COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

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Doc. 407

SUZANNE DOYLE, ETC , ET AL , :

PLAINTIFFS, :

-VS- : CASE NO 239783

BERT M BROWN, M D , ET AL , :

DEFENDANTS :

- - -

Deposition of DONALD A SHWE ICK, M D , a witness herein, taken by the plaintiffs at 11:10 a.m. on Friday, August 12, 1994 before Lois A Roell, RPR, a notary public within and for the State of Ohio.

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APPEARANCES:

On behalf of the Plaintiffs:

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of

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On behalf of the Defendants, Dr. Bert Brown and Cleveland Ear, Nose, Throat:

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S T I P U L A T I O N S

It is stipulated by and among counsel for the respective parties that the deposition of DONALD A. SHUMRICK, M.D., a witness herein, may be taken as upon cross-examination pursuant to the Ohio Rules of Civil Procedure and pursuant to agreement and Notice to Take Deposition; that the deposition may be taken in stenotypy by the notary public-court reporter and transcribed by her out of the presence of the witness; that the transcribed deposition is to be submitted to the witness for his examination and signature, and that signature may be affixed out of the presence of the notary public-court reporter.

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I N D E X

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DONALD A. SHUMRICR, M.D.

of lawful age, a witness herein, being first duly sworn as hereinafter certified, was examined and deposed as follows:

CROSS-EXAMINATION

BY MR. YOUNG:

Q. Dr. Shumrick, would you state your name for the record, please.

A. Donald A. Shumrick.

Q. And your business address here?

A. University of Cincinnati Medical Center, Mail Location 528, Cincinnati, Ohio 45267. We just changed our address, that's why I'm waffling on the numbers.

Q. Doctor, you have told me that you will provide me with a CV at a later date, but do I inderstand that you are a Board certified physician?

A. Yes, I am.

Q. In what area?

A. Otolaryngology, head/neck surgery.

Q. And what is the position that you iold here with the University of Cincinnati?

A. I am a full professor of

otolaryngology and head/neck surgery, and I was chairman of the department for 28 years. I'm not chairman now. I stepped down.

Q. And in connection with the Allen Boyd matter, you received a request from Mr. Murphy; is that correct?

A. Yes.

Q. Did the request actually come from Mr. Murphy?

A. Yes, it did.

Q. Can you tell me approximately when Mr. Murphy would have contacted you concerning this case?

A. Sometime in 1993, I don't recall the date to be honest.

Q. And --

A. I think in the fall, about a year ago.

Q. Okay. And can you tell me how that contact was made?

A. I think originally he called me.

Q. By telephone?

A. Yes.

Q. And what did he tell you when he

contacted you?

A. He asked me if I would be available to review a case that he was involved in.

Q. All right. Now, I understand that you have a file on this matter but that it is not in the building today; is that correct?

A. Yes.

Q. And you have agreed to provide me with a complete copy of that file without any deletions, any corrections or anything?

A. Yes, yes, of course.

Q. Can you tell me what materials Mr. Murphy provided to you in connection with this matter?

A. Well, I had some depositions to review.

MR. MURPHY: I can give you specifics on that.

THE WITNESS: Yes, if you would.

MR. YOUNG: Thank you.

MR. MURPHY: When I was looking for the CV, I saw a cover letter. That's a list of what I sent you.

THE WITNESS: All right. Shall I

read them?
BY MR. YOUNG:
Q. Yes, if you would just for the record.
A. The office records from Dr. Brown; office records from Dr. Parsanko; record from the Brunswick Primary Care Center; Dr. Nowak, N O W A K, Dr. Nowak's office records; excerpts from the Medina General Hospital admission of October 2, 1990; excerpts from the Medina General Hospital admission of October 17, 1990; a consultation report from Dr. S., last name Hazra, H A Z R A, a medical oncologist, dated October 5, 1990; excerpts from Medina General Hospital admission of November 8, 1990; pathology report from the Cleveland Clinic Foundation with reference to the pathologist's slides previously read by Dr. Alonso at Mariemont Hospital; and a copy of Dr. Bert Brown's deposition testimony.
Q. Okay.
MR. MURPHY: Since then, Chuck --
MR. YOUNG: Please.
MR. MURPHY: -- I did send him Dr. Alonso's deposition, but I don't think there's been

anything else.

THE WITNESS: Yes, he did.

BY MR. YOUNG:

Q Have you received copies of some of the experts' reports in this matter?

A Yes, I have.

Q The report of Dr. Brett, an oncologist in California?

A. Yes.

Q The report of Dr. Haine, a pathologist in Mississippi, Stephen Haine?

A I don't recall that.

MR. MURPHY: I don't remember.

Q Have you received the report of Dr. Jacob, an ear, nose and throat physician from Detroit?

A. Yes.

Q. Are any of these experts known to you in any manner?

A. No.

Q Have you receive the report of Dr. Mendelsohn from Mt. Sinai in Cleveland?

A Yes.

Q Is Dr. Mendelsohn known to you?

A. No.

Q. Before you received these materials, and I assume a copy of this letter will be contained in your file, correct?

A. I assume so, yes.

Q. Before you received any of these materials, did you know Pat Murphy?

A. Yes.

Q. How had you known him?

A. It must be three or four years ago I reviewed a case for him. He was representing the physician, and he asked me to review one for him and I did.

Q. And did you review and prepare a report in that case?

A. Yes.

Q. And were you called upon to testify?

A. Yes.

Q. Do you recall the name of the case?

A. No, I don't.

Q. Do you recall the circumstances surrounding the case, that being the medical issues involved?

It had to do with a peritectomy in

which the facial nerve was injured.

Q. Did that matter go to trial?

A. Yes.

Q. And you testified in the Cleveland area?

A. Yes.

Q. Have you reviewed any other case for Mr. Murphy at any point in time?

A. No.

Q. Have you had any other contacts with him other than in that matter?

A. No.

Q. Have you had any contacts with other attorneys who are with the Jacobson, Maynard office?

A. I don't know how to answer that.

Q. Well, in terms of consultation or review of cases, have you reviewed cases for any other attorneys who would actually be employed by or partners of the Jacobson, Maynard, Tuschman and Kalur office?

A. I don't know how to answer that.

Q. Why not?

A. I'm not quite sure what you mean by

review and what you mean by employed.

Q. I'm going to get into PIE matters and review for PIE at another time, but in terms of review of cases for purposes of preparation of a report and testifying, have you been consulted by any other Jacobson, Maynard attorneys?

A. No.

Q. So essentially in terms of a professional relationship in terms of anticipating testifying, you've only had two occasions where you've worked with the firm?

A. No, only one.

Q. I'm sorry, and this case?

A. Oh, I'm sorry.

Q. so two?

A. Yes.

Q. Now, you've testified as an expert witness I assume on many occasions?

A. Testified or reviewed?

Q. Well, let's use reviewed first of all.

A. Well, not that many. Some.

Q. Can you approximate the number for me over the course of your career?

A. No. Maybe -- well, let's differentiate them. I do see some -- I do do some independent medical examinations on personal injury. This is the majority of the medical/legal things that I see anyway. As far as malpractice is concerned, very, very few.

Q. And would we say fewer than ten in the course of your career?

A. Yes.

Q. And you do work involving independent medical exams; do you do that on behalf of defense counsel here in the Greater Cincinnati area?

A. Defense or plaintiff, either way. Attorneys are looking for a definitive opinion as to an injury somebody sustained secondary to some type of accident or something, and we just do -- I just do the examinations, that's all.

Q. And that is an examination that takes place where you're not involved as a treating physician for the patient?

A. That's right, yes.

Q. Generally the bulk of that work would be done by defense counsel, would it not?

A. I have no idea. Because plaintiff's

counsel needs the same material.

Q. But generally obtains that material from the treating physician?

A. I don't know. I don't ask them, to be quite frank. I am asked to review, do an independent medical exam, and to give an opinion. That's my --

Q. Are you insured by PIE?

MR. MURPHY: Objection.

A. Yes.

Q. For what period of time have you been insured by PIE?

MR. MURPHY: Let me note a continuing objection to this.

MR. YOUNG: Of course, yeah.

A. I don't know to be honest. My corporation -- my corporation has been insured by PIE, in all honesty it must be ten years, but I don't know. I should state though that as of September I will no longer be insured by PIE.

Q. What is the reason for that?

A. I'm going under the university's program. Right now I'm insured by both the university and PIE, and we continued the PIE but

we're phasing out of it.

Q. But you've been insured in some manner by PIE over a period of some years?

A. Yes.

Q. Have you ever been involved in the business of PIE in any manner?

A. No.

Q. PIE is a mutual insurance company, that being the physicians essentially have some participating interest in the loss ratio of the carrier. Do you ever receive reports or any information concerning how that business has done in the previous year or over some period of time?

MR. MURPHY: Objection. Go ahead.

A. If I do, I don't even recall it. I'm not interested in that.

Q. Have you ever participated in any way in the review of claims for PIE, and I should say of medical matters for PIE?

A. Well, just in the one previous case that I mentioned.

Q. Where you were actually retained in some manner in anticipation of testifying in litigation?

A. That was the only time.

Q. All right. Have you ever been involved in the analysis of claims within the insurance organization itself and asked to review claims in that --

A. In PIE?

Q. Yes.

A. No.

Q. In any insurer or business?

A. No.

Q. Are you acquainted with any *of* the people involved in the business of PIE?

A. No. My chairman, Dr. Jack Kluckman, I'm not sure if he's on -- do you have a local board or something, I'm not sure about that.

Q. But you yourself have not been involved in a local board of PIE?

A. No.

Q. You've not been a board member?

A. I've had no dealings with them except the single case that I did with Mr. Murphy before.

Q. Okay. Doctor, you've been asked to render an opinion concerning Dr. Brown's participation in the care of Allen Boyd, and I have

before us here exhibits that I've marked Dr. Brown Exhibits 1 through 6 in his deposition. You've had the opportunity to review his deposition, have you not?

A. Yes.

Q. What do you understand the facts to be with regard to his treatment of Allen Boyd?

A. It appears that Mr. Boyd came to see him for a small lesion around the middle third of the lateral margin of his tongue on the left. If I recall, Dr. Boyd felt that this was most likely not malignant, and did an excisional biopsy of that lesion in the office. The pathologist reported that it was not malignant, and Dr. Boyd --

MR. MURPHY: Dr. Brown actually.

A. I mean, I'm sorry, Dr. Brown, told the patient to make an appointment and come back in one week. Dr. Boyd -- excuse me, Dr. Brown also discussed with Dr. Alonso, the pathologist apparently that read the slide, as to the diagnosis of it, and so noted I think on this sheet that's before us now. As I understand it, the patient did not come back and went on to develop further involvement concerning his left cervical neck and

so forth.

Q. And rather than get into the specifics of the size of the lesion, the color of the lesion, and so forth, would it be safe to say that your information concerning that has been taken primarily from his office records and from his deposition?

A. As it involves him, yes.

Q. Now, I believe that we're not sure if you've reviewed Dr. Alonso's deposition, is that correct, or have you reviewed it?

A. I received it, but to be quite frank, I can't recall a lot of the particulars in it.

Q. All right. Dr. Brown testified in his deposition that he performed a differential diagnosis when Mr. Boyd came into his office complaining of a sore on the tongue; is that correct?

A Yes

Q And performing a differential diagnosis would certainly be accepted care under those circumstances, would it not?

A Yes

Q In performing a differential

diagnosis, is it safe to say that the physician looks and gathers all of the symptoms of which the patient is complaining initially?

A. Yes.

Q

then prioritizes the causes or possible diseases that could cause such symptoms?

A. Yes.

Q

prioritize those things which could be causing the symptoms in order to determine which could be most severe; is that correct?

A

based on probability.

Q. Do you prioritize them based on probability of occurrence?

A. Occurrence?

Q. Yeah, I'm not sure what you mean by based on probability.

A. Well, probability versus possibility. What would the most probable series of events that produced not only the symptoms but by the way the, in this case the tissue looked and felt, that would be your first differential point.

Then you would say, but if it isn't this, and then you would work your way down, eventually slipping into the area of possibility, and by then it's sort of a guesstimate.

Q. Perhaps we're saying the same thing.

A. In different ways.

Q. And it's not an issue, but as I understand a differential diagnosis from what I've seen and what I've read, essentially a physician has to prioritize the disease processes that could cause symptoms based on seriousness of morbidity and mortality in order to eliminate those things that may need immediate treatment or that may be life threatening before he can conclude that it is a less serious cause; is that fair?

A. Well, that's a very wordy description, but when you get down to reality, I really don't think that's how it really works. A patient comes in with a set of symptoms. You listen to the symptoms, you ask questions and so forth. Then you examine the patient. You now have both ends. What it is that brought the patient in, what's bothering him and so forth, and what you see or feel. You then perhaps order other tests,

x-rays, lab, or whatever it's going to be, and then when you have all this material, you say all of this probably, versus possibly, probably is caused by whatever as your number one differential, and then you don't say it, but you're certainly thinking that if it isn't that with all this material indicating whatever, it's number two, number three, number four.

Q. All right. Perhaps we're getting --

A. It has nothing to do with morbidity and mortality unless the patient comes in critically ill and, of course, we're not talking about that in this case, but unless the patient comes in in that way, I don't think anyone would really realistically think of morbidity and mortality at that point.

Q. Well, Dr. Brown was dealing with a white plaque lesion here, was he not?

A. Apparently, yes.

Q. And would we say that that was leukoplakia?

A. I wouldn't.

Q. No?

A. No. That's a bad word.

Q. Why?

A. It doesn't say anything. If we were five physicians sitting in a room and I said leukoplakia, immediately in five minds comes a lesion, and if you could believe it, none of them are the same. It means white plaque, he's suffering from white plaque. That's a garbage description. It doesn't say anything, it's just strictly, what's the word, descriptive.

Q. Let's use white plaque then. This gentleman presented on November 22, 1989 with what we will call a white plaque lesion?

A. Okay. I don't even like that either, but go ahead.

Q. What would you describe it as?

A. Well, you describe the lesion, what did it look like, what did it feel like, you describe it. And you can't code out someone from the hospital with leukoplakia or white plaque. There has to be a histological diagnosis.

Q. All right. Now, I'm just trying to use a term that Dr. Brown used.

A. I know you are, and no, no, I don't mean to be difficult.

Q.

A.

Society are trying to remove the word leukoplakia from medical dictionaries because it's so misleading, that it doesn't say anything, and I think it confuses many people.

Q

white plaque lesion? Maybe I can find a term we can use.

f

some type. That's a histological diagnosis, that one you can code out, but the other word doesn't have any status.

Q Okay. Dr. Brown testified, if I can summarize from his deposition, that essentially he was dealing with what he termed a white plaque lesion, and that as part of the differential diagnosis he had to consider whether it was cancer. Anytime you're dealing with white plaque lesion, you have to consider whether it's cancer; is that fair?

A. No.

Q. Is that fair on his testimony, is that his testimony as you understand it to be?

A. Oh, I'm sorry, yes, I see what you mean, yes.

Q. All right. Now you're saying that medically that's not true; is that correct?

A. Yes.

Q. Why not?

A. Well, there are many white hyperkeratotic lesions in the oral cavity that are not malignant, will never become malignant, and almost everyone has them. You frequently see them along the cheek lines as that tissue abuts against the teeth. Is it due to friction from the mucosal lining against the teeth? I don't know. It all depends on its appearance and how it feels and has it changed in a relatively reasonable length of time. Patients are sent to us from primary care people who can't figure out which is which, so they send them in for us to make that kind of a judgment.

Q. Certainly you don't question his judgment in considering cancer in the evaluation of this lesion, do *you?*

A. No, not at all.

Q. It was a proper thing to do?

A. Yes. What he did, I thought it was very appropriate. That wasn't quite what you asked me.

Q. I understand. I'm just trying to find some terms upon which we can agree to find where we disagree.

As part of his differential diagnosis he considered whether this lesion could be caused by cancer; is that fair?

A. Yes.

Q. And that was the proper thing for him to consider and a proper thing for him to do?

A. Yes.

Q. Would you agree that based on the symptoms with which this person presented, performing a differential diagnosis required that we eliminate the possibility of cancer before we concluded that it was a benign lesion?

A. Yes.

Q. All right. In connection with that and in order to do that, Dr. Brown did a biopsy here in his office, correct?

A. Yes.

Q. When presented with the circumstances

with which he was presented in his office on that date, do accepted standards of practice require that he take a certain type of biopsy?

A. What do you mean, type?

Q. That he remove the lesion in a given manner procedurally?

A. No.

Q. Mechanically?

A. No.

Q. Okay. Would accepted standards of practice permit him to do an incisional or an excisional biopsy?

A. Yes.

Q. If he does an incisional biopsy, do accepted standards of practice require that he administer additional care beyond what would be required if he had done an excisional?

A. I'm sorry, say that again.

Q. If he does an incisional biopsy as opposed to excisional biopsy, would accepted standards of practice require that he do something more in the treatment of a patient?

A. I'm not sure I understand "more."

Q. Well --

A. If he did -- well --

Q. Let me ask it this way, let me withdraw that and approach it this way. Everything I've read seems to indicate that the physician in considering this type of lesion should do an excisional biopsy.

A. Why?

Q. I don't know. I mean I have my own thoughts on it, but I'm not an expert in the area, would you agree or disagree with that?

A. Well, because of the size of the lesion, I think an excisional biopsy would be an appropriate procedure.

Q. That meaning this was a small lesion?

A. Yes, very small.

Q. And if we're dealing with a very large lesion, then perhaps incisional biopsy would be sufficient?

A. Yes.

Q. Certainly it would be appropriate for him to do an excisional biopsy on this lesion?

A. Yes.

Q. But it's your opinion that accepted standards of care would not require him to do an

excisional biopsy; is that correct?

A. Well, there are a number of incisional type biopsies. I mean when you say incision, I think you're thinking of some kind of a wedge in which you get part of a tumor and maybe part adjacent tissue.

Q. Right.

A. That would be one, but there are little cookie cutter type biopsies that we do take because we want some tissue but we want to minimize the defect created by the biopsy itself. There are a lot of other ways of doing it, but --

Q. All right. When a surgeon is presented with a large lesion, rather than do a lot of damage to surrounding tissue, he may take an incisional biopsy until he determines what's causing it?

A. Right.

Q. But when dealing with a lesion that is small enough that he doesn't create unnecessary damage to surrounding tissue, accepted standards of practice would require an excisional biopsy, would it not?

A. The thing in this case, if I can

answer it this way.

Q. Go ahead.

A. That I think would indicate it, that an excisional biopsy was appropriate really was the size of the lesion. It was just so simple to do that this would be the way to do it.

Q. Okay.

A. It would give you all the tissue there to send to the pathologist and have them look at the whole thing and give you some kind of an answer.

Q. All right. Would doing less than that and taking only a part of the lesion, an incisional biopsy, taking a wedge from the lesion have been a breach of accepted standard of practice for Dr. Brown on November 22nd, 1989?

MR. MURPHY: Objection. It's been asked and answered. Go ahead.

A. I would say no, and I will tell you why. If Dr. Brown really thought that there was a good probability that this was malignant, he may well do an incisional biopsy, because if it came back as he suspected as being malignant, he may well then plan a bigger, more inclusive type of a

procedure, which I think would be very appropriate.

Q. In doing an incisional biopsy, is it possible that the surgeon will find atypical cells but not actually the cancer cells which would provide a firm diagnosis of the lesion?

A. How will he know they're atypical at the time of surgery?

Q. No, he won't know that at the time of surgery. I'm saying in performing an incisional biopsy as opposed to an excisional biopsy, is it possible that he'll miss the cancer and get some atypical cells and get a bad reading from the pathologist?

A. I suppose that there is a possibility, but I have to assume if he's going to take that responsibility to do an incisional biopsy, he would obviously biopsy it in a most likely site that would give him as much information as possible and that he would also include normal tissue with the suspect tissue so that a clear junction could be seen between the lesion and then normal tissue. Pathologists love that kind of a biopsy.

Q. You've concluded that Dr. Brown did

an excisional biopsy on November 22nd, 1989, correct?

A. Yes.

Q. What facts support your conclusion or from what material did you draw that conclusion?

A. Well, as I recall it, that was what he said in his office records, and if I recall Dr. Alonso's path report, I believe she listed it as an excisional biopsy as well.

presented with a very small lesion as we have here --

A. Right.

Q. His or her efforts are directed to removing the entire lesion?

A. Right.

Q. And excising all of the diseased tissue?

A. Right.

Q I think you testified that it was proper for Dr. Brown to consider whether this lesion was cancer, and certainly if it were cancer, it would be life threatening, would it not?

A Yes, I suppose all cancers are life threatening.

Q. Were there any other life-threatening conditions or serious conditions which could have caused this small lesion which was present on November 22nd, 1989?

A I can't think of any.

Q So essentially the far most serious condition that could have been present was cancer, and that was the primary thing that had to be ruled out before we drew a lesser diagnosis, would you

agree?

A. Yes.

Q. Did you have the opportunity to take a look at -- it's a silly question, of course you did -- Dr. Alonso's written pathology report?

A. Yes.

Q. Are you able to conclude anything concerning the type of biopsy which was done, excisional versus incisional, based upon the specimen that was received by the pathology department?

A. I'm sorry, say that again.

Q. Based on the size -- let me give a little better background to this. Showing you what's been marked for identification purposes as Bert Brown, MD, Deposition Exhibit 4, we have the written pathology report from Dr. Alonso; is that correct?

A. Yes.

Q. And Dr. Alonso has a gross description of the specimen that was received by her, correct?

A. Yes.

Q. When the surgeon does the surgery,

essentially he comes up with an estimate of what the size of the lesion would be, but the actual measurement of it is done by the pathologist, correct?

A. No.

Q. No?

A. No, that has nothing to do with the lesion. Remember the pathologist just measures the specimen that they receive. When you do any kind of a biopsy, the defect is always larger and the specimen is always smaller. The specimen obviously contracts after it's been removed, and I am assuming, and I think justifiably *so,* that the specimen was placed in formalin, which would even contract it more. Thirdly, these are silly numbers when you're dealing in nothing bigger than one centimeter and then you get down into millimeters. There are times when the measurement of a lesion is very appropriate and may even be very 'important, but otherwise they're just guesstimates, and I will lay you odds Dr. **Alonso** didn't measure it. She too did what Dr. Brown probably did, looked at it. I don't know whether he did measure it or not, but I would guess he didn't.

Q. I now have 25 questions from that. Let me see if I can back up. Based on the size of that lesion, I take it from your testimony that this lesion was small enough that the measurement of it was not critical?

A. True.

Q. In terms of probability of survival and other such things, it didn't make any difference for this lesion, correct?

A. True.

Q. I think the testimony from Dr. Brown was that he did not actually measure the specimen, but, yes, the defect would be larger than the specimen which was forwarded to pathology.

A. Yes.

Q. And I believe that the testimony is from Dr. Alonso that she actually measured the specimen in arriving at the gross description, but let me ask it in this manner: Is there anything from the gross description *of* the specimen which causes you to question whether an excisional biopsy was performed by Dr. Brown?

A. I don't know how to answer that. I didn't see the lesion, I didn't see what he

encompassed when he made his incisions and so forth. I don't know how to -- he said that he did an excisional biopsy. I am assuming that, and I think rightfully so, that he, that that was what he thought he did or attempted to do it and did it.

Q. When you say you're assuming that, rightfully so, what is it that causes you to say "rightfully so"? I can understand you accepting his testimony and drawing your conclusion based on that. Is there anything other than his testimony that supports the conclusion that this was an excisional biopsy?

A. Well, it's what he said he intended to do. And 35 years of experience indicates to me, and I have no reason to doubt Dr. Brown, if he said I'm going to do an excisional biopsy, he did what he said he did. I'm sorry, I just have to assume that. I think we all have to assume it since none of us were there.

Q. Well, if we go to Dr. Alonso's deposition, I'm looking at page 67 of the deposition, she disagreed that an excisional biopsy had been performed, and it was her conclusion that an incisional biopsy had been performed based on

the nature of the tissue that she received, the size, the fact that there were two pieces, and what she was able to see through the microscope. Do you recall reading that testimony, first *of* all?

A. I do recall, yes, parts of that.

Q. **Do** you question her conclusion based upon her observations that this was an incisional biopsy?

A. Of course.

Q. Do you question it based only on Dr. Brown's conclusion that it was an excisional biopsy?

A. No. How could we possibly put any credence in anything she says. One, she was not there to see the lesion preoperatively. Two, she did not see what was removed at the time that it was removed. The smaller piece **of** tissue may well have been another rim, another piece of margin that Dr. **Brown** felt ought to be included. There's no mysteries to this. You're making all of this as though it was the first time one was ever done. If he said he thought he did and that was what he intended to do, an excisional biopsy, **I** don't see where there's any problem with that, and certainly,

certainly I would never expect a pathologist to tell you what kind of an operation you did.

Q. The only part I object to is I'm not drawing the conclusion, I'm just trying to understand the testimony of the two physicians.

A. I mean you, it was as though I was saying Dr. Alonso. We have in our pathology department, they will make a comment that if I see it's an excisional biopsy, they can't question it even if the lesion ran to the margin. It didn't make any difference because 1 thought I had excised all of it, and if it went to the margin, which I could neither see nor feel and didn't know, it didn't mean I did an incisional biopsy and left tumor behind.

Q. If I can paraphrase Dr. Alonso's testimony, she said on deposition that she had two very small superficial pieces of tissue and that due to the superficial nature of the tissue, she wasn't even able to identify the surgical margins. Does that make sense to you?

A. Well, she also said things on this paper that weren't necessarily correct.

Q. This paper meaning Exhibit 4, her

pathology report?

A. I'm sorry, yes. So I'm not -- forgive me if I don't wildly accept -- I don't know how she would make that kind of an assumption since she was neither there nor did the procedure herself. That's a strange view for a pathologist. I don't think I've ever heard one say that.

Q. Well, she said on deposition that she wasn't there and she didn't know what he did, but based on the superficial nature of the biopsy, it was difficult to read and difficult to identify the margins. She could not tell if there were clear margins because she couldn't identify what the margins were. Does that make sense to you when you take a look at the pathology report and the depositions involved here?

A. Well, the pathology report probably is one of the most confusing reports that I've ever read. It looks almost, forgive me, legal. It's full of terms and expressions. She has larded it with all these terms, and I would never accept a pathology report of this type.

Q. I'm going to get back to that, we'll get into the pathology report and what that is, but

in terms of her ability to question the type of lesion based on the specimen received, you question that; is that fair?

A. I think she should be able to come up with a histological diagnosis based on the tissue she received, and this is backed by further pathogenic examination of the same slide in which a definitive diagnosis was made. Why couldn't she do it if somebody else could or several people could.

Q. That's a good point. I mean, we're -- pathologists are not always able to come up with histologic diagnoses based on reading the slide, are they?

A. What pathologists do, they report what they see on the slide. Now this may be supported by some previous history or something like that, but they report what they see on the slide, and then based on what they see, they make a diagnosis.

Q. All right. But there are occasions when as a result of one circumstance or another, what they see on the slide does not enable them to reach a diagnosis; would you agree with that?

A. Only if I'm allowed to qualify it.

Q. How?

A. If they can't make a diagnosis based on what they see on the slide, then they are obliged to say I don't know, I can't make a diagnosis on this, I need more tissue or I would like someone else to review it with me and so forth. I can't recall a time, and I suppose it has happened even in my own career, but I can't recall it, where a pathologist where it says diagnosis and he says none or I can't make it or something, and I suppose there are times when there is insufficient tissue, but this doesn't seem to be the case here.

Q. Why do you say that?

A. Because she doesn't say it.

Q. All right.

A. She doesn't say I can't make a diagnosis. She babbles under that particular area on the bottom with all the words that they have usually in the head and neck area, but I don't necessarily see a firm diagnosis. I don't see her saying, I'm sorry, I didn't have enough tissue and I can't make a diagnosis. That would be a perfectly legitimate thing to say.

Q. All right. If a pathologist receives

a tissue specimen, examines it microscopically and is unable to reach a diagnosis, is it a breach of accepted standard of care to fail to say that in the written report?

MR. HUPP: Objection.

MR. MURPHY: Let me note an objection. If you're asking if he's qualified, fine. If you're asking for pathologists --

MR. YOUNG: No, I'm asking him as a surgeon whether in his opinion it's a breach of accepted standard of care.

THE WITNESS: Please again.

MR. YOUNG: Would you please read that back.

(The record was read back by the court reporter.)

THE WITNESS: Yes.

BY MR. YOUNG:

Q Maybe I should go on with those things on which we can agree and then go out from there. Essentially when Dr. Brown testified on deposition, he said he was performing a differential diagnosis of this lesion, and so he biopsied it to eliminate or rule out the possibility of cancer. Are you aware of that

testimony?

A. Yes.

Q. And he testified that based on this written pathology report, he was able to rule out the possibility of cancer; do you recall that testimony?

A. Yes.

Q. Do you agree that based on the written pathology report, it was proper for Dr. Brown to rule out cancer as a cause for this lesion?

A. Yes.

Q. what is it about this pathology report that permitted him to do that?

A. Because Dr. Alonso did not make a diagnosis of cancer, either in situ, which would be a very, very early lesion, or anything invasive.

Q. All right. And is it your testimony that if those magic words are not contained within the pathology report, that the surgeon can properly rule out cancer?

A. I object to your using the term "magic words."

Q. Okay.

A. We're not playing marbles here. This is important, and if she in any way suspected a neoplastic process, she is obliged to say it in her phone call and on her written report, to tell him I don't know, but it looks and all these kind of things, and I think we should have more tissue or whatever.

Q. Let me carry that one step further and say, without going into the definition of all of those things that can be precancerous and going into that, in your opinion could Dr. Brown rule out the possibility that this was a precancerous lesion based on the written pathology report?

A. Yes. Don't --

Q. What is it about the report that permits him to do that?

A. No, your question of precancer, don't hang on to that because there really isn't precancerous -- you can read some of the works from Washington University of McCavern and Bauers in which they indicated very clearly that what we used to think was precancerous isn't and that patients who were followed for long periods of time with what were thought to be hyperkeratoses that turned

to cancer didn't, and the concept was that many people were treated on the precancerous theory that never would have gotten it anyway.

Q. What would the dates of those studies be?

A. Back in the '60's. Beautiful papers, changed the whole way we handle things.

Q. What's the relevance of the observation in the microscopic description of dyskeratosis?

A. Cells that are shaped differently than others. Not as mature.

Q. And does the presence of dyskeratosis indicate that we may have a premalignant lesion?

A. Not necessarily, no.

Q. I'm not asking if it necessarily does, does it possibly indicate that the lesion could be precancerous?

A. Any lesion can be -- I don't know what you mean by precancerous. You mean there is a series of events that are set in place and that are ultimately and eventually going to proceed to cancer?

Q. No, I don't mean ultimately and

definitely, I mean that good practice would require a surgeon to keep an eye on dyskeratosis or a lesion which is microscopically read as containing dyskeratosis to make sure it doesn't become malignant.

A

Alonso so packed this relatively short report with so many different things and she doesn't in her final diagnosis even mention dyskeratosis.

Q

written pathology report is so confusing as to -- withdraw that

have before us prepared by Dr. Alonso, does it contain a diagnosis?

A. Yes.

Q. What was the diagnosis?

A. Moderate papillary hyperplasia with hyperkeratosis, focal mild atypia and chronic inflammation from tongue.

Q. Does that diagnosis mean anything to you?

A. Yeah.

Q. Does it appear to be a proper

diagnosis of a benign condition?

A. Yes. The term chronic inflammation, meaning an inflammatory process that is not acute but has been going on for some time, might account for all the other words that she used.

Q. Are there ever occasions when a surgeon should continue to follow a benign lesion believing that in fact it could warn of coming cancer?

A. In the oral cavity I can't think of any.

Q. Okay. I mean I've read a lot of studies which deal with dyskeratosis being premalignant and certain areas of the oral cavity where white plaque lesions could be premalignant. Do you disagree with those conclusions?

A. Yes, I do.

Q. Here's an old study, if I look at the Clinical Symposia done in 1973.

A. You know who that is?

Q. Who is that?

A. Oh, I'm sorry, I thought it was Frank Netter's drawings. He has marvelous drawings.

Q. I've been looking at your drawings in

your Color Atlas of Oral Diseases here. I look at the authors in dealing with white plaque --

MR. MURPHY: Can you identify that.

Q. Sure, Clinical Symposia, White Lesions of the Mouth, 25th Anniversary Issue of Clinical Symposia published by CIBA. They're classifying white plaque lesions in the oral cavity, and they conclude that in the dyskeratotic leukoplakia, and that's a term that Dr. Shumrick doesn't like to use but they've defined it here, and they also are concerned with being improper use of --

A. Are they, do they really say that?

Q. Yes. They define it and they say that there's not generally accepted use of the term.

A. Good.

Q. But they talk about focal keratosis, they talk about dyskeratosis, and hyperkeratosis. And they define dyskeratotic leukoplakia or histologic leukoplakia, synonym hyperkeratosis complex or dysplastic leukoplakia, they say these lesions, which also do not rub off easily, have dyskeratotic changes in some of the epithelium but

do not involve all epithelial strata, as does carcinoma in situ. Dyskeratotic leukoplakia should be considered a premalignant lesion. And they talk about the incidence of cancer in males and so forth. You disagree with that conclusion?

A. Sure. May I see it?

Q. Yes. And I don't cite that as an authoritative source necessarily, I simply use it for my own guidance.

A. I understand. As 1 say, I've never heard of any of these people, but that doesn't mean anything.

Q. I took the liberty of browsing through your library when 1 was standing here waiting for the deposition to start, and I find the Color Atlas of Oral Diseases by Crispian Scully and Stephen Flint. Is this something that's used im the training here at the university?

A. It's a reference source. We like the pictures.

Q. Some great pictures. And when you look at oral lesions, they always come up with photographs of the largest and most frightening lesion as examples, but if I look at pages 142 and

143, we're talking about keratosis. What is keratosis for the record, Doctor?

A. It's a characterization of either skin or mucosa, a thickening of it.

May I bring up another issue?

Q. Yes, go ahead.

A. Here we have a picture of a dyskeratosis conjunctiva. Now, do we think we should follow this for cancer? This is a child.

Q. Should we?

A. No, I don't think so.

Q. Are there any dyskeratosis in adults or otherwise that we should follow to see if it is premalignant?

A. I really cannot accept the term premalignant. It's a convenient way to do it, and on some of these lesions you would see in something like this or even in there, what they will do is they will -- I give lectures to the medical students about this very issue -- you will biopsy a lesion and it may be hyperkeratosis and you will biopsy another part of the same lesion and it's squamous carcinoma. Therefore, hyperkeratosis, which is benign, became squamous carcinoma, and

there's absolutely no proof to that proven anywhere, that's just not true. Because they are next ***to*** each other, even contiguous to each other, it doesn't mean one converted to the other.

Q. I remember taking a deposition in 1975, and the doctor saying to me benign doesn't change to malignant, a benign lesion does not change to malignant. Do you agree with that? Are there benign lesions of the oral cavity which have a tendency to become malignant?

A. Yes.

Q. Are there benign --

A. See, his statement was too inclusive.

Q. Okay. What benign conditions of the oral cavity could tend to become squamous cell carcinoma?

A. That I don't know. I cannot relate those two.

Q. Doctor, again I'm referring to the Color Atlas of Oral Diseases by Crispian Scully and Stephen Flint, do you know who these gentlemen are, Scully and Flint?

A. No. I know who Crispian is.

Q. Oh, that's four people as opposed to

two people, Crispian, Scully, Stephen, and Flint?

A. Yeah.

Q. Kingdom and them practicing there. I look at page 143 of this atlas and they refer to figure 9.248, with the language immediately beside it, keratosis of the ventrum of the tongue and floor of the mouth has a higher premalignant potential than similar lesions elsewhere. Would you agree or disagree with that statement?

A say that. If you're saying it is more commonly associated, that doesn't mean that there was a conversion from the benign process to a malignant one.

Q. All right, that's fine. You've indicated in your testimony that simply because you find two conditions together, that doesn't mean that one arose from the other?

A. I agree with that completely.

Q. But if you find keratosis or dyskeratosis of the oral cavity, is there a higher incidence of malignancy in certain circumstances where you find that in certain areas?

A. I don't know, I can't answer that.

Q. So that in your practice you would not be more prone to continue to observe one patient over another if they have a benign reading on the pathology report simply because of the observation of keratosis or dyskeratosis; is that fair?

THE WITNESS: Read it again, please.

(The record was read back by the court reporter.)

A. I don't know. You're asking me things that are very difficult to answer because they're all words, and we're not looking at a particular lesion. I can't feel it, I can't see it, I can't give you an opinion based on experience or based on the things that I would use to make a diagnosis. That's just not a fair question.

Q. Let me withdraw that.

A. What you're saying is all theoretical, and I don't know how to respond to those.

Q. Let me withdraw that and ask it in this way. In your practice are there conditions of the oral cavity, benign diagnoses of keratosis or

dyskeratosis which you continue to follow on a regular basis to determine whether the patient will develop oral cancer?

A. No.

Q. All right. Would it be your practice to eliminate those condit ons rather than to continue to follow them?

A. Yes.

Q. I thought that's what I got from your answer. In other words, if you see keratosis or dyskeratosis and that type of lesion, even though you get a benign pathology report, in your practice you would eliminate the condition rather than follow it?

A. Yes.

MR. MURPHY: What do you mean by eliminating the condition?

MR. YOUNG: Cut it out.

THE WITNESS: I think that's what 3r. Brown thought he did.

3Y MR. YOUNG:

Q. Okay. Going on in your report to Mr. Murphy, you conclude that based upon the pathology report, Dr. Brown's management was appropriate in

this case, correct?

A. Yes.

Q. You're aware of the fact that Dr. Brown had a telephone conversation with Dr. Alonso at the time that she was trying to prepare a diagnosis and a written report in this case, correct?

A. Yes.

Q. What is your understanding of the conversation that took place?

A. That, I'm paraphrasing, but that she told him that it was a benign lesion.

Q. And that their telephone conversation was essentially consistent with the written report, that was Dr. Brown's testimony, correct?

A. Yes.

Q. Are you aware of the fact that Dr. Alonso said that she called Dr. Brown because she said she had some atypia on the specimen and she couldn't identify the cause?

A. The cause?

Q. The cause of the atypia.

A. I'm afraid I don't understand how she would ever hope to determine the cause of an

atypia, I mean there's nothing in the slide that's going to cause some other part of the slide to be atypical.

Q. Well, Dr. Brown thought initially when he took this biopsy that he was dealing with a Candida?

A. Yes.

Q. And Candida could cause this type of lesion, could it not?

A. It's possible, yes.

Q. And if it did, there would be some viral elements contained in the specimen and on the slide, correct?

A. No, not necessarily relating to Candida.

Q. All right. Dr. Alonso testified that based on her microscopic examination of this slide, she was able to eliminate Candida as a possibility for the lesion; are you aware of that?

A. Yes.

Q. Do you agree that she could do 'chat?

A. Yes.

Q. And she described atypia, cells that were not normal but not one specific cause for the

condition; are you aware of her testimony to that?

A. Yes, but she --

MR. MURPHY: What page are you on?

Q. I'm at 106 right now, but I'm going to be flipping around here and I will identify it for the record.

A. She -- I'm confused.

Q. Okay.

A. How do I put this.

MR. MURPHY: I think the only question is are you aware of certain testimony of hers. I think that was the question.

Q. That is the question at this time, and then we'll go on from there.

A. The thing that I'm having trouble with is you're saying she can't identify the cause, how could she possibly identify the cause of a cellular change in Mr. Boyd's tongue?

Q. Let me go at it in this manner, looking at page 105 of her testimony, I asked the question, and my question is: "Did you find in your interpretation of these slides that they were highly suspicious for well-differentiated squamous cell carcinoma?" The answer was: "I'm not saying

highly suspicious. Like I said before, they are suspicious." "They are suspicious for squamous cell carcinoma?" Answer, "And other things." "Did your report alert, and by that I mean your written report, did your written report alert Dr. Brown that these slides were highly suspicious, or in your words suspicious, for squamous cell carcinoma?" The answer was: "It alerted him of diseases but not specifically one disease. So it should alert him to follow up the diseases."

A. That's garbage.

Q. Why?

A. Because she's not saying anything, she's trying to cover her own tail. She doesn't say anything in here about being suspicious, concerned, couldn't help, would wonder about squamous cell carcinoma. She says nothing.

Q. Do you conclude from the fact she doesn't set forth any question here in the written report, do you question the testimony that she did so in a telephone call?

A. How could I? I didn't hear the telephone call.

Q. That's my point. She testified --

A. But here she's under oath saying this and that and so forth. That I do object to. I didn't hear the phone call, but her saying there that -- whatever you said up there on the top, up in here somewhere.

Q. I'm going to refer to a -- I'll get to specific references, Doctor, and we'll talk about that, but to paraphrase Dr. Alonso's testimony, she said essentially that she was having a difficult time making a diagnosis, that she saw atypia that was consistent with many disease processes and so she called Dr. Brown to alert him to that and to the need to either completely cut this condition out or to follow it closely. Are you aware of that testimony; you've had the opportunity to read it?

A. Yes. I assumed she called him to give him a quick report because the written report would take time to be typed up and sent out and so forth, which is a courtesy pathologists frequently do.

Q. Both Dr. Brown and Dr. Alonso testified that really those telephone calls only took place not to give benign reports but whether

there was need for further information or immediate response or some other such issue.

MR. MURPHY: Objection.

MR. HUPP: Objection.

Q. Let me ask it this way: You've concluded that Dr. Brown was appropriate in the management **of** this case, correct?

A. Yes.

Q. If Dr. Alonso called him and told him that she was having difficulty with the diagnosis and that he would have to closely follow it, that being the condition, or cut these disease cells out, would his management in the manner in which it was managed have been appropriate?

MR. HUPP: Objection.

MR. MURPHY: Objection to the hypothetical.

A. No.

Q. If Dr. Alonso alerted Dr. Brown to a suspicious condition, then it would have been his luty to go back and fully excise the abnormal cells or to closely monitor them; would you agree with .hat?

MR. MURPHY: Objection.

A. It would depend on what you mean by suspicious, whatever you said.

Q. Suspicious lesion.

A. Lesion.

Q. In the differential diagnosis of an oral lesion where you don't have direct evidence of cancer in the specimen, it is possible still that cancer is causing the problem, is it not?

A. Yes.

Q. And that you will find on the specimen or in the slides atypical cells and an inflammatory process and yet not have gotten deep enough in the biopsy to obtain the actual cancer cells that cause that inflammatory process, correct?

A. Wrong.

Q. How so, how is it wrong?

A. Squamous cell carcinoma, and this is what we're worried about or what we should be I think discussing, is a surface phenomenon. It starts on the surface. There has to be a break in the surface. This is not something -- yes, this is --

Q. There must be an induration of some

sort?

A. No, a break, a frank break in the surface. That's what causes the pain. Squamous cell carcinoma are exquisitely tender in the tongue, and it has to be a break, and the tenderness comes from the fact that you now have a break in the mucosa and all the contaminants of the oral cavity flood in, fungal, bacterial, viral, whatever is floating around in there, and mucosa will never go up and cover and bury a tumor, a squamous cell. Now, it's not a matter of not getting deep enough; it should be right on the surface.

If Dr. Alonso said, well, there's an in situ lesion, which means that there is a neoplastic process that does not go below the basement membrane, well, then Dr. Brown has all kinds of things he should be thinking and doing and so forth. But she didn't say that. She didn't tell him that. It wasn't a matter of not getting deep enough because this was a superficial problem as we well know later, squamous cell all the way through. It wasn't something -- what's the word I want, adenoid cystic or something that it was of a

glandular. There's no break in the mucosa in those cases. So it's not a matter of getting deep enough. She should have been able to pick it up right up on the top, at least something.

Q. It is possible to biopsy a lesion and to get evidence of the inflammatory process and the fungus and so forth that comes from that frank break in the skin and yet not biopsy the cancer cells, is it not?

A. Absolutely.

Q. All right. And where you have evidence of that type of a biopsy, there is a duty to go back and excise further tissue to determine what is causing that, is there not?

A. No, not necessarily. Look, one of the most difficult things we have to do is to rebiopsy something that's already been biopsied. Our colleagues who refer patients to us, we plead with them if you think it may be malignant, send them and don't biopsy it because, as you say, when you go back in the second time, you get acute and chronic inflammation and all the words the pathologists love to use, but there's no mention of cancer, even though you know it's cancer by the

first guy's biopsy. Now you know it's malignant, but you can't get a positive diagnosis, so what we usually do is put them on antibiotics and leave them alone for two, three, four weeks to clean it up. The tumor won't go away, but the inflammation and so forth will.

Now, he had no indication there was malignancy. We're talking about something that is a centimeter or less. You know, we're not talking about something, some big bulk of a thing we see and somehow miss getting the right cells. We didn't hear anything about what the right cells were one way or the other.

Q. I can go through Dr. Alonso's deposition and I can draw out specific reference, and I don't believe that is necessary. Dr. Alonso did testify that based on the written report alone Dr. Brown should have followed this condition or more fully excised the diseased cells. Do you agree or disagree with that?

A. Which part?

Q. With Dr. Brown's obligation based on his written report.

A. One, I think he thought he had since

it's so small, that he had removed the diseased cells. She couldn't come up with a diagnosis. That isn't his fault. Secondly, as I recall it, he did tell the patient to come back. Make an appointment within a week.

Q. We'll get to that, that's a different issue.

A. No, it isn't. You just said he should have followed it. He is following it, he said come back within a week.

Q. So that I have a direct answer to the testimony given by Dr. Alonso, she testified essentially that she contacted Dr. Brown to alert him to the need for further care in this case by the surgeon. Do you question the validity of that testimony?

MR. HUPP: Objection.

A. I don't know how to answer that. I didn't hear her saying it, nor did I hear the telephone conversation. Forgive me if I am somewhat suspect of Dr. Alonso's motives, but that does creep into the thinking a little bit. I don't know. I wish she would have said that in her written report, which would have been a real

document, not just a hearsay thing, and I would suspect that she would say it. I would like more tissue. She did say my findings are very suggestive of a viral infection. Well, why mislead the poor surgeon with words and talk like that if that wasn't what you meant or thought.

Q. If she does in fact contact him to alert him to the need for further care, it would have been his duty to follow up and to manage the case in that manner, would it not?

A. And that's what he did.

Q. Now, the last line or the third part of your report says essentially that Dr. Brown told Mr. Boyd to follow up, correct?

A. Yes.

Q. Do you know how that follow-up instruction was given?

A. I assume verbally.

Q. By whom?

A. Dr. Boyd.

Q. Dr. Brown?

A. I'm sorry.

Q. That's all right.

A. I keep doing that.

Q. I do that as well.

A. Dr. Brown, I'm assuming, I have to assume said to him, I would like to see you in a week.

Q. You assume that based on the fact that written in his chart is the information?

MR. MURPHY: It says follow-up one week.

Q. FU one week, and you assume that instruction was given to Allen Boyd, correct?

A. Yes.

Q. Now, would it be a breach of accepted standards of care not to follow up in this case, by that I mean for Dr. Brown not to tell the patient to come in in some period of time?

A. Well, yes. He just removed some tissue, he has to have the patient come in after he had the path report to see how it was healing and so forth.

Q. Accepted standards of practice would require Dr. Brown or someone on his behalf to, number one, communicate as to the result of the pathology report, correct?

A. Yes.

Q. Two, to follow up on this defect, this surgical area, correct?

A. Yes.

Q. To see that it was healing?

A. (Nodding head.)

Q. Would accepted standards of practice also have required him under the circumstances with which you're familiar to have monitored the condition with any concern for cancer after having received the pathology report?

A. I'll go along with everything but the last part. No, I think Dr. Alonso ruled that out.

Q. So the need for follow-up was that, number one, you have to tell the patient that it's benign and, number two, you have to see that the surgical area is healing?

A. Right. And a week is an appropriate time. You should have the report back by then and you also should have essentially complete healing within a week.

Q. And when that patient follows up and comes in one week, if Allen Boyd had followed up, essentially the standard of care would have required Dr. Brown or part of his office staff to

say it's benign, don't worry about it?

A. I don't think the office staff would do that, I think Dr. Brown would do it.

Q. Would have required Dr. Brown to say it's benign?

A. Yeah.

Q. And it's healing very well. Would any further follow-up have been required?

A. No, not necessarily. I would say to the patient, if you're asking me how I would handle it, if you have any changes or if there are any other problems that arise, then come back and see me.

Q. To your knowledge, was the result of the pathology report ever communicated to Allen Boyd?

A. I don't know.

Q. In your practice would it be unusual for a person to have a biopsy and be told that the biopsy is being taken to make sure it isn't cancer and then to go away and not come back, being unconcerned about whether it was malignant?

A. Very unusual. In fact, patients will call the next day or two days later, do you have a

report, even though they have an appointment for one week, and I personally, and I think most physicians do not like to give the results of biopsies on the phone. I would rather have the patient come in. I do this all the time. I'll tell relatives who are waiting that we do a lot of outpatient surgery and so forth, parents who are going to take the patient home, I would like to see them on Tuesday, you call and make an appointment that's convenient for you timewise, but, and here's what you do and so forth, and that would be to me very normal.

Q. Okay. This probably isn't an issue and so let me ask it in this way: The follow-up by Allen Boyd and his failure to appear in the office did not change the way in which Dr. Brown would have managed this case, did it?

MR. MURPHY: Objection.

Q. If he practiced in accordance with the accepted standards of care, I mean Dr. Brown would have told him it's benign, it's healing, and you don't need to come back?

MR. MURPHY: I'm going to object. You don't know what Dr. Brown would have seen had

the patient come back, that's the basis of my objection.

A. I'm sorry.

Q. Let me withdraw it and ask this. In your opinion did the failure -- did Allen Boyd's failure to reappear in Dr. Brown's office in one week affect the care that was given, have an effect?

A. I don't know. I don't know how *to* answer that. I do truly believe there is a certain patient responsibility, unless the patient is obviously unable to comprehend simple instructions. To hypothetically pretend he did come back and then pretend Dr. Brown saw something or didn't or felt something, I mean would he have had him to come back another time, I mean --

Q. Let me ask it this way. Dr. Brown had a duty to advise Allen Boyd to come back because he had to tell him about the pathology result?

A. Right.

Q. And he had to look at the surgical wound?

A. Right.

Q. Not because he had to be any further concerned with cancer, he had a benign report from Dr. Alonso, correct?

A. Yes.

Q. We know that Dr. Brown excised this lesion, not because it was his standard practice based on what he saw, but because of the anxiety of Allen Boyd, correct? You saw that in the deposition?

A. Well, I would like to think that he felt, you know, that --

Q. It wasn't a breach of the standard of care, it was good practice?

A. That's what I meant.

Q. But the reason he did it rather than follow it is because this man was so concerned with the possibility that it was cancer?

A. And then strange that he didn't come back.

Q. That is strange. Suzanne Boyd testified that Allen received the pathology results by telephone from someone in Dr. Brown's office. Would the communication of the results in that manner without further follow-up have been a breach

of the accepted standard of care?

MR. MURPHY: Objection to hypothetical. Go ahead and answer.

A. I don't know. That's -- when they get that hypothetical, it's very difficult to answer.

MR. YOUNG: I take from Dr. Shumrick's report that he has not been asked to give any opinion and he has not considered the issue of probability of survival, cure, and so forth; is that accurate?

MR. MURPHY: Well, it's not -- we talked about that this morning, to be honest with you.

MR. YOUNG: Is it your intention to supplement the report?

MR. MURPHY: Yeah.

MR. YOUNG: That would be your intention?

MR. MURPHY: Yes. I'll tell you the issue we discussed this morning was a second primary. If one argues that the first lesion that Dr. Brown saw was a primary, there's an issue of a second primary in Dr. Shumrick's opinion.

MR. YOUNG: Let me think, I'm not sure I can -- let me ask a few questions to understand what the issue is there.

MR. MURPHY: That's something you may want to follow up later.

MR. YOUNG: Yeah, I may have *to.* If I can examine today, I'll do it.

BY MR. YOUNG:

Q. Dr. Brown testified on deposition that if he had been told that -- withdraw it.

Dr. Brown testified on deposition that if the pathology report had indicated that this lesion was suspicious for squamous cell carcinoma, he would have gone back into surgery and re-excised the area. Would that have been proper management of the case?

A. Yes.

Q. He further testified that if he had had the opportunity to do that, the probability of Mr. Boyd's cure or survival would have been a given percentage which he used, which has now escaped me. Do you recall reading that testimony?

A. Yes.

Q. Do you agree with his testimony?

A. I don't know how to answer this because it is my feeling that Mr. Boyd's ultimate demise did not come from the lesion in his tongue. So I don't know if I can agree -- if Dr. Brown felt this was the only squamous cell carcinoma in the head/neck area or in other parts of the body, if he felt that this was the only one, and obviously if he had re-excised it, yes, the chance of survival would have been better.

Q. But you question whether this was the primary tumor which caused his demise?

A. Yes, I do.

Q. What is the basis for questioning whether this is the primary tumor?

A. Well, in the first place you recall this was really finally picked up by the oncologist, who in getting more history was told that, oh, by the way, I had a -- and even then he nad already been examined by a dentist, he had been txamined by other capable people, no one saw this, no one felt this. For it to be as aggressive, almost an overwhelmingly unstoppable metastatic Lesion, I mean this is a big tumor, this tumor was actually necrotic in the neck. It ran out of its

own blood supply and died. That's what the needle aspiration read. He said he got purulent looking material. That wasn't purulent looking material, that was dead lipid cells. That's why they didn't culture anything out. This thing grew so aggressively it literally consumed him, but the tongue lesion apparently didn't change much at all.

Now based on experience from a service in this institution in which we do the majority of this kind of tumor work in this city and this area, that is a very, very unusual situation. And if one out of three -- let me explain -- I forget who -- what was the other guy's name that started with a C?

MR. MURPHY: Doctors in this case? You're referring to Cervino?

A. I guess so. He did what he called triscopes or something. We do quadscopes, four. Why do we do that? Because 11 percent of patients with a head and neck tumor upon presentation of that head and neck tumor have another one that has yet not caused symptoms, has not produced any pain, discomfort, bleeding or anything else.

Q. Are you talking about metastatic tumor?

A; No, another primary. So we are concerned that while we are attending to the primary tumor for which he complains, there is another one going on somewhere else. The carcinogenesis of this problem isn't just to one area. The carcinogens in the cigarettes, the smoke, depending whether you believe it or not, bathe all kinds of areas, including the nasopharynx, the hypopharynx, lungs, larynx, esophagus, bronchi, trachea, involve all these particular areas. So while we are aggressively after a particular tumor, we must assure ourselves that there are no other tumors.

MR. YOUNG: Okay. Just for the record so that we don't misunderstand here, we're in an area that I know nothing about, have not been put on notice with any report, but we're here in Cincinnati a few hundred miles from home, and I am going to try to examine so that I understand the opinion, but I'm not going to waive my right to further examine this witness if there is a supplementation of the report and it is permitted

by the court, and then we'll examine further.

Q. Doctor, you talk about in your opinion another primary lesion having been present on November 22nd, 1989, correct?

A. Yes.

Q. Do you draw --

A. Excuse me.

Q. Go ahead.

A. It may not have been present on that day, but it was certainly subsequently I feel present to the point that it caused that massive metastasis, massive metastasis.

Q. I don't understand. Do you mean that -- how can you conclude from this massive metastasis that there was another tumor as opposed to this tumor which was not entirely removed?

A. Because I don't believe it came from that tongue lesion.

Q. Why?

A. Because the tongue lesion didn't change. Remember it should be growing, if I can use that term, at the same aggressive rate as the metastasis. Well, the metastasis was unbelievable.

Q. Not all tumors grow even on the same

host and of the same type at the same rate, do they?

A. No, but you don't have something that measures one or so centimeters in size metastasize first to a supraclavicular area, wrong chain, wrong place. It should be up high in the jugulo digastric area. There were a few smaller nodes there, but the massive one, the one with cavitation and so forth were all down just above the clavicle. Wrong place, how come down there.

Q. Do you believe in your opinion this other primary tumor that you're describing -- first of all, do you believe to a reasonable medical probability that there was another primary tumor which gave rise to the metastasis?

A. Yes.

Q. Do you have an opinion as to when that other primary tumor first occurred?

A. No.

Q. Do you have an opinion to a reasonable medical probability as to whether it was present in the body on November 22nd, 1989?

A. No.

Q. Do you have any reason to believe

that had that -- first of all, do you have an opinion concerning where that second primary tumor would have been located?

A. Somewhere in the aerodigestive tract.

Q. Have you found any evidence at any point in time of such a tumor having existed in Allen Boyd?

A. Just the one CT report in which they mentioned a lesion at the carina.

Q. Are we talking about in October or in the November CT?

MR. MURPHY: October 10.

Q. October 10. What about the October 10 CT -- well, let me just pull it.

Here's a copy of the report, ignore the highlighting. Mr. Murphy swoops in quickly.

A. Okay, under impressions, 2, 1/11 skip 1 because it has to do with the previous surgical site.

Q. Just for the record, we're referring to the written CT report of October 11th.

A. October 11th, 1990.

Q. What in this report causes you to believe that there was a second primary tumor?

A. I didn't say that, you didn't ask me that before. You said to me is there any evidence that there might be a second primary.

Q. Yes, any physical evidence that supports your conclusion.

A. Would you accept a CT as physical evidence?

Q. I would certainly like to see what you have.

A. The chest is otherwise unremarkable except for some irregularity in the posterior wall of the trachea immediately above the carina, extending into the proximal posterior right main stem bronchus. The lesion would measure between 1 and 2 centimeters in length. That's bigger than the lesion in the tongue. The possibility that this could represent the primary lesion, the source of the apparently biopsied proven metastatic lymph node is suggested. I don't know, I'm just -- if you study the pathophysiology of squamous cell carcinoma and if you look at it in light of the idea that tumors have rules, oddly enough, that they usually follow, now I'm not saying all the time, but they usually follow the -- in the first

place, this guy is only 33 years of age. That's young. Squamous cell carcinoma is thought to be a disease of males, I agree, but of older males, upper 50's, 60's, and 70's. Thirty-three is young. And I don't know when he started smoking, but, hell, he couldn't have been smoking -- if he started when he was 20, so he's smoking for 13 years, or if he started at 15 or whatever. This is a very unusual situation. And it would seem to me that it overwhelmed his immune system by just the reports of a large rapidly growing tumor. Within weeks this thing went from 5 centimeters up to 8 centimeters and so forth, and the tongue even went undiagnosed.

Q. **I think it went** from **3 centimeters to** 8 in a week and a half.

A. **Yeah, that's what I'm saying. Again,** these are hard to judge without feeling and so forth. You may be only going over the top of the iceberg literally, and it could be shaped such and there's other material above it that masks it. This is a scary one. This is almost like a science fiction one because the tongue remains quietly seeding this and it is totally out of control.

That's why they didn't make any attempt to cure him because even they knew this was not curable.

Q. In October and November of '90 it was uncurable?

A. Right.

Q. And there's no reason to believe in November of 1989 it was out of control, is there?

A. No, there's no reason to believe there was tumor there.

Q. And if this gentleman in November of 1989 had been diagnosed with squamous cell carcinoma --

A. Of the tongue.

Q. Of the tongue and properly screened to determine whether there were any other lesions present, and that would have been done, would it not?

A. Yes.

Q. I mean proper management of the case would have required that he be examined and carefully screened by CT and otherwise to determine whether there are other lesions?

A. Yes.

Q. You have no reason to believe that to

a reasonable medical probability his treatment would not have enabled him to survive or be cured, do you?

A. Only if I were to accept the fact that the lesion of the tongue -- was that the only primary lesion throughout the entire process?

Q. Let's assume there's a second primary lesion as you've described.

A. Right.

Q. As exists in your opinion. Do you have any reason to believe that he could not have been cured or survived with proper treatment and with diagnosis of that lesion?

A. Why would one look for a second primary if one didn't have a primary tumor?

Q. Whether it's primary or metastatic --

A. Well, but at the time it was metastatic.

Q. In 1989?

A. But he had a report that it wasn't malignant, so why would he go looking for something else?

Q. I understand, that's not my question. Let's assume that a diagnosis of this

primary lesion of the tongue had been made. Certainly he would have been screened for other squamous cell carcinoma also?

A. Yes, he would.

Q. Whether it be metastatic or primary because there are --

A. Yes, yes.

Q. So he would have been examined and he would have been treated for any other primary lesion that would have been diagnosed?

A. Yes.

Q. All right. And CT scans would have been conducted in an effort to determine whether there might be other primary lesions?

A. If the tongue had been diagnosed in '89 of squamous cell carcinoma, yes, he would have gone through the whole process.

Q. All right. Do I take it from that then that you are unable to conclude to a reasonable medical probability that his statistical probability of survival would have changed with a second primary tumor?

A. I can't answer that, I don't know how to answer that.

Q. Okay. You don't have any opinion to a reasonable medical probability as to whether even if he had had a primary lesion it would have -- I'm trying to understand the import of your opinion that there is a second primary tumor. Dr. Brown has testified that Mr. Boyd had anywhere between a 70 and a 90 percent probability of cure or survival had he received a pathology report which indicated suspicious for squamous cell carcinoma. You've indicated that, as I understand it, the only basis for disagreeing with those statistics that you have would be that this man might have had a second primary tumor, correct?

A. Yes. You guys, lawyers have a way of documenting, measuring, weighing, taking height. We don't. I mean look at this range, 70 to 92 or whatever number you said, that's a big range. I can't comment on that. Who has had exactly 100 of those kinds of cases with that size, that shape, and that location that you can, I mean --

Q. We do that because the law requires us --

A. No, no, I'm not being critical, I'm envious because we can't say that. I think Dr.

Brown was giving a generality when he said that kind *of* an expression.

Q. But this man probably would have been cured and probably would have survived if Dr. Brown had been told this lesion is suspicious for squamous cell carcinoma in his opinion. Now you're questioning that if there's a second primary tumor, and my question is how would the second primary tumor have caused a different result with proper treatment?

A. If it could be detected, but the second tumor was occult enough never to be properly treated or diagnosed, so we don't know.

Q. Occult enough meaning it hadn't grown to the point that you would provide it was there?

A. Or it produced symptoms or there was some other indication that something was present. You have to understand how these tumors grow and that lesion of the tongue I cannot accept. The pathophysiology of it just is not the way they behave, and tumors do behave in characteristic fashion.

Q. I understand, but my question is once you diagnose a fellow with a squamous cell

carcinoma, you do everything you can to det mine the extent of the disease?

A. Right.

Q. Whether there's other disease area present and to properly treat it, correct?

A. Correct.

Q. And had that been done with Allen Boyd, even if there are other primary tumors present, if we diagnosed them at the T1 or T2 stage, he's probably going to survive with proper treatment?

A. True.

Q. And when you diagnose someone as having cancer, it requires a regular follow-up even if you surgically treat the person and you radiate and so forth, you regularly follow that person for a period of years, do you not?

A. True.

Q. Until statistically, whether it be five years or whatever it might be, you know that there is no increased likelihood of incidence of cancer?

A. True.

Q. And good practice would have required

Dr. Brown or whomever would have treated this man with this disease to continue to do that?

A. If he had --

Q. If he had the proper diagnosis.

A. Right, true.

MR. YOUNG: Let me take a few minutes if I may, I think I'm done, but let me look through my notes.

(Brief recess.)

BY MR. YOUNG:

Q. As I go through this, Doctor, one question occurs to me. You testified earlier that an incisional biopsy on November 22, 1989 would not have been improper by Dr. Brown even under the circumstances of this small lesion.

A. No, it wouldn't have been improper or whatever --

Q. It would have been easier to do an excisional biopsy and more proper?

A. Yes.

Q. Based on the pathology report that Dr. Brown received from Dr. Alonso, had he done an incisional biopsy, should he have rendered further care in the management of this lesion?

A. Again, it would depend on what Dr. Alonso told him the lesion was histologically.

Q. In written form or by telephone?

A. It doesn't make any difference, both or -- everything has to be in written form, but we cannot accept hearsay on the phone.

Q. Based on the written report, would his management of the case have been proper had he performed an incisional biopsy?

A. Yes.

Q. Doctor, have you formed any opinions in this case which you have not expressed here today?

A. None that I can think of offhand, no.

Q. Is it your intention to supplement the report that you've given to Mr. Murphy concerning a possible second primary tumor?

MR. MURPHY: We haven't discussed it yet. It came up this morning.

MR. YOUNG: So you don't know at this point?

MR. MURPHY: I will ask him to do it, though it's an issue we have to look at.

You didn't know you were going to have more work after this, did you?

THE WITNESS: No.

MR. YOUNG: I have nothing further at this time. Thank you. And I will reserve my right to further cross-examine depending on any supplemental reports.

MR. MURPHY: Let me just note on the record that John Jackson, who is the primary lawyer for Dr. Alonso, asked that his rights be reserved if after he reads this he wants to ask some questions.

MR. YOUNG: Of course, I will object to that, but that's something we'll deal with at the time.

DONALD A. SHUMRICK, M.D.

- - -

DEPOSITION CONCLUDED AT 1:00 P.M.

- - -

C E R T I F I C A T E

STATE OF OHIO :

: SS

COUNTY OF HAMILTON :

I, LOIS A. ROELL, RPR, the undersigned, a duly qualified and commissioned notary public within and for the State of Ohio, do hereby certify that before the giving of his aforesaid deposition, the said DONALD A. SHUMRICK, M.D., was by me first duly sworn to tell the truth, the whole truth and nothing but the truth; that the foregoing is the deposition given at said time and place by the said DONALD A. SHUMRICK, M.D.; that said deposition was taken in all respects pursuant to agreement and Notice to Take Deposition; that said deposition was taken by me in stenotypy and transcribed by computer-aided transcription under my supervision; that the transcribed deposition is to be submitted to the witness for his examination and signature; that I am neither a relative of nor attorney for any of the parties to this cause, nor relative of or employee for any of their counsel, and have no interest whatever in the result of the action,

IN WITNESS WHEREOF, I hereunto set my hand

and official seal of office at Cincinnati, Ohio, this day of , 1994.

MY COMMISSION EXPIRES: AUGUST 12, 1997.

LOIS A. ROELL, RPR
NOTARY PUBLIC-STATE OF OHIO

Spangler Reporting Services

August 18, 1994

Patrick J. Murphy, Esq.
Jacobson, Maynard, Tuschman & Kalur
1001 Lakeside Avenue, Suite 1600
Cleveland, Ohio 44114-1192

In Re: Suzanne Boyd, Etc., et al. vs Bert M. Brown M.D., et al.
Case No. 233783

Dear Mr. Murphy,

Please find enclosed your copy of the deposition of Donald A. Shumrick, M.D., taken August 12, 1994 in the above matter.

Please allow the deponent to review and sign your copy of his deposition, make any corrections that are in order on the enclosed errata sheets, and return the signature page and corrections to our office as soon as possible.

Pursuant to Rule (30)E of the Ohio Rules of Civil Procedure, the deponent has 7 days in which to review, sign and return signature to our office. If the deponent fails to do so, the certificate may be certified and forwarded to the attorney ordering the original or filed with the court upon request.

At the same time a copy is being forwarded to Charles M. Young, Esq.

Your courtesy and cooperation is greatly appreciated.

Sincerely,

Mary Trimborn

Mt :mn
enclosure
cc-Charles M. Young, Esq.

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