my opinion, yes.

Q. Have you had patients that have gone through chemotherapy and radiology?

A. Yes.

Q. Are you aware of what the patient goes through when they go through chemotherapy and radiation?

A. I am.

Q. What is the quality of life for a

patient that goes through chemotherapy and radiation?

A. It -- it depends on the individual patient. Some tolerate it better than others. But it can be very uncomfortable, and a number of unpleasant sequelae can come, particularly from the radiation, such as inflammation of the colon and -- and burned skin, et cetera.

Q. Doctor, could you give us your professional opinion as to the quality of care given by Dr. Eisenberg to Edith James?

A. In my opinion, it was not adequate to meet Mrs. James' needs through the course of her history of polyps and her subsequent cancer.

MR. RUF: Thank you, Doctor.

Mr. Golwasser?

MR. GOLWASSER: Are you finished with your direct examination?

MR. RUF: Yes I am.

MR. GOLWASSER All right.

EXAMINATION

BY MR. GOLWASSER:

Q. Dr. Olden, I apologize to you and most particularly to the jury who will hear this and

view this videotape for my absence there in Phoenix this evening. My airplane was canceled upon my arrival at the airport; so I was unable to join you this evening.

If you don't hear me through this telephone communication, you'll let me know, will you, please?

A. You bet. One, I hear you fine, and, secondly, I too have had planes canceled; so I sympathize. I completely understand.

Q. Doctor, in 1985, a polyp was diagnosed by barium enema, correct?

A. That is correct.

Q. And Mrs. James was then referred to Dr. Eisenberg, a board-certified colorectal surgeon, for the purpose of undergoing a colonoscopy and polypectomy, was she not?

A. That's correct.

Q. Now, you have testified previously when I took your deposition under oath, that Dr. Eisenberg should have done a colonoscopy within one to three years upon removal of the polyp, the removal being in 1985.

Remember testifying to that?

A. I do.

Q. Doctor, we know that if, in fact, a colonoscopy had been done within one to three years, it undoubtedly would have been a normal examination, would it not?

A. In my opinion, yes.

Q. Now, some colon cancers, Doctor -- in some colon cancer, the growth begins below the mucosa, does it not?

A. In certain situations it can, yes.

Q. And the mucosa is the -- as you've explained earlier, is the -- the lining, the lining that is within the lumen of the colon and is the -- the -- the wall of the inside of the colon, correct?

A. Correct.

Q. And if -- a colon cancer growth begins submucosa or below the mucosa and does not become perceptible to an examiner unless and/or until it breaks through the mucosa or pushes the colon wall up isn't that true?

A. That's correct.

Q. Now, the -- an endoscopic exam of the colon, as you ve explained, is by way of colonoscopy or sigmoidoscopy, correct?

A. Correct.

Q. And it involves direct visualization of the mucosa, correct?

A. Correct.

Q. And a lesion should be and/or can be discerned if it is distinct, correct?

A. Correct.

Q. And a growth under the mucosa may not be perceptible; isn't that true?

A. Correct.

Q. Now, in this case involving Mrs. James, it's my understanding you are assuming that her cancer began with a precancerous polyp growing outside of the wall of the colon; isn't that true -- or the mucosa is what I mean to say?

A. That's correct.

Q. Then we're into a situation in which we saw in 1985 when the polyp was diagnosed as being present and removed, correct?

A. Correct.

Q. Now, if, just hypothetically, that this was one of those unusual cases where the cancerous growth was not initially presented as a polyp but began as a submucosal growth, then it is not necessarily diagnosable by sigmoidoscopy or colonoscopy until, as

we've said, it broke through the wall or pushes up on the wall; isn't that true?

A. If a lesion like that occurred, that would be the case, yes.

Q. Now, we know that Mrs. James' cancer was not in the same location in the colon as was the polyp which was removed in 1985; isn't that true?

A. That's my assumption, yes.

Q. We know from the description that the '85 polyp was removed at approximately 45 to 50 centimeters from the anal verge, and the cancer that was ultimately diagnosed in 1995 was at 30 to 35 centimeters, correct?

A. Correct.

Q. You mentioned about -- something about a polyp being observed on barium enema in '85 at or near the splenic flexure.

Do you remember testifying to that?

A. I do.

Q. And, in fact, the cancer that was diagnosed in Mrs. James was not at or near the splenic flexure, was it?

A. That's correct.

Q. On April 1994, Dr. Eisenberg

examined the colon up to 38 centimeters, and you have explained what you believe to be a possible explanation as to why he perhaps did not, in fact, go up that high; isn't that true?

A. Yes.

Q. But if he did go up the 38 centimeters from the anal verge, the cancer that was ultimately diagnosed in October 1995 was not visible by way of sigmoidoscopy; isn't that true?

A. if he had been at -- we assume that 38 centimeters was an accurate measure, that's correct, yes.

Q. Now, if hypothetically, Mrs. James' cancer began with submucosal changes, it would not necessarily have been seen in April of 1994; isn't that true?

A. Well, there is two issues. One, it being submucosal, and, secondly, the time of the tumor. I'm also assuming that, given the size of the tumor in 1995, i.e., almost completely occluding, that there would have been tumor present in the lumen of the colon in 1994

Q. Most colon cancer develops in the rectosigmoid region of the colon; does it not?

A. Sixty percent, that's correct.

Q. And that turned out to be true for Mrs. James; isn't that correct?

A. That's right.

Q. I mean, you have repeatedly, in response to questions asked by plaintiff's counsel, talked about the need for colonoscopy to examine the entire colon, but, in fact, as it turned out for Mrs. James, her cancer, in fact, was confined to the region of the rectosigmoid colon, was it not?

A. Correct.

Q. And, as you've indicated, Dr. Eisenberg, as often as six times during the course of 10 years, examined the region of the rectosigmoid colon, did he not?

A. Correct.

Q. A poorly differentiated adenocarcinoma grows quickly, doesn't it?

A. They can grow in varying rates. I mean, it's hard to say. I mean, what we do know is it takes about five years to go from a de novo polyp to a full-blown cancer. So I don't know if that is fast or slow.

Q. Well, but I'm talking about once it

becomes a cancer, and once it becomes a poorly differentiated adenocarcinoma it grows quickly, doesn't it?

A. Right. The longer it's there, the most rapidly it grows.

Q. Well, it may be present microscopically or imperceptibly and thus not something that would be observed by an examining physician; isn't that true?

A. I'm sorry. Ask that again.

Q. Adenocarcinoma, which is poorly differentiated may be present microscopically and/or imperceptibly and thus not perceptible or noticeable to the examining physician; isn't that true?

A. Well, actually, my opinion, no. A poorly differentiated carcinoma is a carcinoma which is quite advanced in terms of time, and that would be very unlikely.

Q. Talking about the symptoms of colon cancer, among those symptoms is bleeding, correct?

A. Correct.

Q. That could be occult or frank bleeding, correct?

A. Correct.

Q. And if there is a -- there was a large polyp which leads to cancer, you would expect to have seen occult blood in the stool, would you not?

A. You wouldn't expect it. You could find it, but it's not -- more times than not, it does not bleed.

Q. Well, Doctor, when I took your deposition in July of this year, on page 26, line 16, I asked this question:

"Would you expect, Doctor, that if there was a large polyp which would lead to cancer, that you would expect to have seen some occult blood in the stool?

"Answer: I would have. But, again, remembering that large polyps in colon cancer bleed intermittent1y."

Do you remember telling me that?

A. I do.

Q. Was your answer different today?

A. Well, actually, I think it's the same answer. What I'm saying is large polyps, indeed, can bleed, but more times than not they will not bleed.

Q. Then, when you told me in July that you would have expected to see an occult blood, you

didn't mean that.

Is that what you're telling me?

A. I guess it's a semantic difference of opinion.

Q. I see, Doctor.

Among the other symptoms of colon cancer, there are changes in bowel habits, correct?

A. Correct.

Q. Among other symptoms of colon cancer, there is weight loss, correct?

A. Right.

Q. Now, Doctor, do you accept the proposition that different physicians can see the same patient and not treat the patient the same, and none are necessarily committing malpractice or negligence as long as the care is acceptable?

A. I do.

Q. You appreciate the fact that medicine is an art as well as a science?

A. I sure do.

Q. And you do agree that the role of the well-trained and experienced physician is to make judgment decisions in the care and treatment of his or her patients?

A. Yes.

Q. You, apparently, have learned from reading Dr. Eisenberg's testimony and reviewing his records that he made a judgment decision that after Ms. James, in 1987, declined a repeat colonoscopy -- or canceled a repeat colonoscopy, I mean to say, that he elected to follow her by examining the rectosigmoid region of her colon, correct?

A. Correct.

Q. And you maintain, apparently, that she was symptom free of colon cancer until April 1994.

Is that what you're contending?

A. In general, yes.

Q. Okay. Well, Doctor, in October of 1994, we know, from her primary care physician, that there was no evidence of, at least, occult blood upon guaiac stool testing, correct?

A. That's right.

Q. We also know that in October of 1994, which is, let's see, that's six months following April '94, Mrs. James' weight, in fact, was 115 pounds, which was more than she weighed nine years earlier.

Were you aware of that?

A. I was.

Q. Pardon me?

A. I was, yes.

Q. We also know, from talkirig to the family and also from the records that we see, that she was not complaining of any change in bowel habits as of October 1994; isn't that true?

A. In October '94, that's correct.

Q. So when she sees Dr. Eisenberg some six months later -- earlier in April, we know that she, in fact, had not had any weight loss. In fact, she undoubtedly weighed more than she did some years earlier.

We know that the only complaint of any blood, as Dr. Eisenberg testified to, was blood on tissue in the presence of hemorrhoids.

MR. RUF: Objection. It's different than his record.

Q. BY MR. GOLWASSER: We also know that, in fact, the patient was not complaining of any significant change in her bowel habits; isn't that true?

A. Well, actually, my reading of Dr. Eisenberg's note of April 25, '94, he says in that note, "Occasionally has several BMs". So I would -- I would consider that to be a change in bowel habits as

noted by him.

Q. Is occasionally having several BMs -- are you telling this jury that, in your judgment, that is a clinical sign of colon cancer?

A. I'm -- I'm saying he reported a change in bowel, her regular bowel habits --

Q. Are you saying that in the constellation of symptoms here that you consider that to be something that a physician should consider a clinical sign of colon cancer?

A. Yes.

Q. Doctor, you said that you received the testimony of Dr. McCarty, but you have not studied it

Is that what you told us?

A. That's right.

Q. But you have previously acknowledged to us that you are not expert in the subject of pathology of colon cancer; isn't that true?

A. That's correct.

Q. Now, Dr. Olden, as a gastroenterologist, I take it that you consider it your duty and obligation to keep up with medical literature as pertains to your specialty interests.

Do you do that?

A. As best I can.

Q. And I trust that you make it a point to read articles in the major prominent medical journals about the long-term risk of colorectal cancer after excision of rectosigmoid adenomas, do you not?

A. I do.

Q. You said that you have not reviewed any literature in particular as pertains to this case.

Did you not tell us that?

A. I did. That's correct.

Q. And, Doctor, in fact, Ms. James is a woman who, in fact, had to be considered as to the long-term risk of colorectal surgery [sic] after excision of a rectal sigmoid adenoma, right?

A. Correct.

Q. That is just what she had in 1985?

A. Right.

Q. Doctor, isn't it true that a definitive study, published in the New England Journal of Medicine in 1992, reviewed the very subject of this long-term risk of colorectal cancer?

MR. RUF: Objection; inadequate foundation.

Q. BY MR. GOLWASSER: Is this not true, Doctor?

A. It's one of a number of articles that have addressed that, right.

Q. You consider the New England Medical -- New England Journal of Medicine to be a well-respected juried publication circulated among the medical community?

A. It sure is.

Q. And, Doctor, do you recognize and accept the conclusion of the literature that, in fact, a patient who presents with one, large, villous adenoma is at small risk for developing cancer?

MR. RUF: Objection.

THE WITNESS: If I remember the article you're citing, which was published, I think it was either '92 or '93, in the New England Journal, as best I can remember that study, it was a study of rigid proctosigmoidoscopy as opposed to flexible sigmoidoscopy.

And my recollection of the article was that in patients who had large adenomas of the sigmoid, they were three times more likely or 3 point something times more likely to have recurrent polyps or

synacrenous polyps than people with small adenomas.

This month in the Journal of Gastroenterology, there is a similar study, a multi-center study published on the same topic, which came to similar but slightly different conclusions in that, where the New England Journal study in '92 said that those patients did not need colonoscopy because most of the lesions, i.e., most of them being small, were not associated with additional polyps, this multi-center trial, which was published just this month, comes to a different conclusion saying that those patients do need colonoscopy.

The data, interestingly, was about the same. Basically, small polyps, by and large, were not associated with additional polyps or large polyp were, but the study authors in both articles came to different conclusions.

Q. BY MR. GOLWASSER: And Dr. Eisenberg, of course, was treating this patient before a month ago, was he not?

A. He certainly was.

Q. Doctor, Mrs. James, as you've discussed, had a diverticular disease of the colon, correct?

A. That's right.

Q. By the way, let me just digress for one moment, Doctor.

You were asked questions about your writings in the field of your specialty, but, in fact, you have never written on the subject of surveillance and endoscopic procedures following a polypectomy, have you?

A. That's correct.

Q. All right. Now, turning to Mrs. James diverticular disease, she was at increased risk for bowel perforation during endoscopic procedure because of that disease, was she not?

A. That's correct.

Q. Doctor, how is it that you happened to meet the plaintiff's attorneys in this case, who are located in Cleveland, and, at the time, I believe you were in San Francisco?

A. They were referred to me by a service, which is based in Fort Lauderdale, Florida.

Q. And this is a service run by a nurse, who runs a brokerage for expert witnesses; isn't that true?

A. That's correct.

Q. And this expert witness brokerage service does not submit cases for you to review on behalf of defendant physicians; isn't that true?

A. By and large, that is absolutely true.

Q. So, Doctor, as we analyze this case, here we have Dr. Eisenberg, who is surveying Mrs. James' rectosigmoid colon over a period of 10 years, correct?

A. Correct.

Q. That a -- that the sigmoidoscopy examinations -- I realize, in some instances, you may be critical of them, but, nevertheless, in no instance did they demonstrate disease other than diverticular disease; isn't that true?

A. That's true.

Q. And while it is your opinion that she became symptomatic in 1994, that is the first time that the record documents such, correct?

A. Correct.

Q. And, according to Dr. Lerner, the patient's primary care physician, that is as of October 1994, the patient was asymptomatic; isn't that true?

A. In her -- in her note of October '94, that's correct.

MR. GOLWASSER: Dr. Olden, I thank you. I have no further questions.

MR. RUF: Doctor, I just have a few follow-up questions.

(Interruption of the proceedings.)

MR. RUF: Doctor, this is Mark Ruf again, counsel for the plaintiff.

EXAMINATION

BY MR. RUF:

Q. Doctor, between the period of 1990 to 1995, were there studies published in respected medical journals that showed if there was surveillance colonoscopy every two to three years following polypectomy that there was a reduced incidence of cancer in most patients?

MR. GOLWASSER: Objection.

THE WITNESS: Yes.

Q. BY MR. RUF: Doctor, can a physician be negligent in making poor judgments?

A. Yes.

Q. Doctor, in your opinion, was Dr. Eisenberg negligent in that he made poor judgments?

A. In my opinion, yes.

MR. RUF: Thank you, Doctor.

MR. GOLWASSER: I have no further questions.

THE VIDEOGRAPHER: This concludes the videotaped deposition of Dr. Kevin Olden. Today's date is September 10, 1998, and the time is now 9:55 p.m.

MR. RUF: It's my understanding you're going to waive the filing requirement.

MR. GOLWASSER: Correct.

MR. RUF: Okay. Thank you, Gary.

Let's go off the record. Waive signature.

(The deposition was concluded at or about 9:57 p.m. in the evening.)

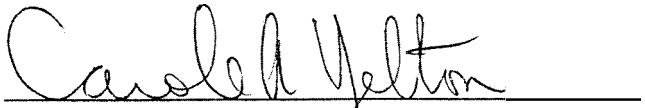
(Signature waived.)
KEVIN W. OLDEN, M.D.

STATE OF ARIZONA)
) ss.
COUNTY OF MARICOPA)

BE IT KNOWN that the foregoing videotaped deposition was taken before me, CAROLE A. YELTON, a Notary Public in the County of Maricopa, for the State of Arizona; that the witness before testifying was duly sworn by me to testify to the whole truth; that the questions propounded to the witness and the answers of the witness thereto were taken down by me in shorthand and thereafter reduced to print under my direction; that the foregoing pages are a true and correct transcript of all proceedings had upon the taking of said deposition.

I FURTHER CERTIFY that I am in no way related to any of the parties hereto nor am I in anywise interested in the outcome hereof.

DATED at Scottsdale, Arizona, this 11th day of September, 1998.



Carole A. Yelton
Court Reporter
Notary Public, Maricopa County, Arizona
My commission expires July 20, 2000