IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

ROSE AGNES BASTIAN,
et al.,

Doc 410

Plaintiffs,

-vs-

JUDGE ANGELOTTA
CASE NO. 202353

KEITH W KOEPKE, M D.

Defendant

- - - -

Deposition of PAULA SILVERMAN, M.D., taken as if upon cross-examination before Lynn D. Thompson, a Notary Public within and for the State of Ohio, at University Hospitals of Cleveland, 2074 Abington Road, Cleveland, Ohio, at 1:15 p.m on Monday, September 14, 1992, pursuant to notice and/or stipulations of counsel. On behalf of the Defendant in this cause

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On behalf of the Defendant.

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PAULA SILVERMAN, M.D., of lawful age, called by the Defendant for the purpose of cross-examination, as provided by the Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION OF PAULA SILVERMAN, M.D.

BY MS. REINKER:

Q. Dr. Silverman, we've met earlier briefly. My name is Susan Reinker, and I'm one of the attorneys representing Dr. Keith Koepke in this case.

A. You mean briefly out there?

Q. Right. Outside in the hall,

A. Yes, right.

Q. As you know, Dr. Koepke's being sued for medical malpractice by Mrs. Bastian and her husband. I believe you're aware of that. And you've been identified as an expert witness in this case against Dr. Koepke.

Could you please state your name for the record?

A. Paula Silverman.

Q. Have you ever had your deposition taken before, Dr. Silverman?

A. No.
Q. If you have any misunderstandings about a question that I put to you, tell me that before you try to answer, all right? Because we have to have the understanding that you know what's being asked before you try to answer it. We don't want to hear later on in court that you didn't understand a question and that's why you answered the way you did. Okay?
A, Okay.
Q. What is your current business address?
A. 2074 Abington Road. Actually, it's University Hospitals of Cleveland, 2074 Abington Road, Cleveland 44106.
Q. What is your profession?
A. I am a physician.
Q. Do you have a specialty field?
A, Yes. Well, I'm an internist. I am a hematologist/oncologist, which is my subspecialty. My own practice is in the area *of* breast cancer.
Q. Who are you employed by?
A. University Physicians -- well, I'm employed by Case Western Reserve. My practice group is University Physicians, Incorporated. You might

understand that relationship better than I do.
Q. Excuse me?
A. Nothing. I -- I believe my employer to be -- my employer is Case Western Reserve, but the -- yes, that's my employer.
Q. That's who writes your paychecks?
A. Yes. You know how it is.
Q. I am looking at your CV here. Is this an up-to-date CV? You handled it to me a little bit ago.
A. Yes, My secretary took it off the word processor this morning. I just want to see if the last article -- yes, it's up to date.
Q. Now, I gather from this that you graduated from Case Medical School in 1981?
A. Correct.
Q. And you have done your internships and residencies all right here at University Hospitals?
A. Correct.
Q. You did your one year of an internship in internal medicine. Is that --
A. Yes.
Q. And then two years residency in internal medicine?

A. Correct.
Q. And then you did a three-year fellowship in hematology and oncology?
A It was actually three-and-a-half years It was till January -- through December of '87
Q How did you happen to get involved in this case?
A Mr. Malakely called me and had -- I forget how he had heard of me as a breast cancer specialist My recollection is -- and I'm not sure My recollection is that his mother had been a newspaper article that I had been quoted in as a specialist in breast cancer
Q Do you know Mrs Bastian?
A No I've never met her.
Q Did you know Mr Malakly before this case?
A No.
Q How about Mr Newman, his partner?
A No.
Q I gather from your curriculum vitae that you have never yourself practiced surgery?
A Correct.
Q You have not done a surgical residency?
A No, I have not.
Q How about pathology; have you done anything in the field of pathology as far as reading slides?

I've not done formal training in pathology. As part of our medical oncology practice and training, we frequently review slides with the pathologists.

Q. Have you ever looked at the slides in this case?

A, No. I have not reviewed the microscope slides, no.

Q. If you would be able to do that, would that be of any benefit to you?

A, Honestly, I doubt if it would be of more benefit than, for example, the pathology review that was done at Metro by the, you know, MetroHealth pathologists. I mean we rely on pathologists for the kind of bottom line of most of this, Although not infrequently I review the slides of my, you know, patients' problems with our pathologists.

Would it help me in this case? I don't think I would get new information that they didn't get at Metro.

Q. In other words, I gather you don't plan to review the slides? You have not been asked to review them?

A. I have not been asked to review the slides.

Q. And you have not felt a desire to review them I

gather? You have not said to Mr. Blakely, "Boy, I'd like to look at those slides"?

A. No, I didn't say to Mr. Blakely, "Boy, I'd like to look at those slides."

Q. How about radiology? Have you ever had any training in radiology?

A, I have not done a residency in radiology. Obviously as part of our practice, we review films quite frequently on our patients.

Q. Have you seen the mammograms in this case?

A. Yes, Actually, just this morning I saw the mammograms in this case.

Q. Was that the first time you had seen them?

A. Yes. I had seen the reports obviously earlier.

Q. Which films did you see this morning?

A. All but the missing film. I saw films from March of '88 and -- do you have my file? I have my file back.

March of '88 and --

THE WITNESS: September of '89?

MR. BLAKELY: September of '89.

A. And there was one film from September of '89 that was missing, a lateral view of the breast.

Q. Have you ever seen the mammograms taken more recently of the left breast?

A. No, I've never seen anything but those two sets. Nor reports other than those two sets,
Q. What is your current practice?
A. Well, I am a medical oncologist. I'm sure you know what that is. You know, I am an internist. I see patients with, well, hematologic and oncological problems, both diseases and cancer. My focus is in breast cancer. And approximately 95 percent of my patients have a breast problem or have had breast cancer, and most of them have had breast cancer, and I give adjuvant treatments, you know, chemotherapy or hormonal, for advanced breast cancer and help in the diagnosis and treatment of breast disease.
Q. When you say "help in the diagnosis," what role do you play in the diagnosis?
A. Well, you know -- well, in two ways. A lot of people -- because I'm one of the breast specialists here at University, if someone is told they have a breast lump and need to be seen, they'll make an appointment with me as opposed to, you know, before they actually see the breast surgeons or have a diagnosis of breast cancer.

And so I do some of that evaluation. And if I think that the problem is significant enough, then they go down and see a breast surgeon, which is who they will eventually need to see for the biopsy. But then, of course, since I follow a large number of breast cancer patients, breast cancer patients that have had one breast cancer tend to get another breast cancer, and so I do follow up and screen for new breast cancers, too.

Q. What percentage of your patients do you see before they've been diagnosed as having breast cancer?

A, This is an estimate.

Q. And I mean no cancer at all. Without any diagnosis.

A. No, I understand that's the question. Oh, when they've never had a diagnosis of cancer?

Q. Correct.

A. Very infrequent. Five to ten percent.

Q. So 90 to 95 percent of your patients have already been diagnosed as having breast cancer before they come to you? Is that fair to say?

A, Yes.

Q. What percentage of those 90 to 95 percent of

your patients have already had surgery before they come to you, before you're brought into the case?

A. Well, it's hard to make a diagnosis of breast cancer without some surgery.

Q. I don't mean a biopsy,

A. Before biopsy, like a needle aspiration positive?

Q. Let's say with patients that have had more than just a biopsy before they come to see you.

A. Okay. So there's a gray zone in there? Patients that fall between no diagnosis of cancer and having had their biopsy?

Q. Right. Now, we are talking about --

A. Which group are you talking about?

Q. We are talking about the 90 to 95 percent of your patients who have already been diagnosed before they come to you, Out of that group, how many of them have already had some sort of definitive surgery?

A. "Definitive surgery" is defined as what?

Q. Either mastectomy or lumpectomy or quadrantectomy, some procedure like that.

A. Again, an estimate would be of the patients with a diagnosis of breast cancer when they come to

see me as a new patient, 90 percent.

Q So of the 90 to 95 percent who have a diagnosis when they see you, out of that group, 90 to 95 percent --

A I said 90.

Q I'm sorry.

-- have already had some sort of definitive surgery?

A Yes.

Q What percent of your time do you spend in the clinical practice of medicine?

A About 75 percent.

Q And what do you do in the other 30 percent?

A 25 percent, 75 percent of my time,

Q I'm sorry. I thought you said 70.

A That's okay. I mumble.

Oh, I do it -- you know, I'm assistant professor here at Case, so I do some teaching. I do -- and a fair amount of administrative work. I administer the inpatient -- one of the inpatient wards. I'm the director of that ward, and there's some administrative responsibilities that goes with that. I do some unpublished, clinical research.

Q What kind of research are you involved in?

A Clinical research clinical trials for the treatment of cancer

Q How about publications, what sort --

A. They are in my CV. Oh, I'm -- we've had some innovative clinical trials in cancer treatment using some -- using a biologic response modifier called tumor necrosis factor There's trials I've been involved in in the last several years And I'm writing up one of those trials now And one -- the results of one of those have been published I wrote a case reported this year on an interesting patient with lymphoma.

Q Do you happen to know Dr Larry Levy?

A. I've met him a couple of times.

Q. Now --

A I've taken care of a fair number of his patients

Q He refers patients down here?

A Yes.

Q Now, you stated before this is the first time you've ever given a deposition?

A Yes

Q Have you ever reviewed a medical malpractice case before this one?

A. I have reviewed two.
Q. And were they for Mr. Blakely or his firm?
A. No.
Q. What were they about, if you recall?
A. hospital on the med surg service when I was doing internal medicine attending who had had developed sacral decubiti at a nursing home, and I was asked to write a letter as to whether there was a relationship between her admission, long admission, to the hospital and her sacral decubiti.
Q. Were you asked to write that letter -- were you asked to actually review the care that had been rendered to that patient at the nursing home?
A. No. No, just whether her hospitalization, whether the cause of her hospitalization -- as I remember it. I'd have to pull the file -- whether the cause of her hospitalization and the length of stay was -- she had a very long hospital stay -- was related to these decubitus ulcers that actually brought her to the hospital.

Does that make sense?

Q. Do you recall who asked you to write that

letter?

A. An attorney.

Q. Was it the attorney representing the patient?

A. The patient's family.

Q. And what was the other case about?

A. Gee, the other case was -- I'm not sure it would be writing -- I forget how you worded the question. I think it was have I ever written a letter --

Q. Have you been asked to review a medical malpractice case before.

A, I'll tell you what I reviewed. I reviewed the medical records of a child who had been given an immunization and then had a seizure afterwards. And the purpose of reviewing that was just to be able to write an affidavit. I think. I think I wrote an affidavit or said I would write an affidavit saying that there might have been some relationship so that they could get this into court under some law that lets you get a certain kind of -- kind of opens the door to get you into this certain kind of legal action for getting some federal money for someone who has been damaged by a child immunization. Does that make any sense?

Q. Well --
A. At any rate, it was just -- I just reviewed it and wrote either a letter or affidavit, signed an affidavit or wrote a letter, and this was for an attorney in town who's a friend.
Q. And that was on behalf of the patient as well?
A. Correct.
Q. So is this the first time you've actually testified against a doctor?
A, Oh, yes. Yes,
Q. I noticed in one of the letters to Mr. Blakely you talked about a fee of $150 an hour. Is that your fee for your deposition time as well?
A. $200 for the deposition.
Q. Have you ever practiced medicine as a general internist, in a practice such as Dr. Koepke?
A. Not in a practice setting.
Q. So you've never practiced in such a way as Dr. Koepke would?
A. Correct.
Q. Do you know him, by any chance?
A. Never met him. Nor heard of him before this.
Q. Now, I've gone through your file a little bit ago. Other than what you now have in front of you, have you looked at anything in preparation

for your testimony today?
A. Well,. I reviewed some of the literature. Does that count? Is that what you're asking?
Q. Yes.
A. And the mammograms that Mr. Blakely has.
Q. That file contains copies of Dr. Koepke's deposition and Dr. Kim's deposition. Did you read those?
A. Yes.
Q. Have you looked at everything in the file, in your file there in front of you?
A. I have at some time looked at everything in my file.
Q. What literature do you have there in front of you? What's the book, first of all?
A. Oh, this is just a breast cancer treatment textbook.
Q. This is by who, Fowble --
A. Fowble, Goodman, Glick and Rosato.
Q. Did you look at any of that today?
A. Yes.
Q. And what is in the folder,
A. An article on breast conservation therapy.
Q. Who's that by?
A. Kurtz. K-u-r-t-z. John Kurtz.

Q. And what journal? Could you give us --
A. Cancer. Do you want the reference number?
Q. I'm looking for a publication date on this,
A. It's Cancer, 1989.
Q. Okay.
A. I brought the NIH consensus development conference statement, because I noticed that I believe you had mentioned it in Dr. Kim's report, from 1990.
Q. In June of 1990?
A, Correct. I brought an article on the prognosis of chronic lymphocytic leukemia, since you had asked Dr. Kim about that.
Q. And this is just a review on the adjuvant system therapy for lymph node negative breast cancer?
A. These reviews are published -- they come in the mail. They're reviews by prominent oncologists.
Q. Were you a participant in the NIH conference, the consensus?
A. No.
Q. Have you read that document, NIH?
A. Yes.
Q. Would you have read it before this case came along just because of your practice?
A. Yes, I -- yes.

Q. Would that be one of the authoritative statements on the care of breast cancer?
A. I think -- it is an authoritative statement on the care of breast cancer.
Q. Have you seen Dr. Leiby and Dr. Salwan's office charts?
A. No.

THE WITNESS: Excuse me. Have I seen any records from them?

A. I think I've seen the operative reports from Dr. Leiby's surgery, I have not seen his office notes or reports.

No, in fact, I'm sure I have not seen either. I've seen a letter from Dr. Salwan to Dr, Mansour. As I remember. I think.

Q. No. I think it was Dr. Kim to Dr. Salwan, if I'm not mistaken. Unless there's another one that I don't know about.
A. It was a referring letter.

MR. BLAKELY: I'm not even sure offhand.

Q. I'm sorry. I think I have seen this.

Now, when I was going through your file, I saw a series of letters in there, and I'm going to read some of these dates. A letter to you

dated 5-11-90 from Mr. Blakely. Do you recall seeing that letter?

A. Yes.

Q. I gather that was the first correspondence which he sent to you?

A. I'd have to see them in order to know what's first.

MR. BLAKELY: For the record, I object, but go ahead.

Q. There is another letter dated 5-25-90?

MR. BLAKELY: Object for the record.

MS. REINKER: What's the basis of your objection?

MR. BLAKELY: Work product.

Q. Did you read these letters, doctor?

A. I did read the letters.

Q. Another letter dated September 4th of '90.

MR. BLAKELY: Objection for the record.

Q. And then a statement apparently written by the plaintiff, Mrs. Bastian. Have you read that?

A. I read most of it. I think I have skimmed it. I would not -- I can't say I read every word in here.

Q. Another letter to you from Mr. Blakely?
A. Maybe I did. I didn't review it this weekend. I did not review that this weekend, This was in my file, and I have looked through it,
Q. Okay. I gather that in preparation of one or the other --
A. Actually, hard to read it all.
Q. Well, this is another letter to you from Mr. Blakely dated 10-24-90.
A. Correct.

MR. BLAKELY: Objection for the record.

Q. Another letter to you, a two-page letter dated 3-4-91.

MR. BLAKELY: Who is that from?

MS. REINKER: From you I believe, It's from Mr. Blakely again,

MR. BLAKELY: Okay. Objection for the record.

Q. Again, you saw that letter?

You have to answer out loud.

A. Yes. I'm sorry. Yes, I saw the letter,
Q. This is a report that I have not seen that you prepared dated April 4th of 1991. Is that another letter from you to Mr. Blakely?

A It's a letter from me to Mr Blakely

Q Well, here is another letter to you from Mr. Blakely. This one is dated 9-18-91.

MR. BLAKELY: Objection.

Q You've read that letter before?

A Yes

Q Another letter to you from Mr Blakely dated 8-31-92

MR. BLAKELY: Objection.

A Correct

Q Now. I gather that you read all that correspondence that I just identified on the record as it came to you. Correct?

A Correct.

Q And I gather that that correspondence and the information given to you in those letters played some role in the opinions you came to in this case. Is that fair to say?

A. No.

Q You don't think anything in either of these?

A I didn't say that I didn't say that nothing in these letters was relevant. but I think that an opinion is based on the medical record and that what the questions Mr Blakely has or hat he wanted to hear about may have influenced my

understanding of the case and, you know, what kind of things he needed to know. But I don't think it's fair to say that he gave me my opinions.

Q. I didn't mean to imply that, But information conveyed to you in these letters, as you said, would have in some way affected your understanding of the case. I think that's how you put it?

A. Is that how I put it?

THE WITNESS: Do you want to read back what I said?

A. I think it would be understanding what he needed to know. A lot of this -- a lot of these letters, quite frankly, were Mr. Blakely trying to understand what had happened to Mrs. Bastian, and actually some of it was just education into what the process was.

Q. Did you find any of the information conveyed in these letters helpful?

A. Helpful in preparing my reports?

Q. Just in adding to your knowledge about the case?

A. It added to my knowledge about the legal action.

Q. Did the information in these letters in any way guide the area of inquiry for you?

A. Yes.
Q. What is this document?
A. I think these were some -- I was just looking at it as you pulled it out of there,

I think these were some handwritten notes that I took the first time I reviewed the first set of records Mr. Blakely sent me. I believe in his first letter, he asked me just to review to see if anything had happened that seemed out of the ordinary or something like that.

Actually, I didn't review the letters this weekend, this letter, but was there anything wrong, was there a problem with either the first breast surgeon that she had seen or with Dr. Koepke. And these were the notes that I took at that time. And I think it looks here that I wrote some notes as I was talking to him on the phone once also. That was something that I added to my --

Q. What is this document that I now put in front of you?
A. This came --
Q. That was sent to you at some point?

MR. BLAKELY: Oh, that was -- for the record, that was an internal memo, and

I object for the record to the use of that.

Q. Was that provided to you, doctor?

A. That was provided to me. Did come in the mail.

Q. And did you read that and review it?

A. Yes.

MS. REINKER: Now, I am going to want to have these all marked as exhibits. Do you want to have copies made first or have the originals marked?

MR. BLAKELY: I guess copies made first.

MS. REINKER: Okay. Can we have somebody make these while we wait?

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(Thereupon, a discussion was had off the record.)

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Q. Now, doctor, I have received -- until a few minutes ago, I had seen two reports that you prepared in this case, one dated June 5th of 1990 and one dated October 30th of 1990. Have you had a chance to look at those reports recently?

A, Let me see where they are in my file. I think I reread them over the weekend.

Q. You might want to pull them out when you can find them.

A. Yes, let me pull them out.

I'm sorry. What what were the dates?

Q. June 5th of '90 and October 30th of '90.

A. And there was another one.

Q. There's one he's xeroxing now.

A. Okay. That's fine. No problem. We'll come back.

Q. Other than what we've talked about already here today, the letters that I commented on before and the two that you're looking at now, are you aware of any other correspondence between yourself and Mr. Blakely?

A. No.

Q. Have you ever met Mr. Newman of his office?

A. No.

Q. How many times have you met with Mr. Blakely?

A. Once.

Q. And that was today?

A. Yes.

Q. How many times have you talked to him about this case?

A, I don't know.

Q. Can you give me an estimate?

A Talked with him at all in any telephone conversation?
Q Correct.
A. I could be wrong. I would say, including a couple phone calls about scheduling this deposition. eight or nine times
Q When you looked these reports over. the one dated June 5th and October 30th of '30, did you see anything in those reports you'd like to correct or modify or change?
A I think these are all right
Q So basically, the opinions you hold today are as you stated them in those reports?
A Yes
Q Doctor, do you hold the opinion that Dr. Koepke's care fell below the recognized standard of the medical community?
A Yes.
Q. And in what way?
A. By not following through on the recommendation for a six-month followup of the mammogram.
Q. Any other way in which you feel Dr. Koepke's care failed to meet standards?
A No I think that has the problem
Q In your report of June 5th you make the

statement, and I'm quoting here, "The best procedure would be to inform the patient of the abnormal result and to perform a careful breast exam of the area noted on the exam."

I presume you mean of the area noted on the mammogram. Do you see that sentence that's in the middle?

A, Yes. I meant the mammographic examination. Either that or it's just a miss -- I misworded it. But, yes, I meant the mammography.

Q. Are you aware that when Mrs. Bastian had her physical exam by Dr. Koepke on March 7th of 1988, there were no abnormalities palpated in the breast? Were you aware of that?

A. You know, when I wrote this letter, I hadn't reviewed the office notes. 1 don't think it was clear at that point that he had just done a breast exam a couple days earlier. I actually think that even if you do a breast exam without any suspicion of abnormalities -- in my practice, if I do a breast exam and there's no suspicion of abnormalities, then I get back an abnormal mammogram report, you know, one option is to review the breast exam and say "Gee, let me feel that area and see if there is anything

suspicious there," because sometimes if you know what you're looking for, it's helpful.

So he could have rereviewed that. He could have repeated the breast exam in conjunction with informing her about the abnormality on the mammogram. He chose not to, It's just one thing that could be done,

Q. But that was not a requirement at that time since he had just examined the breast?

A. Depending on his comfort level that he had done a careful exam. I don't have any idea how cursory or careful his examination was.

Q. _____

_____

would careful exam probably or [illegible] about in September

A.

Q.

A.

operative note said that he wasn't -- indicated that he wasn't sure if he could feel that, he thought there was something there,

CSR

Q So my point is that it was not an obvious palpable lesion even then, correct, in September of '89?

A It wasn't obvious -- well, I don't know if it was an obvious palpable lesion Dr Levy wasn't positive he could feel the same lesion that he saw, that was seen on the mammography And that s -- you know, it's often difficult to tell if what you feel is what you see mammographically. I don't really know how palpable that was in '89.

Q Are you aware that Dr Koepke again had a normal breast exam in September of '89?

A. Correct. Yes. I'm aware.

Q So he at least did not palpate any abnormality in the breast?

A That s correct

Q Now, knowing all that, I'm going back to your statement in the report of June. We've talked already about the need or option to perform a breast -- to reexamine the breast Again, your statement is the best procedure would be to inform the patient of the abnormal result

Are you aware from reading Dr Koepke's deposition that it is his position he did tell

Mrs. Bastian of the abnormal result and that he needed followup in six months?

A. I am aware that that is his position.

Q. You've seen the mammogram report in the office chart?

A, I've seen the copy of the mammography report from the office chart.

Q. And did you see the note handwritten on the bottom of the mammogram report that says "Advised patient followup six months"?

A. I saw that.

Q. And that's Dr. Koepke's testimony, that he wrote that on there when he called the patient with the results?

A. I understand that. I read his deposition.

Q. Now, assuming that to be the truth, that he did in fact tell Mrs. Bastian the abnormal result and that she needed a followup visit in six months, if that were true, would you then feel that he met the standard of care?

A, Well, no, because he still has to schedule the mammogram. You know, a patient can't walk in and go to the office and get a mammogram, He needs to request a mammogram for a certain case and kind of schedule it.

Q. What do you do with regards to your patients if you say "I want you to have another mammogram in let's say six months"?

A. Every time I see a patient in the office -- and I really -- I think -- every time. As far as I know, every time I see the patient in the office, if I have their chart available to me, if it's not missing, if it's a followup visit, a routine followup visit, you know, I check to see when the last followup radiologic diagnoses were done and to see if anything needed to be updated. So that's -- if it hasn't been scheduled, then I would schedule it the next time she was in the office.

I see my patients, because they're mostly breast cancer followup, quite frequently -- that's my own internal check, is that I know I see almost everyone in my practice every three to four months, and so I know that they'll be in and that I can -- if it's a longer time, like if it's a six-month followup, if it was a six-month mammogram followup, then I would schedule it for the next time they were in the office.

If it was a test that needed to be done before I would see them again, and that happens

quite frequently, I make the arrangements that day with my secretary, and I say, "Pam, can you schedule a CAT scan on Mrs. So And So for the next available visit" or in two months or whatever. If they're in the office when I want to schedule it, we have a followup sheet, you know, that we write down what the next tests are and when we need it, If I need things done in January, I can set them up now for January, if I need to, and the requisitions are made and it's all done.

Q. You have no way of knowing whether that was available though at York Medical X-ray back in 1988, do you, to schedule these six months in advance?

A. I don't know.

Q. Do you ever give your patients an instruction and expect them to follow up on it?

A. Well, of course. There are instructions we give to patients that we expect them to follow up on.

Q. The patient does play some role in that, correct?

A. Yes.

Q. And I understand your practice, specializing in breast cancer, would be different than

Dr. K©epke's practice, specializing in internal medicine, which is a whole variety of things other than breast cancer, correct?

A. Correct.

Q. I gather then at least one thing that you feel would be an appropriate thing for Dr. Koepke to do was to tell the patient of the need for followup?

A. One thing appropriate would be to tell her the need for followup, tell her how to -- if it was clearly her responsibility to call and make the appointment, then that would have needed to be -- you know, to call back in four months to set it up for six months or to set it up for one day, whatever it was, that there had to be some very clear guidelines. If you're leaving it in the hands of the patient, I think that then it's your responsibility to make it quite clear what and when the patient is supposed to do, when they need to do it. That's certainly my practice.

Q. If that was done, that would be an appropriate way to handle this, correct?

A. If there was no way to set it up at the time and you don't know if you're going to have the

patient in your office again and the only way you have to do it is to have the patient call back and make sure. is that appropriate? Is that sort of the question?

Q I'm saying is the kind of instructions you just talked about were in fact given to the patient that would be an appropriate way to handle follow-up in this kind of a report. correct?

A Yes

Q. If the mammogram would have been done six months later -- let's say that would have been September of 1988 -- do you have an opinion what it would have shown?

A It probably would have shown a lesion intermediate between what was there in March of '87 and what was there in September of '89 Is that clear enough? You know, somewhere in between

Q Now. you said that you did see the mammogram, the report of which is dated March 5th, I believe. of '88 You saw that this morning?

A Yes

Q And that was read by the radiologist as showing an area of asymmetric dense mammary parenchyma in the outer upper quadrant of the right breast.

correct?

A. That is correct. That was there.

Q. The radiologist did not describe a specific dominant mass or lesion in this report, correct?

A. That is correct.

Q. Did you see anything other than what the radiologist is reporting when you looked at the film?

A. I saw what the radiologist was reporting.

Q. You did not see any dominant mass or lesion, did you? Or did you?

A. No.

Q. Now, we know when the mammogram was repeated in September of '89, the radiologist reported an ill-defined slightly spiculated dominant density in the outer upper quadrant of the right breast, and the size is given as 1.8 by 1 centimeter. Correct? Do you recall?

That is the report.

Q. Did you see that film today?

A. Yes, I did. And that film has that density on it. And there is also sort of a vague shadow which is somewhat larger than that kind of around that lesion. Which I wouldn't necessarily say was a measurable part of the

those measurements. Then there was sort of this vague irregular area surrounding the dominant mass.

Q. Now, you've just rendered an opinion that if the mammogram had been repeated in September of '88, it would have shown something somewhere in between what we agreed, what you and the radiologist agreed, was present in March of '88 and what you saw in September of '89?

A. Yes.

Q. Where would it have been on the spectrum in September of '88? Do you have any opinion on that?

A. I actually believe that if they had seen that again -- well, if I had seen that again even in September of '88, it would have suggested that maybe some more additional views, additional mammographic views be done. You know, like they did when they saw it in September of '89. You know, they did a bunch of pictures in September of '89.

When you see an abnormality, you do something called spot compression views to get a better look to see if this thing that looks like

a mass disappears when you compress the breast tissue and to make sure you get enough views of it and go all the way around it. If they had might have gone back and looked again to see if there was really not just a vague density but if there was possibly a mass there.

And, in fact, since things develop over dense six months later than it was six months earlier because tumors grow and develop over time.

Q. But again my question to you is can you tell me how it would have looked in September of 1988 to a reasonable degree of medical certainty?

A. I believe it would have been an abnormal mammogram that would have been called an abnormal -- a mammogram with a higher index of suspicion. Does that answer your question?

Could it have been the kind of mammogram that again the radiologist suggested followup in six months?

A. It could have been, but I think that that is not the most likely scenario.

Q. How large would the lesion have been described

in September of 1988?
A. September of '88.
Q. If a film were done then?
A. The vague area was somewhat less than a centimeter, and I guess in March of -- the vague area in March of '88 was somewhat less than a centimeter. It was 1.8 by 1 centimeter in September of '89. It would have had to be somewhere in between there in size.
Q. Do you have any opinion where it would have been in size?
A. That's really an impossible question,
Q. So you have no opinion on that?
A. On what the size would have been?
Q. In September of 1988.
A. Mammographically, the size would have been somewhere between 1 centimeter and 1.8 centimeters.
Q. But you have no opinion where it would have been between there?
A. You know -- no, I have no opinion. The vague area in '89 is larger than 1.8 centimeters. By '89, what I would consider this vague area is about three-and-a-half centimeters. And the mass, the dominant mass itself is what

appeared. I guess. Yes, Within the vague area.

For the record, this one film, mammogram film, missing from the '89 films --

Q. Well, they're missing from the group that you looked at.

A. I understand.

Q. I don't know that they're missing from our group.

MR. BLAKELY: Why do I recall Anna Carulas saying after she got it that she wasn't able to look at it?

MS. REINKER: I don't know.

Q. Do you have an opinion as to when this breast cancer should have been diagnosed? Let's say what's the latest point in time you think this should have been diagnosed and still have met the standard of care?

A. Six months after the first mammogram.

Q. In your opinion, there would have been a diagnosable breast cancer by September of 1988?

A. Yes.

Q. If Mrs. Bastian had come in for the physical exam she was supposed to --

A. And I think that because I think that if they

had done spot films even in March -- if the mammographers had done spot films in March, I honestly think that they might have suspected an abnormality even then.

And that's easy for me to say in retrospect because I can see what it developed into in '89, but I think that there was a little abnormality. That's what I mean. If they had seen it again six months later, that might have prompted them to do spot films and work it up a little more in the mammography suite. So I think that six months later, they would have made the diagnosis because they would have seen it twice.

Q. But, again, that would have nothing to do with Dr. Koepke. That's what the radiology people are doing down in their office. Correct?

A. It had to do with -- that film wasn't done, and that film would have prompted the diagnosis. That's why I think that in six months later, the diagnosis would have been made, because the mammographers would have seen it again. Do you see what I mean?

Q. Actually, first of all, you said back in March of '88. Any decision about spot films, that

would have been up to the radiology people to do so?

A. Absolutely. Which they decided not to. But I believe that a mammographer seeing that lesion twice in a six-month period, presumably with some progression, because cancers progress, that that would have prompted a further workup and six months later that diagnosis would have been made.

Q. Now, that's all an assumption on your part, correct?

A. That's what you're asking for.

Q. Well, but you have no way of knowing what this particular radiologist would have seen or would have done in September of '88?

A. Well, I know if it was there in March of '88, it would have been nothing less than was there in March of '88. Presumably it would have been something more.

Q. But again you're assuming; you have no way of knowing what this radiologist would have done in September of '88 had that film been taken?

A. I can only tell through my experience, since I review lots and lots of mammograms and mammogram reports and I work with our mammographers here

on our own cases, that I know that mammographer: when they see a persistent lesion, that a persistent lesion is one signal to report out ar abnormality to the doctor and to do additional views.

Q. Do you know Dr. Yoon?

A. Yes.

Q. Dr. Sai B. Yoon?

A. Wait a minute. No. No, I'm thinking of a Yoon here. I don't think so.

Q. So you've never worked with Dr. Yoon?

A. No.

Q. So you don't know what Dr. Yoon would have done in September of '88 had he been the one to look at the films again then, correct?

A. Correct.

Q. If Mrs. Bastian had come in for her physical exam, as was suggested to her, in the spring of -- or I mean April of '89 and her yearly followup mammogram would have been done then, do you think that the film would have shown an abnormality?

A. Yes, I do.

Q. And do you think a diagnosis would have been made at that point in time if she had come in?

A. Yes.
Q. Now, you have reviewed the records from Metro General for the mastectomy, I presume?
A. Correct.
Q. Now, we know that when the mastectomy was done, as regards some of the diagnostic studies that were done, the tumor was ER/PR positive. It was --
A, No. That's not correct, I'm sorry. I believe it was progesterone receptor negative and estrogen receptor positive.
Q. I believe Dr. Kim considered them both positive. I apologize.
A, There may have been two reports.
Q. Here's the report, if you want to look at that.
A. When was her mastectomy?
Q. October 23rd of '89.
A. Yes, this was the specimen sent from the mastectomy. I believe there was a specimen also sent from Parma.

MR. BLAKELY: For the record, can you identify that document?

MS. REINKER: Yes. We're looking at one of the path reports.

Q. The one that I showed you, were those both

positive?

A. Yes. And, actually, I found the ones that had been sent from Parma. They were both positive also. But again the progesterone receptor was

Q.

A.

Q.

nodes negative and a negative metastatic workup.

Do you agree with all of those facts as related to you from the studies that were done at Metro General at the time of her mastectomy?

A. Could I see that Metro General report again, the one you had just shown me?

Q. Sure.

A. Sure. Nodes negative. Yes, I agree.

Q. Now, those were all positive prognostic factors for this patient, correct?

A. Yes. They are all favorable,

Q. One of the physicians at Metro referred to her as a low-risk patient. Would you agree with

that?

A. Realizing that that's a very relative categorization, she is at relatively low risk for recurrence

Q In his report -- you've seen Dr Levy's report I believe?

A. Just this morning, actually.

Q. That's the first time you saw it?

A. Yes.

Q He makes the statement that the most significant discriminant of prognosis in treating patients with breast cancer is the status of the lymph nodes Do you agree with that?

A Yes.

Q And this lady has 17 nodes negative?

A That's correct

Q The path report on the tumor that has removed in October of '99 also came back reported as an infiltrating lobular carcinoma in the histology?

A That's correct

Q. What's the significance of that to you?

A. Infiltrating lobular carcinoma is a relatively uncommon pathologic type of breast cancer. It occurs in -- about five to ten percent of diagnosed cases of breast cancer are of this

subtype. The prognosis is about the same as for infiltrating lobulars as other more common types of breast cancer.

In several series, there is a somewhat higher incidence of multifocality within the breast with infiltrating lobular tumors and infiltrating ductile tumors,

Do you want me to explain what multifocality is or is that not important?

Q. Why don't you go ahead.

A. A multifocality might also mean that there are not only primary well-circumscribed tumors but other tumor areas within the breast.

Q. What's the significance of that as far as treatment goes?

A. I think there's very little significance as far as treatment goes.

Q. Isn't it a fact that if there's a multifocal tumor, the patient is not a candidate for lumpectomy?

A. If you know that there's a multifocal tumor. That is, if you know that there are tumors in other quadrants or portions of the breasts, For example, if you see a mammogram that has an abnormality on the upper inward quadrant and an

abnormality in the lower outer quadrant, that makes them a poor candidate for a breast sparing operation. In my opinion, the diagnosis of infiltrating lobular carcinoma does not make someone a poor candidate for a lumpectomy procedure.

Q. If the diagnosis in this case had been made six months earlier than it was, let's say if Mrs. Bastian had come in in April of '89, how would that have changed the outcome of the case in any way?

A. I don't know. I think that one possible outcome that would have been more favorable would have been that if the tumor was smaller, there might have been clean margins of excisional -- I'm sorry. A partial mastectomy would have been feasible, or a lumpectomy-type operation would have been feasible.

Q. You're talking about in April of '89?

A. It's possible.

Q. How about if the diagnosis could have been made a year earlier, in September of '88?

A. I think the outcome would be increasingly likely that the tumor would have been small enough that a complete excision could have been done.

Q. Can you think of any other way that the outcome or the prognosis or anything would have been different if the diagnosis had been made in September of '88?
A, Yes. Her prognosis would be better,
Q. Why?
A. Because a tumor would have been smaller.
Q. Now, all of her prognostic factors were favorable in this case, correct?
A. No, That's not correct. The tumor size is not favorable. A 3.5-centimeter tumor is not favorable,
Q. Where did you get the 3.5 from?
A. The pathologic report from Parma.
Q. And that's the one you're relying on for the size of the tumor?
A. Yes.
Q. Every other prognostic factor was favorable, correct?
A. I actually don't think a progesterone receptor of five is favorable. I think that that's very low. But that point aside, the other ones were favorable.

I really want to point out that in lymph node negative breast cancer, I think most all

experts would agree that tumor size -- if the lymph nodes are negative, actual size is the most important prognostic factor There are no others besides tumor size that are in that ballpark

Q You said assuming everything else is favorable, then tumor size becomes the most important factor?

A No. If you're looking at prognostic indicators for the development of metastases and the risk of dying of breast cancer -- okay?

Q Okay.

A -- the most important is the lymph node status, negative or positive Second most important is tumor size After that, these other things, R and PR, diploid tumors, S-phase -- these other things fall below in terms of contribution to risk. I think that's pretty well established.

Q What sort of prognosis would you give Mrs Bastian? Let's say for five-year survival.

A. Actually, I think I have some data.

Q I mean that's assuming --

A It's about 70, 75 percent No Five-year survival?

Q. Yes.
A. Five-year survival is going to be quite good. It's probably about -- it's probably about 80 percent. But the ten-year survival will be less, and it'll be 70, 75 percent.

Really, breast cancer, you should use ten-year survival rates. Generally people do. I can give you some data.

See, yes, actually probably -- if you use tumor size as a determinant of five-year breast cancer survival in a series of 13,000 women --
Q. Is this node negative patients?
A. Node negative breast cancer. 3.90 to 3.9, the five-year survival is 86 percent, Whereas, if it's, say, 1 to 1.9 centimeters, it's 86 percent.
Q. What were you reading from there?
A. The Adjuvant System Therapy for Node Negative Breast Cancer by Davidson and Abeloff.

But the ten-year survival for women with tumor sizes 2 to 5 centimeters in a series from Shottenfield from '76 is 65 percent.
Q. In node negative patients?
A. Yes. And in three different series from three different authors -- if you want the authors and

dates, I'll give them to you -- the five-year relapse rate -- which is different than the survival rate. These are the percentage of patients who will relapse with breast cancer.

Within five years, in the 2 to 5 centimeter ranges, between 19 and 24 percent. And that's why I come up with the number of around 75 percent. I think that there's -- the bottom line from these series of numbers is that women with tumors that are around three-and-a-half centimeter, 70, 75 percent can be surgically cured.

Q. So again just to summarize, for Mrs. Bastian, assuming that her tumor size was 3.5 centimeters -- and that's assuming. As you know, the records are not clear on the actual microscopic measurements of this tumor. Would you agree with that?

A, We don't usually do microscopic measurements of tumors. The tumor sizes, and from series like this, the tumor sizes are usually based on gross descriptions of tumor from the pathologists who cut in the pathology after the specimen is received, and I believe her tumor was grossly 3.5 centimeters.

Q. Assuming this patient has a 3.5-centimeter tumor, node negative and the other prognostic factors being what they were in this case, is it your opinion that she had an 86 percent chance of five-year survival and a 75 percent chance of ten-year survival, ten-year cure?

A. Yes,

Q. Now, setting aside her prognosis for the moment, you said --

- - - -

(Thereupon, a discussion was had off the record.)

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Q. Now, I believe you said earlier that if the diagnosis had been made a year earlier, there would have been an increasing possibility that her surgical treatment could have been different than it was? Is that fair to say?

A. That's fair to say.

Q. Who makes the decision as to what sort of surgery the patient's going to have?

A. Most commonly, the patient in conjunction with her surgeon. At this institution.

Q. Do you know --

A. In some settings, the surgeon makes the call.

Q. And not being a surgeon, you've never had to make that call, correct?

A. That's not correct. I said most commonly. I advice my patients quite freely as to what my recommendations are for them,

Q. Do the surgeons always take your advice?

A. Do the surgeons or the patients?

Q. The surgeons.

A. I don't advise my surgeons. I advise my patients. I do confer with the surgeons about it, and we might review pathology together at either a tumor board or individually on certain cases if it's a case I'm involved in, and I confer quite ,frequentlywith the breast surgeons about what kind of operation to do and whether someone is a good candidate.

And then I often -- if it's a patient I have a relationship with, often counsel the patient in addition to the discussions the patient has with her surgeon about it. So I'm involved in these conversation. Not that infrequently since all I do is breast cancer.

Q. You've never been actually the one standing holding the knife though deciding what procedure or actually making the cut for what surgery is

going to be done?

A. That's correct.

Q. Have you ever had a surgeon disagree with your recommendation as to what sort of surgery was going to be done?

A. Yes.

Q. And in that case, who made the ultimate call, the surgeon or you?

patient's reasonable, you all come to a decision together about what's best for the patient.

But I mean when you said has a surgeon ever disagreed, I can remember a case where the surgeon disagreed, and in that case, the patient ended up taking my opinion. I mean taking my recommendation.

I am sure I could think of others. I'd have to think through and try to remember some other cases where we've disagreed. You do try to come to a consensus. I think it's difficult for a patient when they have two doctors that they trust and they disagree. So you try to make, you know, a reasonable opinion and give it

to your patient.
Q. Do you subscribe to the surgical journals?
A. No.
Q. Do you know what criteria the surgeons use in making a decision as to what sort of surgery -- back in 1988 -- a patient would have?
A. Do you mean '89?
Q. '88. When you stated the diagnosis should have been made.
A. Oh, Do I know what --
Q. What criteria a surgeon uses in making the decision as to what kind of surgery the patient should have?
A. Well, there are a number of criteria surgeons use. And different surgeons have different criteria. I mean I work with a lot of surgeons, and they all seem to have, you know, many of their own ideas about, you know, which operation to recommend for a patient.
Q. Do you know what the prevailing school of thought was among the community of surgeons back in 1988 for treatment of infiltrating lobular breast cancer?
A. I don't think I can fairly say of a sense of what the community of surgeons thought at that

time. I wouldn't have had an insight as to what their community of thinking was at that time, if there was a community of thinking,

Q. You have read Dr. Kim's deposition?

A. Yes, I have.

Q. And in his deposition, I asked him whether he agreed, and he did agree, that the majority school of thought in 1988 and '89 for treatment of infiltrating lobular breast cancer was to perform a mastectomy.

A. That surprised me. Because I have not been, I guess, exposed to that opinion here in my training at University Hospitals. I go to t mor board here regularly, where we actually mostly review breast cancer cases and make decisions, you know, jointly regarding surgical -- you know, what kinds of surgical -- you know, they'll review a breast biopsy, you know, one just like this, and, you know, they'll go around and talk to the radiation therapists. "This is a good candidate for lump excision."

I then get an opinion from the medical oncologist, get an opinion from the surgeon, And I don't recollect ever hearing a discussion that "Gee, this is infiltrating lobular reason.

Let's recommend a lumpectom Let's do a mastectomy."

That really did surprise me that he thought, that was the prevailing view, because not only is it not something --

Q. So are you saying he's wrong on that? He was wrong?

A. Well, I don't know -- I told you already I don't know what the prevailing surgical view is. It surprised me. I was not aware of that. I don't think that it increases the risk after -- I don't think that there is really an increase in risk if you do a lumpectomy in patients with infiltrating lobular, so I don't agree with his opinion. But I can't say that that wasn't the surgical opinion in '89. It may have been.

Q. Do you have an opinion what the treatment would have been if the diagnosis had been made in September of '88, one year earlier than it was?

A. I think it would have been much more likely that Dr. Kim or Dr. Leiby would have recommended a lumpectomy with axillary dissection instead of a mastectomy.

Q. Can you say to a reasonable degree of medical certainty that the treatment would have been

different than it was in October of '89?

A. I think it's very hard to rewind film that's sort of out of the box, It's almost impossible to make a tumor ungrow to find out where it would have been in time and what the result of an operation would have been a year earlier,

But I do think that the tumor would have been smaller and the chances for complete excision would have been greater if it had been a year earlier.

I didn't answer your question.

Q. No. I mean, unfortunately, the question -- what I'm hearing from you I think is that you really can't say to a reasonable degree of medical certainty that the treatment would have been different in '88 than it was in '89.

A. I think more likely than not, she would have been able to have a lumpectomy in '88, because the tumor margins would have probably been clean.

Q. Are you aware that Dr. Kim testified that the size of the tumor, the 3.5 centimeter size of the tumor, was not in itself the reason why he elected to go with a mastectomy?

A. Yes, I am.

Q. Are you aware that even at that size, the patient could have had a lumpectomy?

A. Yes, I am.

Why is it your feeling then that th treatment would have been any different year earlier?

A. I think the reason that he recommended a mastectomy and not a lumpectomy had little to do with the infiltrating lobular but had to do with the positive margins of resection. The fact that there was microscopic tumor involvement at the margins of the resected specimen.

Q. One option would have been to do a re-excision, correct?

A, That is correct.

Q. That was an option that Dr. Kim could have performed?

A. That is an option.

Q. Do you think that his decision to do a mastectomy was inappropriate?

A. No. I think often when there's multifocal tumor at the margins in several -- my understanding was that on review of this primary pathology, the tumor was pretty widespread over the specimen that Dr. Leiby resected and that when we see tumors like that that are spread

throughout that breast specimen, microscopically that, you know, we often are conservative in our approach and recommend a mastectomy. I think it was an appropriate recommendation,

Q. Why is that? Why do you recommend a mastectomy in that kind of a case?

A. The risk of recurrence is higher when there are involved margins.

Q. Is there also a risk that this cancer is present in other parts of the breast?

A. Yes.

Q. What was your understanding of the meaning of the pathology report that found multifocal tumor in this breast?

A. Let me review that.

Which one was it?

Q. It's the pathology report on October 23rd.

A. The Metro pathology report?

Q. Yes. It's read as finding residual infiltrating lobular carcinoma of the breast with multifocal --

A. Let me find it. Multifocal in situ.

Q. What's the significance of that to you?

A. Well, the lobular carcinoma in situ is a marker for the development of a subsequent breast

cancer. That's the way to think about that. It's not to think about it as a cancer but as a premalignant lesion that is a marker for the development of breast cancer. Patients with that finding have a very high risk of breast cancer.

Q. That means those markers are occurring in other parts of the breast?

A. Not necessarily.

Q. Do you have any opinion in this case where those marker-type lesions were?

A, Can you wait until I get the report?

Q. Sure.

A. I am having trouble using my memory and three different path reports.

Q. Sure. Here.

A. Okay. What they found was at the margin of resection -- I believe what they found was at the margin of resection, they found residual infiltrating lobular carcinoma. There was some at the edge in the biopsy cavity. And then in other areas, there was multifocal lobular carcinoma in situ.

Q. In other areas of the breast? Or of the margin?

A. It's unclear.

But since it was lobular carcinoma in situ -- see, when they say "residual infiltrating lobular carcinoma," in my experience, that refers to what's at the margin of the resection and not to other parts of the breast. They would call this multicentric or another area of infiltrating area was found in another part of the breast, They would talk about it that way.

The fact that there was multifocal lobular carcinomas in situ and focal lobular carcinoma in situ, whether it was near the margin or in other parts of the breast in my opinion doesn't make very much difference. It's only a marker for development of breast cancer, and she's got breast cancer.

Q. Would it make any difference in the decision whether to do a mastectomy or a lumpectomy?

A. This is in the mastectomy specimen.

Q. Correct.

A. The mastectomy is done. When you have these findings, the mastectomy is done. They didn't find that in the biopsy.

Q. Correct.

A. They found only the infiltrating component, as I

remember, in the biopsy

Q Knowing that they found it in other parts of the breast, would that not mean that the mastectomy was the appropriate treatment for this patient?

A. No.

Q So it would have been all right to leave on the breast with those other areas?

A Yes See, infiltrating lobular carcinoma is only a marker for the development -- I'm sorry That's an error. Lobular carcinoma in situ is only a marker for the development of breast cancer. You can leave that in. If we get a biopsy that says "lobular carcinoma in situ," that doesn't mean someone needs all of that removed or a mastectomy or really anything else. It's a marker for development of breast cancer.

It's sort of like having two sisters and an aunt and your mother with breast cancer It's a high risk thing, but it doesn't mean that you need a mastectomy necessarily.

It's very controversial about what to do about lobular carcinoma in situ Because they use -- today's thinking that diagnosis -- lobular carcinoma in situ used to be a diagnosis

because of bilateral and high risk of breast cancer. This was the diagnosis whereby lateral mastectomies were recommended, no matter which breast you found it in,

Currently, I think that most physicians are treating that as a marker, high-risk marker, following carefully, doing mammograms, breast exams and discussing with their patients the risk of breast cancer but usually not doing prophylactic surgery.

Are you following?

Q. Yes, Based on what you see in that pathology report, if Dr. Kim had elected just to do another re-excision and not take off the entire breast, would this patient have done all right in your opinion?

A. It depends on if with the re-excision, the residual infiltrating carcinoma would have been removed with clean margins. And one of the things that goes into that decision is, you know, how much breast tissue is left. I really don't know, you know, what she looks like, whether there could have been a good cosmetic result if he had done a re-excision.

Q. But that's a possibility for this patient, she

could have had perhaps a re-excision of the area and not a mastectomy?

A. If that would have given an acceptable cosmetic result, that would have been one approach. Whether it would have given you clean margins I don't know. I don't know whether they would have gotten clean margins or again had positive margins. That's the downside of doing it again.

Q. Do you know why this patient elected not to have any reconstructive surgery?

A. No.

Q. That would have been an option for her, correct, if they were concerned about the cosmetic appearance of her breast?

A. It is a medical option.

Q. If Mrs. Bastian had had a lumpectomy in 1989, or even in 1988, what other treatment would she have needed?

I'm looking for the review from Metro of the Parma slides. I think I know where it is though.

I've got it. I just want to make sure I'm not forgetting something important.

No, that's fine,

Q. What's fine?

A. I just reviewed what Metro had thought about the Parma report on the biopsy from I guess it was September, early October, the first biopsy. Just wanted to make sure there wasn't any additional information in that report that I wanted to discuss.

You had asked a question though.

Q. If Mrs. Bastian had had a lumpectomy either in '89, at the time Dr. Kim treated her, or in '88, a year earlier, what other treatment would she have needed?

A. It would have been recommended that she have breast radiation treatments.

Q. Both times?

A. Oh, yes.

Q. Either year?

A, Either year.

Q. How about chemotherapy?

A. Well, hormonal therapy is the adjuvant treatment that was offered to her, and I presume you aren't including that as a chemotherapy. Or are you?

Q. I'm not. She's taking tamoxifen is what you're

referring to? Or she was?

A. Well, was or is. I don't know.

Q. Would the treatment have been any different as far as chemotherapeutic changes if she had had a lumpectomy as opposed to a mastectomy?

A, No,

Q. Mrs. Bastian is still doing well as far as her breast cancer goes, I gather, as far as you know? Prognostically?

A. Unless -- you mentioned something about a new mammogram, and then I don't know where I saw it, but I thought there was something about -- is there a question that something is going on in her left breast? Did you mention that? Where did I hear that?

Q. Well, she said on deposition I believe they were concerned about abnormalities in her other breast now.

A, I don't think I saw her deposition. Did I? I don't have her deposition.

MR. BLAKELY: I don't think so.

A. So I don't know where -- maybe that was just -- I don't know. As far as I know, she's doing fine.

Has anything that has happened to her since thi

in any way affected the outcome of either her breast cancer or her general life status? I'm referring to primarily her leukemia, but I think she has also had some cardiac complaints?

A. I don't know anything about her cardiac complaints. I understand again, and I don't know what part of the record it was in, and haven't reviewed the details of that and certainly not as a -- I haven't as a hematologist looked at that part of her problem, but I understand that she's developed chronic lymphatic leukemia.

Q. And how does that affect her prognosis?

A. Well, depends on what her stage is. And I haven't seen anything on her stage.

Q. Have you seen the bone marrow biopsy results?

A. No. Although that wouldn't give me her stage.

Q. There's a whole series of reports there.

A. Is that it?

Q. That's all I saw.

A. Well, this really doesn't give me a diagnosis of CLL in here. Actually, it looks like it was a pretty normal bone marrow, unless I'm missing something.

I did see somewhere that Dr. Schmotzer had

made the diagnosis of CLL but --

Q. I saw that, too.

A. -- I don't think I had those reports.

Q. What is chronic Leukocytic Leukemia?

A. Again, it depends on the stage. I didn't see in any of the reports, and I have a feeling that it would have come up somewhere in three separate reports, palpable lymph nodes, which would have made her stage higher, I believe these probably.

Q. I have noticed --

A. Do you have Schmotzer's record? He's really compulsive.

Q. Yes.

A. And I have an idea -- that was a two-centimeter palpable lymph node apparently. Is this helpful? I haven't seen these reports.

She wasn't -- a formal stage wasn't given in Dr. Schmotzer's notes, and I don't know what the significance of the left -- the single left axillary lymph node, whether it's benign or whether it's a part of the process, but she's either Stage 0 or Stage 1, which gives her a seven to ten-year median survival, median survival from her CLL. Seven or ten years

depends on her stage.

Q. That's from the time of diagnosis?

A. Correct.

Q. I gather then in your opinion -- well, let me ask. I asked you earlier whether you believed the treatment would have been different if the diagnosis had been -- surgical treatment would have been different if the diagnosis had been

[redacted]

A.

Q. diagnosis had been made in '88, September of '88, a mastectomy could have been recommended by the surgeon or the patient could have chosen to go that route?

A. That is correct.

Q. It would not have been inappropriate to do a mastectomy even in September of '88?

A. A mastectomy is always one choice, one appropriate choice in the treatment of breast

cancer. It is not the only choice. It is often recommended by surgeons and opted for by patients.

Q. And also in October of '89, a lumpectomy was a choice, as a mastectomy was an option?

A. When there is a large tumor, and a 3.5-centimeter tumor is a large tumor with involvement of the surgical margins, most people would probably recommend a mastectomy.

Q. But a re-excision was an option even then, was it not?

A. It wasn't given to her as an option by her doctors.

Q. That was something though Dr. Kim could have elected to do, was it not? I think he said in his deposition that even at that size --

A. But that was not his recommendation, because being conservative and wanting to provide her with the lowest risk of breast recurrence, I think he opted for the mastectomy. Could it physically have been done? Yes, it could have physically have been done.

Q. The NIH statement, the consensus statement that you referred to earlier, they took the position that tumors over 4 centimeters should not be

handled by lumpectomy, correct?

A. Let me look at that again.

Well, actually the only thing that it mentioned about centimeters is actually sort of in one of the last sentences of a rather lengthy discussion of this, and the main point they say is that breast conservation treatment is an appropriate method of primary therapy for the majority of women with Stage 1 and 2 breast cancer and is preferable because it provides surgical equivalent to total mastectomy and also preserves the breast.

The statement they make about 4 centimeters comes a bit later and says prospective studies comparing primary therapies have included women whose primary tumors were usually less than or equal to 4 centimeters in diameter.

And if you have another statement in here about not doing it over 4, I haven't seen that.

Q. So those studies essentially were done comparing therapies including women whose tumors were less than or up to 4 centimeters?

A. There have been studies that -- the studies have compared women with tumors usually less than or equal to 4 centimeters, Some studies have only

treated women less than 2 centimeters.

Q. Right.

A. With lumpectomy. Some studies have gone up to 4 centimeters. Some studies have gone up to 5 centimeters in controlled, randomized trials. It varied from study to study what patients were eligible.

Q. Did you read Dr. Levy's report?

A. Yes.

Q. Was there anything in that report that you found you disagree with?

A. Can you hand it to me?

Q. I think I have it here. You've got a copy there somewhere.

A. I am sure I do. But I think things have been shifted quite a bit here this afternoon.

Yes, got it.

Boy. I don't agree entirely with the paragraph that says if you don't feel a palpable mass, then an area of asymmetry is not significant. If it's significant enough for a mammographer to recommend a six-month followup, it's significant, And the lesion I saw I thought was clearly an abnormality and at least needed a six-month followup at the minimum.

MEMO

TO: Paul

FROM: Jon/jh

DATE: September 18, 1991

RE: Bastian vs. Koepke

FACTUAL BACKGROUND

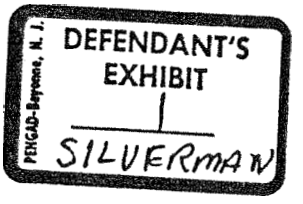
On March 7, 1988, Rose Bastian had a complete physical examination performed on her by Dr. Keith Koepke. As part of the physical, Dr. Koepke told Mrs. Bastian to schedule a mammogram with York X-ray. York X-ray is in the same building as Dr. Koepke's office.

The report from this mammogram was dated March 15, 1988. It identified an ". . .asymmetric dense mammary parenchyma" on the outer upper quadrant of Mrs. Bastian's right breast. This was a lesion or density with irregular borders. Breast cancer often appears on mammograms as densities with irregular borders. The report stated there were no secondary signs of malignancy (cancer), but recommended that a follow-up mammogram be performed in six (6) months. In the years preceding this mammogram, Mrs. Bastian had had mammograms either yearly or bi-yearly.

After receiving this report, Dr. Xoepke did nothing further. He did not inform to follow up in 6 months. If he had, Mrs. Bastian would have immediately scheduled a mammography test 6 months in advance.

Dr. Koepke's office chart did not have any entry indicating he advised Mrs. Bastian to follow up in 6 months. He did have entries indicating he advised her of test results in other situations. Further, he had an entry in September, 1989, when he advised Mrs. Bastian of the results of this second mammogram.

On Dr. Koepke's copy of the March 15, 1988, mammogram report, he wrote that he advised patient to follow up in 6 months. However, this was not in his office chart. Second, he did not write on *any* of the other test reports that he advised Mrs. Bastian of results. Rather, he had entries in his office chart stating he advised Mrs. Bastian of the various test results (those subsequent to March, 1988). Finally, Mrs. Bastian will testify, as will her family and others, that her greatest fear has been getting cancer. This fear stems to the time she was 20 years old and took care of her mother for 4 months, while her mother wasted away and died from stomach cancer.



After the March, 1988, physical examination, Mrs. Bastian visited Dr. Koepke's office on the following dates: April 18, 1988; May 18, 1988; July 21, 1988; September 12, 1988; October 18, 1988; November 15, 1988; and January 24, 1989. Dr. Koepke did not tell or mention to her that she should schedule a follow-up mammogram to the March, 1988, one. He did tell her to schedule numerous tests during these office visits for minor, unrelated items. Every test he told Mrs. Bastian to schedule, she did. All tests were administered in the same building as Dr. Koepke's office. There are separate entries in Dr. Koepke's office chart indicating he advised Mrs. Bastian of the test results. At no time did he write on any of these reports to state he advised Mrs. Bastian about the test results.

On April 27, 1988, Mrs. Bastian called Dr. Koepke to inform him she had broken her foot. She called because she was concerned about her yearly physical examination (of which the administration of a mammography test was a part). He told her not to worry about it, and eventually **a** physical was scheduled for September 12, 1989.

On September 12, 1989, 18 months after her last physical, Dr. Koepke again performed a complete physical examination on Mrs Bastian. Dr. Koepke told Mrs. Bastian to schedule a mammography test with York X-ray. The report was dated September 14, 1989. It identified an ". . .ill-defined dominant density" at the same spot where the "asymmetric dense mammary parnechyma" was identified in the March 15, 1988, report. The September 14, 1989, report advised that a biopsy be performed. Dr. Koepke's office chart had an entry on September 15, 1989, that he advised Mrs. Bastian of the results of this report and that he referred her to Dr. Leiby, who performed the biopsy.

On September 25, 1989, Dr. Leiby performed a biopsy. The September 14, 1989, report indicated the tumor was 1.8 cm. Dr. Leiby thought he could successfully remove the tumor without having to remove the breast. When Dr. Leiby removed the tumor, the pathologist's report indicated the tumor extended to the margin. When a biopsy is performed and **a** tumor removed, there should be a margin of healthy skin surrounding the tumor. This was not done **by** Dr. Leiby, apparently because the tumor was much larger than shown **on** the mammogram report. The tumor was 3.5 cm. Its location **was** 5 cm. from the areola (nipple). The tumor was not palpable.

Mrs. Bastian was later told by Dr. Leiby that the tumor was malignant and that a mastectomy was needed. She scheduled an appointment with Dr. Salwan for a second opinion on September 28, 1989. Dr. Salwan's office girl asked Mrs. Bastian to **pick** up the September 14, 1989, mammogram report from York X-ray for her appointment with Dr. Salwan.

On September 27, 1989, Mrs. Bastian picked up the report from York X-ray. Out of the clear blue sky, she asked if she could have a copy of the March 15, 1988, mammogram report to compare the two reports. This was the first time she learned she should have had a follow-up mammogram 6 months after the March, 1988, one. Mr. Bastian was with her and will testify as to her reaction.

Eventually, Mrs. Bastian saw Dr. Kim for a third opinion, since Dr. Salwan had recommended a double mastectomy. He recommended she have a radical mastectomy. On October 23, 1989, Dr. Kim performed a modified radical mastectomy. He also removed all of the lymph nodes from Mrs. Bastian's right arm pit, since breast cancer usually metastasizes (spreads) through lymph nodes. He gave her the option of having chemotherapy or radiation treatment, in addition to the mastectomy. Mrs. Bastian chose not to.

Currently, Mrs. Bastian's prognosis is good. Her breast cancer had not metastasized to the lymph nodes and there currently is no evidence of any metastatic disease (the spread of the breast cancer). However, the risk of metastatic disease is directly related to the size of the tumor. Mrs. Bastian is checked every 3 months for signs of any spreading of her breast cancer.

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DEFENDANT'S EXHIBIT 2 SILVERMAN

PENGAD-Bayonne, N. J.

UP 19/90

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UPI9/90

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TRANSMITTAL ADVICE

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From: _____

Date: _____

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Fee: $ _____

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UP19/90

DEFENDANT'S EXHIBIT 3 SILVERMAN

9/24/91

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PAUL A. NEWMAN
A. P. LEARY
EDWARD T. BRICE
BARBARA J. BURDETTE
JONATHAN P. BLAKELY

September 18, 1991

Paula Silverman, M.D.
Ireland Cancer Center
2074 Abington Rd.
Cleveland, OH 44106

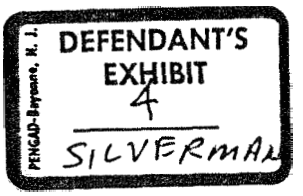
Re: Rose Bastian

Dear Dr. Silverman:

I want to advise you as to the current status of this case. I have enclosed copies of the Complaint filed by us, Dr. Koepke's Answer, Interrogatories sent to Mrs. Bastian, and Interrogatories sent to Dr. Koepke. Regarding those sent to Dr. Koepke, I only asked him to answer Numbers 7, 8, 10, 12, 17, 19, and 21-31 since I had submitted too many interrogatories under the Ohio Civil Rules of Procedure. Dr. Koepke voluntarily answered Number 20, probably because one of his patients underwent a double radical mastectomy with Dr. Salwan shortly before Mrs. Bastian saw Dr. Salwan for a second opinion.

I have also enclosed a copy of a memo regarding the facts of this case and copies of the records sent to me by Dr. Koepke, including his office chart. These records are in the same order in which I received them. I found it unusual that Dr. Koepke wrote directly on the March, 1988, mammogram report that he advised Mrs. Bastian to follow up in six (6) months yet did not have a corresponding entry in his office chart. For the September, 1989, mammogram report, and other test reports, Dr. Koepke had dated entires in his office chart that he advised Mrs. Bastian of the results of the test reports. He did not write on any of the other reports.

I am currently attempting to schedule a deposition of Dr. Koepke for the week of September 23, 1991, and they are trying to schedule a deposition of Mrs. Bastian for the same week. They have not expressed an intent to take your deposition. Their expert is Dr. Larry Levy from Mt. Sinai. Although Anna Carulas (one of Dr. Koepke's attorneys) met with Dr. Levy in June, he has not yet furnished a report. I am anxious to see it, as I cannot imagine a doctor supporting Dr. Koepke's actions or stating a twelve (12) to eighteen (18) months delay in diagnosing breast cancer is of no consequence.



Please review these documents at your earliest convenience. I would appreciate knowing any comments or concerns you have, especially regarding Dr. Koepke's office chart and/or falsifying his records. Please send these comments to me as soon as possible.

Thank you for your assistance. Please do not hesitate to contact me with any questions or comments.

Sincerely,

Jonathan P. Blakely

JONATHAN P. BLAKELY

JPB:jh
Encls.

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August 31, 1992

Paula Silverman, M.D.
Ireland Cancer Center
2074 Abington Rd.
Cleveland, Ohio 44106

RE: Rose Bastian

Dear Dr. Silverman:

Today I advised Susan Reinker's secretary that the currently scheduled deposition date of September 4th is inconvenient. We are attempting to reschedule it for Monday, September 14, 1992. Please let me know if that is acceptable to you.

Of course, I will want to meet with you at some length to discuss this case prior to your deposition.

Enclosed please find copies of the depositions of Dr. Koepke, and Dr. Benjamin Kim. These should help to give you an indication of the kinds of questions you will be asked, and to help give you a complete picture of this case. Also enclosed is a copy of Dr. Levy's report. While I am sure he is an excellent doctor, I would be surprised if some of his conclusions were accepted by a majority of similar physicians.

At any rate, please review these documents and I will be contacting you sometime next week to arrange a time when we can review this case in further detail.

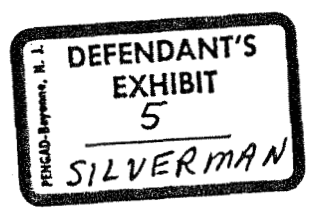
Thank you for your assistance and please do not hesitate to contact me with any questions or comments.

Sincerely,

Jon Blakely

JONATHAN P. BLAKELY

JPB:ds



IRELAND CANCER CENTER
University Hospitals of Cleveland / Case Western Reserve University

April 1, 1991

Mr. Jonathan P. Blakely
Attorney at Law
Law Offices of Newman, Leary,
and Brice
214 East Park Street
Chardon, OH 44024

Re: Rose Agnes Bastian

Dear Mr. Blakely:

In your letter of March 4, 1991, you report that Mrs. Bastian has now been diagnosed with chronic lymphatic leukemia. I see no connection between this illness and her breast cancer, nor with metastases from her breast cancer. Although it is true that breast cancer can metastasize to lymph nodes, the pathologic appearance of breast cancer in lymph nodes is quite different than that of chronic lymphatic leukemia, and in fact the diseases are entirely separate.

Regarding your question about the invasive nature of Mrs. Bastian's cancer: Mrs. Bastian did have infiltrating lobular carcinoma and invasive breast cancer. Fortunately for Mrs. Bastian this cancer appears not to have metastasized to her lymph nodes or distantly by our testing. The significance of the invasive nature of her breast cancer is that it does put her at risk for the clinically apparenr development of breast cancer metastases in the future. The risk of developing metastatic disease is related to the size of the tumor at the time of mastectomy.

Nolvadex and tamoxifen are the same drug. Tamoxifen is the generic name of Nolvadex. The usual dose of Nolvadex (or tamoxifen) is 10 mg taken twice daily. Tamoxifen is used both in the setting Mrs. Bastian is in, i.e. postoperatively to prevent breast cancer recurrences, and for the palliation of advanced breast cancer.

2074 Abington Road / Cleveland, Ohio 44106

The number of axillary lymph nodes recovered at surgery is quite variable. Seventeen is approximately an average number; more than ten is considered an adequate axillary dissection. The number of lymph nodes recovered depends not only on the extent of operation, but also on some human variability in the number of lymph nodes present, and also in the aggressiveness of the pathologist in searching for and identifying each resected lymph node. It is unlikely that there were metastases in the lymph nodes that were not detected by pathologic review. Sinus histiocytosis is descriptive term for reactive changes in the lymph nodes that have little clinical significance. The noted enlargement *of* the lymph nodes is *of* little clinical concern and is not indicative of metastases. Of course I have not personally reviewed the pathology on this case, but am using your reports as the basis for my opinion.

I hope these comments were helpful. If you have further questions, please do not hesitate to contact me.

Sincerely yours,

Paula Silverman

Paula Silverman, M.D.
Assistant Professor *of* Medicine

PS:pl

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PAUL A. NEWMAN
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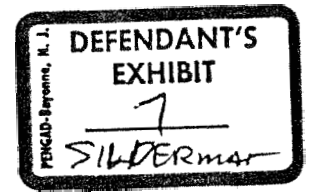
JONATHAN P. BLAKELY

March 4, 1991

Paula Silverman, M.D.
University Hospital of Cleveland
Case Western Reserve University
2074 Abington Road
Cleveland, Oh 44106



Re: Rose Bastian

Dear Dr. Silverman:

I want to update you on the status of the case and to receive an opinion as to whether metastases can manifest itself as chronic lymphatic leukemia.

Regarding the case, I filed a Complaint December 12, 1990, because the statute of limitations would have run on December 15, 1990. (This means Mrs. Bastian could never file a malpractice action in the future against Dr. Koepke; she could file a malpractice action against me after December 15). Dr. Koepke filed an Answer, along with Interrogatories (written questions requiring written answers regarding the case and Mrs. Bastian's background) and a Requst for Production of Documents (i.e. medical reports). We will submit these soon and I will send copies to you.

We are preparing our own Interrogatories and Request for Documents, and I will send you copies of those when they are completed and returned to me by Dr. Koepke.

In the meantime, I would like your opinion on whether or not chronic lymphatic leukemia could be a manifestation of breast cancer metastases. In January, Mrs. Bastian learned she had chronic lymphatic leukemia after Dr. Schmotzer, a hematologist at Metro General, obtained the results of a bone marrow biopsy. He indicated that in three (3) years, it will be a problem but should not cause too much discomfort until then. He also indicated to Mrs. Bastian he was not sure where or how it started.

The reason I think the two (2) cancers are related is because it is a lymphatic leukemia. It is my understanding that the lymph nodes are of prime importance in determining a breast cancer patient's prognosis. Is this because breast cancer metastases is through the lymph nodes?

I understand that there appeased to be no eivdence of metastases; however, several factors concern me. First, Mrs. Bastian's cancer was invasive (infiltrating) lobular carcinoma, which is unusual in that most lobular carcinomas are noninvasive. Is the fact that it is invasive significant? Dr. Stevenson, who monitors Mrs. Bastian for metastases every three (3) months, told her although there is no sign of metastases now, there is a good chance metastases will occur in the future.

Second, Mrs. Bastian has to take two (2) Novadex pills a day for life. It is my understanding that Novadex serves the same purpose as Tamoxifen. It is further my understanding that Tamoxifen is a drug usually used for the palliation of advanced breast cancer in post-monopausal women. Would the fact that Mrs. Bastian has to take two (2) Novadex pills per day for the rest of her life indicate her breast cancer was advanced, or is Novadex also commonly prescribed in less advanced breast cancer cases as a precaution?

Finally, I have a concern regarding the axillary lymph nodes. A pathologist's report of October 28, 1989, stated a sinus histiocytosis of seventeen (17) axillary lymph nodes showed no tumors were present. I believe there are more than seventeen (17) axillary lymph nodes on the right side. Could there have been evidence of metastases in the axillary lymph nodes that weren't subjected to a sinus histiocytosis? Also, some or at least one of Mrs. Bastian's axillary lymph nodes was enlarged. Is this indicative of metastases?

please send me your written opinion at your earlist convenience, and charge me in increments of one-tenth (1/10) of an hour at the rate of $150/hour.

If you have any questions or comments, please do not hesitate to contact me.

Thank you for your assistance.

Very truly yours,,

Jonathan P. Blakely

JONATHAN P. BLAKELY

JPB:jh

Newman, Leary & Brice

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PAUL A. NEWMAN
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JONATHAN P. BLAKELY

October 24, 1990

Paula Silverman, M.D.
Assistant Professor of Medicine
University Hospitals of Cleveland
Lakeside - Room 3103
2074 Abington Road
Cleveland, OH 44106

Re: Rose Bastian

Dear Dr. Silverman:

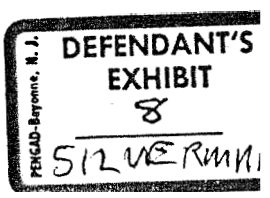
Enclosed please find copies of the following:

1) the records from Metro General Hospital;
2) Dr. Leiby's report, dated September 24, 1990;
3) Dr. Salwan's report, dated October 15, 1990; and
4) a written narration of Mrs. Bastian's of her visits and communications with Drs. Leiby, Salwan, and Kim.

Mrs. Bastian wrote this narration prior to her mastectomy in late October, 1989, when events were still fresh in her mind. In reviewing the file, Dr. Leiby thought a wide re-excision could work at the time he finished the initial excision. Apparently he felt a mastectomy was needed after reviewing the pathology report pertaining to the biopsy. He told Mrs. Bastian and her husband she would probably need a mastectomy. In fact, in his "Operative Report" dated October 10, 1989, he stated, "I don't think that she is going to be a candidate for a lumpectomy."

At any rate, Dr. Salwan and Dr. Kim both felt a mastectomy was needed. I believe Dr. Salwan initially thought a double mastectomy was needed, but modified his opinion to a right mastectomy after Mrs. Bastian saw Dr. Kim.

I have requested copies of the slides, X-rays, and other records from York Medical X-Ray, Inc. I will send them to you when I receive them.



If you meed additional documents, please let me know.

As always, thank you for your assistance.

Sincerely,

Jonathan P. Blakely

JONATHAN P. BLAKELY

JPB:lr
Enclosures

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JONATHAN P. BLAKELY

September 4, 1990

Paula Silverman, M.D.
Assistant Professor of Medicine
University Hospitals of Cleveland
Lakeside - Room 3103
2074 Abington Road
Cleveland, OH 44106

Re: Rose Agnes Bastian

Dear Dr. Silverman:

I want to update you on the status of Mrs. Bastian's potential claim against Dr. Koepke. On June 15, 1990, I sent Dr. Koepke a letter indicating Mrs. Bastian was contemplating bringing a malpractice action against him and that he should therefore contact his liability carrier. On July 11, 1990, I sent him a follow-up letter.

On July 12, 1990, I was contacted by Anna Moore Carulas, an attorney with the law firm that represents Dr. Koepke's liability carrier. She stated they were evaluating Mrs. Bastian's claim, and requested I send her a letter describing the nature of the claim and medical reports. Attached is a copy of the letter I sent her. I mentioned to her that a physician reviewed the medical reports I had, but I did not identify you, discuss what was said, or send her a copy of your opinion.

Hopefully, Ms. Carulas will evaluate Mrs. Bastian's claim on its merits, and not try to figure out a way to deny coverage.

In the meantime, I would like further opinion on whether Dr. Koepke's failure to administer a follow-up mamogram six (6) months after the March, 1988 mamogram, or his failure to perform a biopsy in March, 1988, was the "proximate cause" of Mrs. Bastian's radical mastectomy. In other words, did Dr. Koepke's failure to properly act present a 51% chance (or higher) that a radical mastectomy was the only viable option for her? Had Dr. Koepke acted properly, would the chances Mrs. Bastian would not have needed a radical mastectomy have been 51% or greater?

In your opinion, based on the medical reports, was Dr. Koepke's failure to act properly 51% (or more) of the reason Mrs. Bastian had to undergo a radical mastectomy?

If this cannot be determined based on the records I previously sent you, please let me know. I have requested the complete records from Dr. Koepke, Dr. Leiby, and Cleveland Metro General Hospital, where Dr. Ben Kim performed the mastectomy and Dr. Jean T. Stevenson is currently monitoring Mrs. Bastian every three (3) months for metastases. I will be glad to send you copies of these when I receive them.

It is my understanding that based on the size of Mrs. Bastian's tumor and the eighteen (18) months between mamograms, that had a biopsy been performed in March, 1988, or a second mamogram been given six (6) months later, a lumpectomy or partial mastectomy would have had a 51% chance (or better) of successfully treating Mrs. Bastian's cancer. Please confirm my understanding in writing.

Please send me a bill for your time, at the rate of $150.00 an hour. Thank you again for all your help.

If you have any questions, comments, or need additional information, please do not hesitate to contact me.

Sincerely,

Jonathan P. Blakely

JONATHAN P. BLAKELY

JPB:lr
Enclosure

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August 24, 1990

Anna Moore Carulas, Esq.
JACOBSON, MAYNARD, TUSCHMAN & KALUR
1001 Lakeside Avenue, Suite 1600
Cleveland, Ohio 44114-1192

RE: Rose Bastian, Your File No. 65192

Dear Ms. Carulas:

Enclosed please find copies of the medical records that I currently have pertaining to Mrs. Bastian's claims against Dr. Koepke. As 1 previously indicated, the additional records will be forwarded as soon as they are received,

The nature *of* the claims against Dr. Keith Koepke are as follows:

(1) negligence in not detecting the breast cancer until the only effective option was to perform a radical masectomy, with a diminished chance of survival; and

(2) fraud, separate and apart from the negligence/ malpractice claim, in not disclosing the results of the first mamogram, which was performed on March 15, 1988.

Prior to the mamogram of March 15, 1988, Mrs. Bastian had a mamogram taken once a year. There is no history of breast cancer in her family. Mrs. Bastian first started seeing Dr. Koepke in January of February, 1988.

In March *of* 1988, Mrs. Bastian had a physical examination conducted by Dr. Koepke. A marnogram was taken as part *of* this examination. This mamogram was abnormal, and showed a lesion in the upper part of the right breast. This is the identical spot where the tumor further developed, according to the

September 14, 1589, mamogram. The March 15, 1588, mamogram further recommended that another mamogram be performed in six (6) months to monitor the progress of the lesion.

Notwithstanding, Dr. Koepke did not inform Mrs. Bastian of the abnormality or of the six-month follow-up recommendation. In fact, he told her that all tests came back negative. Further, Dr. Koepke never subsequently informed Mrs. Bastian to come beck for a follow-up marnogram six months later. Mrs. Bastian did not see, nor was she aware of, the results of the March 15, 1988, mamogram until after the second mamogram of September 14, 1989, was taken.

Mrs. Bastian visited Dr. Koepke at least seven times between the time the two mamograms were administered. **Dr.** Koepke had her undergo numerous tests for other unrelated problems. Every test that he recommended, Mrs. Bastian promptly performed. However, Dr. Koepke failed to reveal the findings of the March, 1988, mamogram, the six-month follow-up recommendation, or administer a second mamogram.

Approximately one (1) year after the March, 1988, mamogram, Mrs. Bastian broke her foot. She then called Dr. Koepke regarding her yearly physical (of which the administration of a mamogram was a part of). She was told not to worry about it and to schedule a physical when she felt better.

Dr. Koepke then scheduled her for a physical in September, 1989, administering the second marnogram. on September 14, 1989. This was eighteen months after the previous abnormal mamogram and one year after the time the recommended mamogram should have been administered.

On Friday, September 15, 1989, Dr. Koepke called Mrs. Bastian to tell her something showed on the mamogram. He referred Mrs. Bastian to Dr. Grant A. Leiby, Jr. Mrs. Bastian called him immediately and had an appointment with him on Monday, September 18, 1989.

Dr. Leiby performed an examination of her right breast and scheduled her for an excision biopsy on September 25, 1989. He was unable *to* completely excise the tumor.

Newman, Leary & Brice

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PAUL A. NEWMAN
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May 25, 1990

Paula Silverman, M.D.
University Hospitals of Cleveland
Lakeside, Room 3103
2074 Abington Road
Cleveland, Ohio 44106

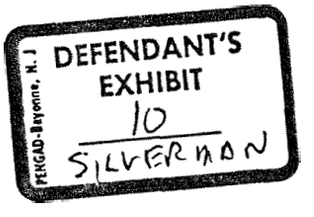
RE: Malpractice Claim *of* Rose Bastian

Dear Dr. Silverman:

It was a pleasure talking to you on Thursday, May 17, 1990. Based on your medical expertise, and my understanding of the law, no action against Dr. Grant A. Leiby will be pursued.

In talking with one of the partners of this firm, he indicated that we need a letter from you regarding Dr. Koepke addressed *to* me. The contents should repeat what you told me that the standards of a reasonably competent doctor would have required a six-month follow up mammogram (or at least would require a doctor to inform the patient of the recommendation and send a follow-up letter to that effect), and that in not performing a follow-up mammogram in six months, the patient's chance of needing a masectomy greatly increased and her life-span possibly reduced (though you indicated this was a slight possibility since the cancer had not spread to the lymph nodes). **Also,** please include any other information **you** feel is important. This is basically a letter indicating your opinion.

I will keep you advised as to the progress of this case Before a lawsuit is filed against Dr. Koepke, **I** will contact him to advise him to contact his liability carrier, as a potential claim exists against him. The liability carrier will contact me in hopes of settling the claim without the need



to even file a lawsuit, let alone proceed to trial. Assuming an offer was made satisfactory to my mother-in-law, that would end the case.

Please send me a statement for your professional services rendered in preparing your opinion letter, at the rate of $150.00 per hour.

Thank you for your assistance and please feel free to contact me with any questions you may have.

Very truly yours,

Jonathan P. Blakely

JONATHAN P. BLAKELY

JPB: **dw**

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May 11, 1990

Paula Silverman, M.D.
University Hospitals of Cleveland
Lakeside, Room **3103**
2074 Abington Road
Cleveland, Ohio **44106**

RE: Review of potential medical malpractice claim

Dear Dr. Silverman:

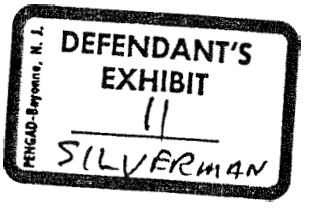
Thank you for agreeing to review the potential claim of my client, Rose Agnes Bastian, arising from treatment of her for breast cancer. As you indicated, your fee is $150.00 per hour. Please send me the bill and my client will take care of payment.

I will briefly outline the relevant factual history of the case. Then I will indicate my areas of concern.

FACTUAL OUTLINE

In March, **1988**, my client had a mammogram taken as part of a physical examination. I am not familiar with medical terminology, but I believe that this mammogram indicated some kind of abnormality. Regardless, it recommended a six-month follow-up study. Dr. Keith Koepke, the treating doctor, did not tell my client she should come back in six months or send her any follow-up letter to this effect. Although my client visited Dr. Koepke seven times or so after this for other reasons, no follow-up mammogram was taken until September, **1989**. This mammogram indicated **a** biopsy was advised as a growth of some kind in the right breast was strongly suggestive of cancer.

Dr. Koepke then referred her to Dr. Grant A. Leiby, Jr. Dr. Leiby stated he would remove the growth, whether or not it was cancerous. Dr. Leiby stated that my client could ***go*** on **a** week-long cruise she had been planning, and when she returned he would



remove the lymph nodes on her right side and start her on radiation therapy. He stated that the removal of the lymph nodes and radiation could be started several weeks or a month after the surgery. He repeatedly stressed that my client would not need a masectomy and that he would remove whatever growth was on the right breast.

During the surgery, **Dr**. Leiby apparently had the growth isolated so he could remove it, but then lost it. He was extremely upset about losing it, though he denied he lost it. After the surgery, my client heard a nurse stating Dr. Leiby does this surgery differently than the other doctors do.

Approximately four **(4)** weeks after Dr. Leiby performed the excision biopsy on my client, she had a radical masectomy on the right side, and the right lymph nodes were removed.

AREAS OF CONCERN REGARDING DR. KOEPKE

1. Should **a** doctor who received a mammogram report, such as the March, **1988**, one with its recommendation of a six-month follow-up, have informed the patient to return in six months and send a follow-up letter or telephone call as a reminder? In other words, did Dr. Koepke's failure to follow-up fall below the standards of a reasonably competent doctor?

2. If Dr. Koepke had followed through with a mammogram six months later, would this have reduced the chance a masectomy would be needed and/or have increased my client's chances of survival down the road? Would the six-month follow-up have made any kind of a difference?

AREAS OF CONCERN REGARDING DR. LEIBY

1. Did Dr. Leiby carelessly perform the excision biopsy in failing to remove the tumor in its entirety?

2. In failing to remove the tumor in its entirety, could this have caused the cancer to spread throughout the entire breast and thus increase the likelihood a radical masectomy would be required? In other words, if only a small tissue sample had

been removed, and the tumor had not been "lost", would the chances have been reduced that a masectomy would be needed?

3. Could Dr. Leiby's failure to remove the tumor, or causing it to "slip", have caused it to spread and reduce my client's potential lifespan?

4. Are there any potential material risks involved in procedures, such as the excision biopsy performed by Dr. Leiby, that should have been disclosed to my client? He did not mention any potential negative aspects whatsoever.

5. Dr. Leiby performed the biopsy on September 25, 1989. The masectomy was performed on October 23, 1989. Was this four-week interval unusually long between the time of the biopsy and the time that the masectomy was performed. Could this delay potentially reduce my client's lifespan?

Before a malpractice action can be brought, Ohio law requires the attorney to first consult with an appropriately qualified physician (one who is licensed to practice and devotes three-fourths of their professional time to "active clinical practice" or "its instruction in an accredited university". I assume that you fall within this definition. If the attorney feels, after the consultation, reasonable grounds exist for brining an action, then it may be brought.

Please review the enclosed information, including my client's narration shortly before her masectomy. If you need additional information, please let me know.

After you have reviewed the enclosed, please contact me. While I would prefer to meet with you to discuss this, a telephone consultation would be satisfactory.

I appreciate your time and look forward to hearing from you. If you have any questions, please do not hesitate contact me.

Very truly yours,

JONATHAN P. BLAKELY

JPB:dw
Encls.

one hour

35 min for review

3^{00} – 35

7^{20}. 7^{10} - read reports

Why necessary mastectomy - Kim's records -

c MGH path review

Salvani's records.

745 Definitely problem c Koepke.

1. definite needed F/u - breast exam at that time and ? surg consult

2. yes, reduce possibility mastectomy ~~most~~ and survival probably

3 Breast exam

Leiby

650 1. Breast tumors often difficult to completely excise in 1st attempt. Difficult to distinguish from nl tissue (needle loc.) Often needs 2nd excision or mast

2. No ↑ chance of spread. Small Sx would not have made necessity for ~~sec~~ mast less.

720 3. No

4. usual surgical risks - anesthesia; bleeding, infection

5. ~~Delay~~ There is some delay, but not material

No action vs surgeon -

Consider action against Radiologist - low yield.

plan to file vs. Koepke.

No action vs. Leiby

? look to radiologists.

DEFENDANT'S EXHIBIT 12 SILVERMAN

PENGAD-Bayonne, N.J.

mammogram. Thursday
Dr. [illegible] called Friday 9/15 [illegible] (preferred Dr. Leily)
Saw Dr. Leily, Monday 9/18/89 - Took report from york x-ray for him

Dr. Leily told me (Bob & me) that if it was malignant - would take it out and there would be no more cancer in right breast - can take cruise as even if malignant, with the tumor out, to remove the nodes on my right side, could wait even a month (a few weeks or a month) Then. When I returned from the cruise, he would remove the nodes & start me on x-ray treatments. That's it

Had biopsy 9/25/89.
Hosp. 7:00 a.m. Intravenous -
X-Ray 8:00 for needle (mammogram) there approx. 45-50 minutes. Needle inserted & then wire left for doctor to know exactly where tumor is.

Debbie (who did mammogram) showed me the X-ray with the 3 dots (∴) and told me that the doctor would take it all out (as he said he would)

To surgery 9:15. Had local with sedative to calm me down. Very relaxed - doctor started procedure then suddenly said very quite concerned, "I lost it - Son of a bitch." Felt suction 2 or 3 times - doctor mentioned bleeding - felt compression against my breast (like fingers) heard someone say "Is this it" and "no" - "S O B" again. Saved me up but prior to that told someone to take the biopsy to Pathology and to have it frozen. I asked Dr. Leily if he got it all out. He said he wasn't sure & I asked what would happen if he didn't - if I'd have to go through what [illegible]

Margin notes: [illegible]; Lord - not hair [illegible] my here; [illegible]

"that wasn't so bad was it," and I answered "no". I asked what I should do when I [got] home & he said to rest & the bandage could be removed "tomorrow evening" & then he ~~went to talk to my husband~~ [left]

One of the nurses in the operating room seemed upset and remarked "He does the procedure different from all the other doctors" - she was talking to another nurse, and did sound upset in speaking to her and said ~~why does he~~ all the other doctors do the procedure differently and she looked angry as she was talking. I was then moved to the recovery room. The doctor came to see me & I asked again what happens if he didn't get the tumor all out and he now said "let's wait until we get the biopsy report" & left to see my husband. He told my husband it looked suspicious & I might need a mastectomy.

I was extremely upset because I knew he didn't get it all out, and now I would need a possible mastectomy when in his office he was adamant about what would happen if it was malignant. My husband called him & told ~~what I~~ him what I said, and the doctor said that "when medicated patients tend to hallucinate" & to wait for the biopsy report.

On Tuesday I called at 12:30 for the biopsy report and was told it wasn't in & probably wouldn't be in for few days. I told nurse/secretary that I was concerned & knowing they'd be closed on [Wed], if the doctor would call me with the report. She then told me to call back at 2:00. Approx. 1:15 the doctor called & said, "Bad news - it's cancer". I told him what I heard in the operating room & he denied

Saw Dr. Kim 10/10/89 - 10:00 am Summary
to date
went sick mid-Dec. I was still sick with
bronchitis. Sat came later from work
Dr. Kim was straightforward and sure
Dr. Seiman didn't have any tests scheduled
as I thought he would, plus I was feeling
more secure with Dr. Kim. Saw Dr.
Kim on 10/12/89 - Told me I needed
right breast removed & lymph nodes
biopsied. I should have gone ~~per~~
per cardiologist ~~for testing before~~
liver scan. I asked him to do surgery
& he indicated I should not make
a decision until next day. To
think but told Bob to help me
with decision. I called Dr. Kim's
Office on 10/13/89 & said I wanted
him to do surgery. Joyce (secretary)
later in day gave me schedule &
tests to have taken - Thurs., Cardiologist
Wed., Liver scan & Pre-testing for
surgery. Cardiologist had me go for
echocardiogram Thurs., & Joyce
cancelled liver scan as I didn't
need it (when I saw her on Thurs. - I
was to call her to see if I needed it,
but since we were at the hospital,
I went & saw her personally).
Surgery scheduled for 9:00 am
Monday, 10/23/89.

through narrative

Saw Koepke every 3 mon. or so, up to around Sept. - then saw him in Jan or Feb. 89 & [illegible] mammogram, told him about [illegible]. (constant cough - [illegible] x-rays) (repeatedly complaining of [illegible] pain [illegible] of breasts - [illegible] - [illegible] he had [illegible] [illegible] - [illegible] [illegible] me [illegible] to see another doctor. I told him my pain [illegible] real - not imagination - he referred me to Dr. [illegible] - that's another story. ([illegible])

1 Koepke around 10 p.m. for day [illegible] to him [illegible].

Told me I'm coughing as acids & particles of food was getting into my lungs - near heart valve - scheduled me for test - tube down throat 1/11/89. Biopsy & hiatal hernia - was told 6" Zantac twice daily - then ~~after about~~ March '89 changed to once at night - referred me to Dr. Kelin because of my frequent exhaustion which I also complained of.

Always - low grade temp.

10/9 Saw Dr. Seluen to pick up everything for Dr. Mansour/Dr. Kim - Gave prescription for my bronchitis & cough syrup - will call by Fri. about results from Metro

Tell doctor only 2 men in [illegible] room (him & I believe Dr. [illegible] — the one who took me into the O.R. & he told me he wasn't going to assist Dr. Leibi — but it was Dr. Leiby's voice I heard throughout the entire surgery except when "is this it" + "yes")

his office with my husband in the room — how he indicated if it was malignant that he'd take the tumor out — my breast would be cancer free, that I can go take the cruise & enjoy myself knowing that it's cancer free. And when I returned (because even if it would be cancer free, it couldn't wait "just a month") then he would make arrangements for the surgery of my lymph nodes — followed by 5 weeks of X-ray treatment, and then, that's it. He changed that to say "if I got it all out"; and then I told him about the girl in X-ray (Debbie, blond, short hair, about 5'6-7") and then Dr. Leiby said, "it was bigger than he thought it was", then discussing another doctor — he said he could refer me to one, and I said "no thank you, I'll get my own" [illegible].

→ I had appointment Fri. 2:15 for removal of stitches

Called Dr. [illegible]'s office — scheduled for appointment 3:45 9/28/89.

Medical

Mammogram

Biopsy

Pathology

Slides

Picked up report from York X-Ray 9/27/89 & out of clear blue sky asked if I could have copy of previous report of 3/88 to compare. Should've read to follow up 6 mos. with another mammogram. Dr. [illegible] never

I do not agree that the fact that the tumor was 3.5 centimeters does not add to the risk of recurrence. There is ample data this increasing tumor size definitely adds to the risk of recurrence, and I'm a little confused why Dr. Levy would say that. That is not in my opinion, That's not correct.

Is still less involved.

There is still the possibility of a reoccurrence even with the smallest tumor, but in fact, the risk is much less if the tumor is much smaller. Do you see my distinction?

Q. Yes.

A, I agree that the -- well.

I don't agree that the consensus development conference said that it would be appropriate to perform a lumpectomy on any patient who had a tumor less than four centimeters. I don't think that's what it says. That's not my reading. A tumor less than -- my reading is that they think that breast conservation is an appropriate management, method of management, for Stage 1 and 2 tumors.

Actually, as a matter of fact, he disagrees

with himself on that.

I don't agree that -- well, I don't think that I agree that most surgeons would have likely performed a mastectomy even if a malignancy could have been diagnosed as early as '88 because I think the tumor would have been much smaller and I think if there had been a completed excision of that tumor with clean margins, Dr. Kim would have been comfortable with a lumpectomy.

Q. You agree with both Dr. Kim and Dr. Levy's statement that most surgeons would do a mastectomy?

A, I think that -- I think he said that on the deposition, but I bet in practice -- my feeling is that in practice, faced with a patient with a complete excision even of an infiltrating lobular tumor that if he had really had a complete excision with negative margins and a smaller tumor, that he would have been comfortable with that recommendation.

It's very different to go back and in the abstract say, you know, in general, we try to do such and such when if you have a patient that's had a clean excision and actually doesn't need a

mastectomy, I think that maybe this would not have been recommended.

Q Is it fair to say that there are different schools of thought among surgeons as how to best treat infiltrated lobular carcinoma?

A It's fair to say that -- I don't know if there are different schools of thought among surgeons. Like I said before, I don't really have, you know, the pulse on the surgical thought.

I do think there are -- certainly surgeons have different schools of thought about how they treat breast cancer. Some surgeons never recommend a lumpectomy under any circumstances Some surgeons perform most of their practice doing lumpectomies and almost never do mastectomies except in the most advanced cases So there's a great deal of variation between and among surgeons, and that's why patients get several opinions before they have an operation.

Q And that's a judgment call that different surgeons make at the time they're dealing with that patient. Is that correct?

A That's correct.

Q Do you know Dr. Bernard Fisher?

A. I know of Dr. Bernard Fisher.
Q. What do you know of him?
A. He's the head of the National Surgical Adjuvant Breast Project. He's a very renowned breast surgeon that's authored lots and lots of papers and been the principal investigator in many studies on the treatment of breast cancer,
Q. Is he one of the authorities on breast cancer in the U.S. today?
A. He is.
Q. How about Dr. Mark Lippman; do you know of him?
A. Yes.
Q. Is he also one of the authorities on breast cancer?
A. I believe Mark Lippman is a medical oncologist and not a breast surgeon. Actually, I am fairly sure of that.
Q. Do you know of anything else you plan to do before you come to court and testify in this case? Anything else you plan to look at or review that you know of today?
A. Not that I know of right now. Not that I've thought about right now.
Q. Have you looked at any other literature other than what you've described today?

A. Well, since my practice is in breast cancer, I've looked at quite -- I've looked at a lot of breast cancer literature. Do you mean in preparation for today?

Q. Correct.

A, I reviewed some of DiVita's textbook principles, I think it's called the Principals of Oncology. Just to look -- some of the numbers I had on recurrence rates in node negative breast cancer came from that. And I don't think I reviewed anything else specifically for this deposition.

Q. Have you taken care of patients with infiltrating lobular carcinoma?

A. Yes, I have.

Q. How many times roughly? Any idea?

A. No.

Q. Do you recall --

A. But it's about five to ten percent of breast cancer, so it would be about -- my guess is it's probably about five to ten percent of my practice.

Q. Do you recall what percent of them, the patients you've taken care, had mastectomies as opposed to lumpectomies?

A. Most of my patients have had mastectomy and not lumpectomies. And I don't -- you know, I honestly don't remember. I honestly couldn't tell you.

Q. Can you think of any infiltrating lobular carcinoma patients who you have had who have had lumpectomies?

A. I want a "no," answer to this. No, but I don't think we make that much of a distinction here, I'm not sure that -- I mean this is one that, you know, really came up -- as I said, I was surprised when I read Dr. Kim's deposition that he was making a general statement that they would be more likely to have mastectomies, It's not a trend that I've noticed at all.

Q. Are you familiar with the rate of recurrence for patients who have a lumpectomy with infiltrating lobular carcinoma for reoccurrences in the same breast?

A. Yes. It's -- well, in the largest series I found, in 67 patients with infiltrating lobular carcinoma that had breast conserving therapy, the five-year overall survival was 92 percent with a 13.5 percent mammary recurrence rate. Which was not statistically significantly

different than for infiltrating ductile carcinoma.

Q. That's 13 percent recurrence within the five years?

A, That's correct. Nine percent with infiltrating ductile.

Q. How about within ten years?

A. They didn't give that in this paper. Do you have it?

Q. Not offhand.

A, Excuse me?

Q. Not offhand?

A. This is the John Kurtz cancer article from '89. 1989 Journal of Cancer.

Q. If a surgeon elected to perform a mastectomy on a patient with infiltrating lobular carcinoma who had a tumor, say, less than three centimeters in size, would you say that surgeon was giving inappropriate care or is this a judgment call?

A. Could you repeat the question?

Q. If a surgeon elected to perform a mastectomy on a patient with lobular infiltrating carcinoma who had a primary tumor less than three centimeters in size, less than two centimeters

in size, is that surgeon performing appropriately, inappropriately or is that a matter of medical judgment?

A, It's a matter of medical judgment.

- - - -

(Thereupon, Defendant's Exhibits 1 through 13 were mark'd for purposes of identification.)

- - - -

Q. Doctor, if there has been a diagnosis made in April of '89 or in September of '88 -- that is, six months or one year earlier than the diagnosis was made -- and assuming it was the same tumor, would you agree that it would have been the same histological type? That is, infiltrating lobular carcinoma?

A. Yes.

Q. And would you assume that the other prognostic factors would have been the same? That is, the ER/PR status, the diploid tumor status, all of those things we talked about earlier?

A. Most probably.

Q. How long has it been that you've been specializing in treating breast cancer patients?

A. January of '88.

Q. So it's really been four years now?
A. Yes,
Q. Almost five years?
A. Correct.
Q. And you've never practiced internal medicine in an office practice such as Dr. Koepke's?
A. Correct.

When we do general internal medicine, outpatient care is part of our medical residency. And I did some what we call moonlighting but part-time work in the Veteran's Hospital screening area,

Q. Do you treat your patients for complaints other than breast cancer?
A. I do. Actually, I often serve as their primary physician.
Q. Do you do things like colonoscopies and sigmoidoscopies?
A. I don't do colonoscopies and sigmoidoscopies. That particular procedure I refer out. But my patients call me for their colds and bronchitis and almost anything that they need, actually. They often have another internist, too, that follows them.

I refer out, you know, hypertension that

isn't easily controlled and most stuff that gets to be a repeated problem just because I think internists, you know, do a better job of the close followup.

Q. If you had a patient who you were seeing yearly for whatever reason and they needed complete physical exams, would you refer them to someone else or would you do that, just a routine yearly physical exam?

A. Patients that I see only -- that's a tough question. My office exam is much like the physical exam that an internist does on what they call their complete yearly physical exam, and I do those on my patients that have had breast cancer, at least if it's within five years of their diagnosis, every three months.

I do a complete physical. The only thing that's not included in my exam is a Pap and pelvic, which I refer out to their gynecologists or their interns if they go to that for them. I sometimes do Pap and pelvics but not very often.

The rest of what practitioners do as a complete physical exam varies. Some people do an EKG. Some people do a chest x-ray. Some

people do things like colonoscopies. Chest x-ray and a mammogram are part of the breast cancer followup, and I do those, and unless someone has another reason to have a colonoscopy, I don't, you know, make a big point of referring people out for that unless they have an additional risk factor for colon cancer or something,

Q. Is it fair to say that your patients you are treating here primarily are in followup for one particular medical problem, which is breast cancer, not the whole gamut of potential medical problems a patient can have? Is that correct?

A. That's correct.

MS. REINKER: Okay. That's it. Nothing further.

_____
PAULA SILVERMAN, M.D.

C E R T I F I C A T E

The State of Ohio,) SS:
County of Cuyahoga.)

I, Lynn D. Thompson, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the above-named PAULA SILVERMAN, M.D., was by me, before the giving of her deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above-set forth was reduced to writing by me by means of stenotypy, and was later transcribed into typewriting under my direction; that this is a true record of the testimony given by the witness, and was subscribed by said witness in my presence; that said deposition was taken at the aforementioned time, date and place, pursuant to notice or stipulations of counsel; that I am not a relative or employee or attorney of any of the parties, or a relative or employee of such attorney or financially interested in this action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this ____ day of _____, A.D. 19 ___.

_____ _____ _____ _____
Lynn D. Thompson, Notary Public, State of Ohio
1750 Midland Building, Cleveland, Ohio 44115
My commission expires January 21, 1995

IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

ROSE AGNES BASTIAN,
et al.,

Plaintiffs,

-vs-

JUDGE ANGELOTTA
CASE NO. 202353

KEITH R. KOEPKE, M.D.,

Defendant.

- - - -

Deposition of PAULA SILVERMAN, M.D., taken as if upon cross-examination before Lynn D. Thompson, a Notary Public within and for the State of Ohio, at University Hospitals of Cleveland, 2074 Abington Road, Cleveland, Ohio, at 1:15 p.m. on Monday, September 14, 1992, pursuant to notice and/or stipulations of counsel, on behalf of the Defendant in this cause.

- - - -

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MS. REINKER: Okay. That's it. Nothing further.

PAULA SILVERMAN, M.D.

TO THE WITNESS: DO NOT WRITE IN TRANSCRIPT EXCEPT TO SIGN. Please note any word changes/corrections on this sheet only. Thank you.

TO THE REPORTER: I have read the entire transcript of my deposition taken on the _____ day of October, 19 ~~19~~ 92 or the same has been read to me. I request that the following changes be entered upon the record for the reasons indicated. I have signed my name to the signature page, and I authorize you to attach the following changes to the original transcript:

PAGE	LINE	CORRECTION OR CHANGE AND REASON THEREFORE
5	9	"handled" should be "handed"
6	10	"mother" should be "mother-in-law"
9	7-8	"both diseases" should be "both hematologic diseases"
		word omitted
12	23	"unpublished" should be deleted; it doesn't make sense
		in the context - I don't think I said it.
18	14	"System" should be "systemic"
30	5	"Levy" should be "Leiby"
32	10	"diagnoses" should be "procedures"
45	7	"failure" should be "value"
47	25	"inward" should be "inner"
51	13	Should be "3.0 - 3.9" not "3.90 - 39"
51	18	"System" should "Systemic"
57	25	"reason" should be "cancer"
58	1	add "not" after the first "Let's"
65	2	"lateral" should be "bilateral"
84	20	"inlets" should be "internists"

10-4-92
Today's date

Signature of Deponent