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THE STATE of OHIO,)
COUNTY of CUYAHOGA.) SS:

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IN THE COURT OF COMMON PLEAS

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RICHARD RICHNAFSKY, et cetera, et al.,)
plaintiffs,)
vs.) Case No. 559008
UNIVERSITY HOSPITALS OF CLEVELAND, et al.,)
defendants.)

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Videotaped deposition of RICHARD MATTHEW WALSH, M.D., a witness herein, called by the plaintiffs as if upon cross-examination, and taken before David J. Collier, RPR, Notary Public within and for the State of Ohio, pursuant to Notice of Deposition and pursuant to the further stipulations of counsel herein contained, on Tuesday, the 18th day of April, 2006 at 4:48 p.m., at the Cleveland Clinic Foundation, 9500 Euclid Avenue, City of Cleveland, County of Cuyahoga, State of Ohio.

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ALSO PRESENT:
George H. Tackla, Videographer

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I N D E X

WITNESS NAME: RICHARD MATTHEW WALSH, M.D.

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RICHARD MATTHEW WALSH, M.D.
being first duly sworn, as hereinafter certified, was examined and testified as follows:

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CROSS-EXAMINATION

BY MR. BECKER:

Q Good afternoon, Doctor.
A Good afternoon.
Q Tell me your full name, please.
A Richard Matthew Walsh.
Q And you're a physician?
A Yes.
Q And you're currently employed by the Cleveland Clinic Foundation?
A Yes, sir.
Q And I have had an opportunity to look at your file. In addition to the materials in front of you, which I see are two or three depositions and the medical chart, have you reviewed anything else that's not before you?
A No.

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Q Do you have any notes, Doctor, that you created as a result of your review in this case?
A No.
Q Is it your practice not to create notes when you review or do a medical/legal review?
A Typically I would not. I might write in the -- in the volumes that I've been given, but not separate notes.
Q Okay. Let's talk about your medical/legal experience. How long have you been reviewing cases?
A Oh, a dozen years.
Q And approximately how many -- what -- how many per year would you review?
A I would say on average less than one.
Q Okay. And do you know how it was that you were contacted on this case?
A No.
Q And have you ever worked for Beverly's law firm before?
A Not that I know of.
Q Do you know Dr. Elkhairi?
A No.
Q Okay. Never met him?
A Never.

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Q Okay.
A Not that I know of.
Q Okay. I looked at a deposition of yours. It appears that you have maybe reviewed 12 to 15 cases; is that fair?
A That seems a little high to me, but it could be right.
Q Have you ever reviewed a plaintiff's case, on behalf of the patient?
A I have never been offered one.
Q Do you --
A So no.
Q So the answer would be no, but is there some kind of prohibition about doing plaintiff's medical/legal work at this institution, to your knowledge?
A Not that I know of.
Q Okay. We can agree that when you're acting as a medical/legal expert, it's very important to be fair, impartial and objective, fair enough?
A I agree wholeheartedly.
Q Have you ever acted as an expert on behalf of a fellow employee of the Cleveland Clinic?
A Not that I know of.

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Q Okay. You've been practicing for roughly 20 years?
A 14.
Q 14.
Could you define the term "incidental finding."
A A finding that is happened to be found that is not directly pertinent to what was -- the test was being performed for.
Q Okay. I forgot to give you my standard caveats. This is a question and answer session under oath. It's important that you understand the question that I ask you. If you don't understand the question, you let me know, I'll be glad to rephrase or restate the question. Fair enough?
A Yes.
Q However, unless you indicate otherwise, I'm going to assume you have fully understood the question that I've posed and you have given me your best and most complete answer today. Fair enough?
A Yes.
Q Now, we were talking about an incidental finding or what it is. What you're saying is

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it's a finding that -- when one doesn't anticipate, runs a test, but it's not anticipated?
A Correct.
Q Okay. Could you tell me approximately how many times on average per year, in your experience, in your preoperative testing that your patients -- in your patients you might have an incidental finding that could be suspicious for cancer?
A Well, I'm personally referred those cases almost every day.
Q You're referred those cases --
A Yes.
Q -- almost every day?
A Um-hum. So it's a common situation.
Q So it would be other physicians referring patients, their patients, to you for further investigation?
A Correct, because -- because I have a particular interest in cysts of the pancreas and they are often found incidentally.
Q Okay. But what about in general, how about in -- I understand you are a general surgeon, correct?

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A Yes.
Q And as a general surgeon, have you ever had a patient that had an abdominal CT or a chest film in preparation for surgery and there was an incidental finding?
A Yes.
Q Could you tell me, does that occur maybe once a year to you, or how often would that --
A Oh, I would say once a month maybe, something like that.
Q Once a month?
A Um-hum.
Q Okay.
A I see a lot of people with CAT scans or order a lot of CAT scans, so --
Q Okay. Have any of those patients, when there's been an incidental finding, had a suspicious spot or lesion on a chest film or CT scan that would be consistent with lung cancer?
A Possibly. Now, these are patients that I'm evaluating, correct?
Q Your patients.
A My patients --
Q Right.

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A -- that I'm working up for a specific complaint.
Q Right.
A Okay.
Q Not a specific complaint for the incidental finding.
A Right, but -- right.
Q So how often would that occur? Once every year or two years, maybe more than that?
A Once -- yeah, I would say a couple times a year.
Q A couple times a year?
A Um-hum. I see a lot of people with pancreatic cancer, so they get CAT scans and --
Q And when you see a suspicious finding on the lungs, let's just kind of focus in on a spot or a suspicious lesion on the lung, an incidental finding, would you yourself arrange for further testing or would you refer the patient out?
A If I am the one who is ordering the -- it depends, but if I'm ordering the test, I may request another test or I might refer -- I might do both.
Q Okay.

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A It's rare that I actually find cancer in the lung, even when it's an incidental finding.
Q But it's happened to your patients in the past?
A I can't think of diagnosing a lung cancer any time recently for that, in that scenario.
Q Well, would you actually be the one to diagnose lung cancer or would you be someone that would be referring the person --
A Well, even if I --
Q -- to a CT surgeon?
A Even if I referred the patient and it subsequently came back lung cancer, that's been very unusual --
Q Okay.
A -- in my practice.
Q Okay. When you have a suspicious finding that is consistent with cancer, do you -- how do you advise the patient of that finding?
A This is a patient I'm working up for another reason, I myself?
Q Yes. Let's just deal with -- since we're talking about --
A Because that's not the situation here though.

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Q Well, we're talking about an appendectomy, so let's just use an appendectomy example. I'm sure you do hundreds of appendectomies, correct?
A I don't do hundreds, no, but --
Q You do appendectomies?
A Yes, sir.
Q Okay. And in the course of doing appendectomies --
A For append -- acute appendicitis, you mean?
Q Right. Right. And have you in fact had a suspicious finding in the chest that could be consistent with cancer?
MS. SANDACZ: Objection. Go ahead.
A Have I seen that?
Q Yes.
A I haven't actually had that exact scenario.
Q Okay. If you had, what would -- let's deal with your actual practice.
What kind of cancers, suspicious lesions that could be cancerous, do you find in incidental findings in your practice, not what's referred to you?
A Right. So I deal a lot with pancreatic cancer, so we're interested in metastatic

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disease to the lung, so that's where -- most everything I'm going to be involved with.
Q Okay.
A Okay?
Q Where the -- where the cancer, the primary --
A Is already in the pancreas.
Q -- source is a pancreatic --
A Right.
Q -- cancer primary metastasized to the lungs?
A But I'm the one taking care of the pancreatic cancer.
Q Okay.
A So I'm trying to decide if the patient has disease going to the lung.
Q Okay. Can you give me any other examples of incidental findings besides pancreatic -- lung cancers secondary to a pancreatic cancer patient?
A Not typically. I mean, it could be found on any CT scan for any reason, but that would be the most typical in my experience.
Q When you have a suspicious finding, can we agree that it's important to inform the patient

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of the suspicious finding?
A Yes.
Q Okay. And how do you typically relay, impart that information to a patient?
A Well, it depends on the exact circumstance, but if it's part of an ongoing investigation, then I will tell the patient what has been found by a test that I ordered and what the next step is going to be, or what I would advise the next step going to be.
Q Okay. But if it's not part of an ongoing investigation, if it's truly an incidental finding, how would you impart that information to the patient?
A I would verbally tell them.
Q And you would -- would you then record that in your chart as a practice?
A It depends. I may, I may not.
Q Okay. Under what --
A I'm --
Q Can you give me some -- I don't mean to interrupt you. It's late in the day.
Can you give me some examples of when you might record that information?
A Well, part of it depends on if I'm doing

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the eval -- if I'm working up a specific thing, and so it's part of that workup. So the typical example is a patient is referred for a mass, already a suspected cancer, and I find something in the lung. I would need to document that. That's part of the evaluation of the process, of the problem I'm dealing with.
Q Okay.
A If for some reason I don't think the patient may follow through, I may want to document it. Otherwise I can't think of a specific example. There are certainly times when I have recommended to patients that they follow up with their regular doctor for any host of problems that is not related to surgery, or my surgery.
Q Okay. And would you send a letter to the referring physician or --
A Sometimes yes, sometimes no. It -- it's -- there isn't a specific criteria that I have that would dictate that.
Q You said that you would document it when you think the patient wouldn't follow up. What do you mean by that?
A If for some reason I thought the patient

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was unreliable but I did want to document that I found something on a specific situation, then I might document that I found it.
Q Do you think you have a responsibility to insure that the patient follows up --
MS. SANDACZ: Objection. Go ahead.
Q -- to an incidental finding that might be suspicious for cancer?
A No. In an adult person, I convey the information and they can decide what they want to do with it.
THE WITNESS: Sorry.
Q Doctor, as you sit here today, can you think of any patients that you've advised them that they have a suspicious finding for cancer when they didn't know they had -- may have cancer and they didn't follow up?
A Yes.
Q Okay. What kind of example is that? What specifically?
A I remember a patient who had a -- an adrenal mass that was enlarging and I thought it was malignant and I recommended a biopsy and they decided not to have one.

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Q Under those circumstances, did you rec -- did you document your recommendation for a biopsy?
A That's what I was being -- the patient was referred for, and I -- for that problem, and I recommended a biopsy for them. Yes, that was documented.
Q Okay. Have you ever written a letter to a fellow physician, either within this -- the Cleveland Clinic family or outside in the community, where their patient has been sent to you for something and there was an incidental finding and you recommend follow-up by that physician?
A Yes.
Q Okay. Can you give me an example of that.
A I can't remember a specific example, but chances are that if I found something in testing, that I might find something, and if I'm writing the letter, let's say, to give them follow-up on what they sent the patient for, that I would, if I was already writing the letter, make a notation that such -- another incidental finding was found, yes. I can't think of a specific time that I did that, but --

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Q Can we agree that an incidental finding of a spot or a lesion on the lung that is suspicious for cancer is certainly a potentially life-threatening condition?
A Yes.
Q Can we agree, Doctor, that a surgeon who becomes aware in an incidental manner of a potentially life-threatening condition has a responsibility to ensure that the patient fully, completely and accurately understands the condition?
MS. SANDACZ: Objection to "ensure." Go ahead.
A I think the patient needs to be told and be offered an opportunity to ask questions. If that satisfied being fully aware, I believe you said, of the -- of the problem, then, yes, I would agree with that.
Q Well, let me just read the question --
A Okay.
Q -- over again.
A Go ahead.
Q If you can answer it directly. If you can't, that's fine too.
MR. BECKER: Are we going to

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listen to this --
MS. SANDACZ: I don't know. I don't know.
THE WITNESS: There's a -- there must be a conference right next door.
MR. TACKLA: Off the record.
- - - - -
(Discussion had off the record.)
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BY MR. BECKER:
Q Let me just try that question again, Doctor.
Can we agree that a doctor, a surgeon who becomes aware in an incidental manner of a potentially life-threatening condition has a responsibility to ensure that the patient fully, completely and accurately understands the condition?
MS. SANDACZ: Objection. Go ahead.
A Yes.
Q Can we agree, Doctor, that a surgeon who becomes aware in an incidental manner of a potentially life-threatening condition has a responsibility to ensure that the patient

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understands the need for follow-up?
MS. SANDACZ: Objection. Go ahead.
A Yes.
Q And can we agree, Doctor, that a surgeon who becomes aware in an incidental manner of a potentially life-threatening condition has a responsibility to actually ensure follow-up himself?
MS. SANDACZ: Objection.
A No.
Q Can we agree, Doctor, that there's kind of a compact or understanding in a physician/patient relationship that when a patient seeks health care from a physician and the physician violates the standard of care and causes harm to the patient, the medical provider should be held responsible for the harm caused by that violation?
MS. SANDACZ: Objection.
A If the standard of care is violated, yes.
Q And if the standard of care is violated, you have no problem that the physician should be held accountable?
A Correct.

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MS. SANDACZ: Objection.
Q Doctor, you are a Fellow of the American College of Surgeons?
A Yes.
Q And Dr. Elkhairi was a member of -- at least at the time he rendered care to Mrs. Richnafsky, of the American College of Surgeons.
A I don't know that --
Q Is that your understanding?
A I don't know that for a fact, but --
Q Okay.
A I've never seen his CV.
Q Okay. For purposes of many of my questions that follow, I want you to assume as true that he also is a -- is a Fellow of the American College.
Can we agree that the American College of Surgeons establish certain statements and principles for their Fellows?
A They may.
Q And can we agree that there is a preamble to the statements and principles -- and I have copies for you, if you'd like to look at one, the preamble, which has been marked as

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Plaintiff's Exhibit 1.
A Okay. But I -- I don't think any of these principles necessarily apply to standard of care.
Q Okay. We'll talk about that in a moment, but let's just deal with the preamble for a moment, and it says here that it's founded to provide opportunities for the continuing education of surgeons. The American College of Surgeons has a deep and effective concern for the improvement of patient care and for the ethical practice of medicine.
Is that what it says?
A That's what it says.
Q And do you agree with that process?
A Yeah, that's fine. That's a preamble.
Q Now, in fact, Doctor, there is a fellowship pledge that each member, before he's inducted, must swear to, and the fellowship pledge, which is on the next two pages over on page 3 states as follows: I hereby pledge myself, as a condition of fellowship in the College, to live in strict accordance with the College's principles and regulations. Correct? Did I read that correctly?

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A Yes.
Q And what that means, sir, is that that -- that a Fellow pledges to abide by, follow, adhere to the principles and to the statements of the College, correct?
MS. SANDACZ: Objection.
A Yes, but that doesn't have anything to do with standard of care again.
Q Okay. We're going to talk about standard of care.
A And we're not talking about sainthood, either.
Q We're not what?
A Talking about sainthood. I mean, they're not infallible.
Q Okay. Now, also there is a prerequisite to entry as a Fellow that the physician must pledge to abide by the Code of Professional Conduct, correct?
A Yes.
Q And that Code of Professional Conduct states that: We treasure the trust that patients have placed in us, because trust is integral to the practice of surgery.
Did I read that right?

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A Yes.
Q And would you agree with that concept about trust and why patients --
A Yes.
Q -- place trust in their doctors?
A Yes, I certainly do.
Q It goes on to say: During the continuum of pre, intra and postoperative care, we accept responsibilities to serve as effective advocates of our patients' needs, be sensitive and respectful of the patients' understanding, their vulnerability during the perioperative period and fully disclose adverse events. Do you see that?
A Yes.
Q Do you agree with that concept?
A Yes.
Q Now, there's a section thereunder relative to informed consent. I think it's on page 5. In that it says that the surgeon must fully inform every patient about his or her illness and the proposed treatment, correct?
A Correct.
Q And you agree with that?
A Yes. In this case as it applies to

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appendicitis.
Q And it says: The information must be presented fairly, clearly, accurately, compassionately, correct?
A Yes.
Q And there's a section entitled Preoperative Diagnosis and Care, and it says that the surgeon is responsible for the patient's safety, the patient's safety, throughout the preoperative, operative -- preoperative, operative, and postoperative period, correct?
A Yes.
Q And you agree with that?
A Sure.
Q And there's a section entitled Continuity of Care, where it says that -- a section that says a surgeon will ensure appropriate continuity of care of that surgical patient, correct?
A Yes.
Q And that means that if the patient is in need of further care, that surgeon has a responsibility to ensure it?
A As it applies to the surgery.
Q Okay. Now --

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MR. BECKER: Off the record a moment.

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(Discussion had off the record.)

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MR. BECKER: Let's go back on the record.
BY MR. BECKER:
Q Doctor, I forgot to ask you a question about incidental findings.
A Yes.
Q And although an incidental finding is unrelated to the actual surgery, we can agree that the new finding, since it was discovered pre -- in preoperative testing, can be deemed a potentially continuing problem associated with the patient's surgical care?
MS. SANDACZ: Objection.
A No --
Q Is that fair?
A Not necessarily, no. This lung nodule didn't have anything to do with this patient's surgical care of acute appendicitis.
Q But if something was discovered in the course of the patient's surgical care --

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A This was discovered before the surgical care.
Q But it was discovered in a preoperative assessment, correct?
A This was discovered for -- during a workup of a complaint that led to surgery.
Q Right.
A Yeah.
Q And it's something that the doctor, surgeon, relied upon in his determination as to whether the patient needed surgery.
MS. SANDACZ: Objection.
Q Right?
A It was part of what he used to make the decision.
Q In part.
A Yes.
Q Now, since it was -- it was discovered in the preoperative testing, is it reasonable to say that that is a potential continuing problem --
MS. SANDACZ: Objection.
Q -- that was discovered during the surgical consultation?
A No. This was ordered -- this wasn't even

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part of his evaluation. This was done prior to being consulted.
Q Incidentally, have you looked at the statements of the College recently in preparation for today's deposition?
A No, I have not.
Q When was the last time you looked at the statement of the College?
A I can say several years.
Q Okay. Showing you Statement 6, and it talks about Statement for Advisory Council, there's just one line I want to ask you about. It says that the general surgeon is the surgical specialist engaged in comprehensive care of a surgical patient, correct?
A Yes.
Q And comprehensive care means complete care of the patient?
A Of the surgical problem.
Q Okay.
A It says surgical patient.
Q Showing you what's been marked as number 4, which is Statement on Principles Number ST-25, it states -- it's entitled Statement on Principles Underlying Perioperative

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Responsibility, correct? Is that the title?
A Yes.
Q And it states: When the time comes that the surgeon will no longer be involved in the follow-up of the patient, he or she is responsible for ensuring appropriate long-term follow-up for continuing problems.
A It says associated with the --
Q Associated with the --
A -- patient's surgical care.
Q -- patient's surgical care.
A So that applies only to the surgery, in this case the appendectomy.
Q So it's your position, you're making the distinction saying because this was discovered preoperatively, although a bases for the decision, that is the study, the CT scan, was a bases for the decision to proceed with surgery, that's -- and a problem was noted in that test, that's not considered part of the patient's surgical care, that finding?
A No.
Q So would it be fair for -- since it's not part of the patient's surgical care, would it be reasonable for Dr. Elkhairi to ignore it?

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A I didn't say ignore it. I said inform the patient of the problem that he's -- that's his responsibility.
Q Okay.
A I didn't say ignore it. But it's not directly related to his surgical care.
Q Is it indirectly related to his surgical care?
A No. It has nothing to do with the surgery that he did.
Q When do you follow up with a patient to make sure that they -- if at all, to make sure that they have followed your advice and gained consultation or had a test done?
MS. SANDACZ: Objection. Go ahead.
A When will I follow up with the patient?
Q Right. Or with the referring physician. If you send the referring physician a note saying this needs to be followed up on.
A I won't -- I usually leave it up to the patient. If I advise something and I gave it as advice, let's say a biopsy, I will typically tell the patient -- I won't schedule it, they can call me when they've decided that they want

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to have it done. I leave it up to them.
Q When --
A So.
Q Would you repeat that? I'm having trouble hearing you.
A I'm sorry. So if I advise a recommendation, I don't twist a patient's arm, if I -- let's say I advise that a biopsy be performed, I leave it up to the patient to call me back to get it scheduled, if they want to consider it. I leave it -- I make sure that they're well-informed of why I think they should follow up, but I will not -- I specifically do not call them to hound them to have something done.
Q Well, if you see a patient and you see them for one reason but see a suspicious lesion or a spot on the lung, would you normally order a chest CT yourself?
A It depends on the situation. If I'm -- again, if I'm involved in the reason -- it's important in whatever evaluation I'm performing, then, yes, perhaps I will order the CAT scan, and depending on -- of the lung, and depending on what that shows, I might do additional

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referrals.
Q Okay. If you were not seeing the patient primarily for that reason, a cancer reason, and you would send this patient for -- make a referral, do you make your referrals in writing?
A Not necessarily. If it's -- if it's advice for a medical problem that I want them to follow up on, I may just verbally tell them.
Q Have you ever made your referral in writing?
A Yes.
Q When do you make -- what is your practice as to when you make your referral in writing?
A It depends. I would say it depends why I'm seeing the patient initially, what the actual problem is, the incidental finding that has occurred, or became known, and if I'm writing the doctor for a specific reason. So it sort of depends on a host of things.
Q Well, how would you -- let's go back to the specific facts of this case.
How would you -- you're doing an appendectomy on a patient and there is a spot that's suspicious for cancer in the lower lobe of the patient that was unexpected, incidental,

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but certainly potentially life-threatening. How would you advise your patient and how would you engage in a referral and what documentation would you generally engage in?

MS. SANDACZ: I'm going to object to the compound question, but go ahead and answer if you can answer all of his questions.

A I would inform the patient what was found and that I would advise that they follow up with their primary care physician, because at that point we don't know what it is, and I may or may not have a written documentation of that.

Q So you may have a written documentation that you inform the patient of what was found, and you may have written documentation by memo or letter to the -- to either the patient and/or the PCP for follow-up?

MS. SANDACZ: Objection. Go ahead.

A Well, the most common documentation of that would be, in my practice, sending the referring doctor a note of the surgery with the pathology, and as part of that, mentioning a -- the incidental finding.

Q To the referring physician?

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A Yes. That would be typic -- that would be common.

Q In what circumstances would you document your finding and discussion with the patient?

A I may not at all, but I may in the letter have said that I mentioned to the patient, but that wouldn't be typical.

Q I thought you just told me that you may document that you in fact informed the patient and you also may document or send a letter to the PCP. If you document --

A Let me clarify. So the most common thing would be that -- written -- the written documentation would be that I dictate a letter to the primary care physician that I have operated on the patient for acute appendicitis and that here is the pathology report, it showed acute appendicitis, she recovered well, but she incidentally was found to have this lung mass and she's going to come back to see you for that. That would --

Q See "you," the referring physician, for that?

A See the referring physician.

Q Okay.

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A That would be the most common documentation.

Q Okay.

A But I wouldn't have said in there, I told the patient -- I wouldn't have documented that necessarily.

Q Okay. But under some circumstances, based on a previous answer ten minutes ago, you -- under some circumstances you would document that you told the patient?

A No, I don't ever remember --

Q Explained to the patient --

A -- saying that I would document that somewhere necessarily. That wouldn't necessarily be a common practice.

Q I didn't say "necessarily," Doctor.

A All right.

Q I just want to say under what circumstances would you document that you discussed this incidental potentially life-threatening condition with the patient?

A Okay. We went to the specific case of this appendicitis, right?

Q I'm not talking about -- we're talking in generalities right now.

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A Oh, okay. So we switched back. So it depends on the situation again. It depends what I'm seeing the patient for and what was found.

Q Okay.

A And so I might document that.

Q Okay. Why would you -- when you might document it, you told the patient this, why would you do it? Why would you make that documentation?

A Because usually I will document it if it has something specific to what the patient was referred to me for.

Q So in the documentation you would say, patient referred for a -- in your chart you would say, patient referred for an appendectomy.

A No. The common scenario would be patient referred for a pancreatic mass and incidentally found to have a lung mass, because it's more directly related to that. That's what they came -- I did the CT scan for the pancreatic mass. That would be the more common scenario.

Q Right. I got that.

A Okay. That's where it's going to be most commonly documented --

Q In your chart --

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A -- that something else was found.
Q -- you told the patient. And you told the patient.
A I would say it's uncommon that I'm going to document that I specifically told the patient that I found that, because to me that's implied, because I'm going to discuss the results with the patient.
Q Well, would you --
A I wouldn't say: And I discussed this incidental finding with the patient. It's -- I would say it's rare that that's going to be -- that sentence is going to be there.
Q Would the sentence be that I discussed my findings?
A I would say the test results were discussed.
Q Okay.
A Something like that.
Q Would that normally be documented, the test results were discussed with the patient?
A I would say commonly in my practice, yes.
Q When you document test results discussed with patient, here is my question: Why do you do it? Why do you write: Test results documented with patient?
A Because I'm writing a note and I'm discussing a problem and that's part of the problem.
Q So it is part of the problem, that incidental finding?
MS. SANDACZ: Objection.
A We're talking about the results of any test that I ordered.
Q Um-hum.
A So we'll discuss the results. If something incidentally came up, I would discuss it with them.
Q And it's part of the problem, because -- you're discussing it because it's part of the problem?
A It may be, but it may not be. Again, if it's something that's totally unrelated, I may very well tell the patient to follow up with their doctor about this -- whatever it is that came up.
Q But you would think, Doctor, that if you're not going to tell -- are you saying there's some circumstances when you would simply refer the patient for follow-up with the referring physician and not tell the patient at all --
A No.
Q -- about this?
A That's not what I said. I said I would tell the patient. I -- it is not necessarily true that I documented that I talked to the patient about that problem, but that I told them to follow up with their primary care physician.
Q Did you see any indication in this chart where there's an entry by Dr. Elkhairi that the test results were discussed with the patient?
A No.
Q Would you have expected to see some indication in the chart -- I'm not talking about standard of care now. I know you want to talk to me about the standard of care --
A Right.
Q -- and we'll get to that. Hang on, okay?
Did you see any indication -- would you have expected Dr. Elkhairi to have documented, quote, test results doc -- discussed with the patient?
A No.
Q Why?
A Because that's not necessarily standard of care.
Q Okay.
A It's not --
Q Now is your time --
A -- related to appendicitis.
Q -- to tell me what your definition of standard of care is.
A My definition of standard of care is the usual practice of a reasonable surgeon, in this case, in the similar circumstance.
Q And where did you obtain that definition?
A That's my understanding of standard of care. I can't --
Q Did some attorney tell you that --
A No.
Q -- or you read it somewhere, or --
A No.
Q You don't know?
A I don't -- I can't give you a specific reference.
Q Okay.
A Whenever I've had standard of care explained to me, that's the short, sweet explanation for it.
Q Okay. Would you have expected a skillful

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and diligent surgeon to document test results discussed with patient?
MS. SANDACZ: Objection. Go ahead.
A Not necessarily. It depends on the circumstance, I would say.
Q Have you ever had any of your patients where there's been an incidental finding on a chest film of a -- of a spot or a one or two centimeter cancerous lesion diagnosed inadvertently or incidentally?
MS. SANDACZ: Objection. Asked and answered. Go ahead.
A Yes.
Q Okay. And --
A I think.
Q And is it those patients that are subject to a resection, based on your knowledge of the medicine?
A I don't know. I refer them to the people who do that.
Q Any of those patients have a resection of the lung, to your knowledge?
MS. SANDACZ: Objection.
Q Can you think of any of your patients?

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A I -- yes, I'm sure some have. I hope they have.
Q Okay. Any of those patients actually have a cancer diagnosed. Obviously, I guess they -- they would have a biopsy confirming the cancer before they would have the resection; is that safe?
MS. SANDACZ: Objection. Go ahead.
A I don't know, actually. I don't --
Q Okay.
A I don't treat that, so I don't know if they all get biopsies or --
Q Okay. Do you treat -- you treat primary pancreatic cancer, you do not treat metastatic pancreatic cancer, that is where there's a primary source and it's spread to the pancreas, or do you treat both?
A I treat both. The latter is highly un -- unusual. Usually unusual.
Q How unusual?
A Well, there -- you know, autopsy series are somewhat high, but the only practical tumors that go to the pancreas are from the kidney.
Q So to your knowledge the only primary

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cancer that spreads to the pancreas, at least in your experience, is kidney cancer; is that what you're saying?
A Pretty much. There aren't -- yes.
Q Okay. What about lung cancer?
A What about lung cancer?
Q Can it spread to the pancreas?
A Not that I know of.
Q What is the survival rate of pancreatic cancer?
MS. SANDACZ: Objection. Go ahead.
A With or without resection?
Q Well, give me both. Just give me a ballpark on both.
A Well --
MS. SANDACZ: Objection. Go ahead.
A The average length of life for people with pancreatic cancer is under -- around six months; but if they're resected, their median survival is about 24 months. That's median survival.
Q And when you say when they're resected, that is the cancer is --
A Removed.

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Q -- surgically removed.
A Um-hum. Yes.
Q So without resection, six months; with resection --
A Yeah, most are found in the late stage.
Q Okay. Where there is -- not amenable to resection?
A Yes.
Q Have you ever written or done lung cancer surgery, written on lung cancer surgery --
A No.
Q -- or --
A No.
Q -- engaged in lung cancer surgery?
A Not as a -- on staff, no. Not since I finished my --
Q Training?
A -- training. Um-hum.
Q Would you agree with this general principle, that with lung cancer, the earlier it's diagnosed, the greater the chance of cure?
MS. SANDACZ: Objection.
A Well, I'm not an expert in the area, but I would seem -- I would think that -- I would hope that that would be true.

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Q Is it true, Doctor, that, to your knowledge, that cancer, if permitted, if unaddressed, will ultimately spread to other parts of the body?
A Typically, yes.
Q And the longer it's permitted to stay unaddressed, the more harmful it may become in one's body?
MS. SANDACZ: Objection. If you know.
A Yes.
Q To your knowledge, Doctor, would a 19 month delay in diagnosing lung cancer likely be harmful to a patient?
MS. SANDACZ: Objection.
A I would say any delay of any cancer is harmful.
Q We can agree, Doctor, that, moving on to Susan Richnafsky and the care rendered by Dr. Elkhairi, that he clearly had multiple opportunities to sit down with her and explain this incidental finding that was suspicious and potentially life-threatening, correct?
A I don't know how many opportunities he had, truly. I know he looked at the report, it's

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initialed, so the most likely op -- single opportunity would have been in the post-op recovery visit.
Q Okay. At least a emergency room physician has given sworn testimony, told Dr. Elkhairi about it before surgery.
A And that's -- a follow-up was arranged for it. Correct.
Q Okay. And so if Dr. Elkhairi knew about it before surgery, he had an opportunity to talk to the patient pre-op, post-op, post-op day one, post-op day two, correct?
A Well, he -- the oppor -- he might view the opportunity as inopportune if the patient was under duress or inappropriately sedated or otherwise recovering, so that might not be an opportunity, even though there's a time opportunity.
Q Absolutely. Probably the most humane and most considerate opportunity to broach this may be in that office visit --
A That would be --
Q -- post-op?
A -- the most likely, I would say.
Q Okay. There's nothing documented -- we

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can -- just to recap this, there's nothing documented that Dr. Elkhairi told either Richard or Susan Richnafsky about this suspicious potentially life-threatening lesion in her right lower lung, correct?
MS. SANDACZ: Objection.
A He did not discuss the incidental finding on the CT scan, that is not documented.
Q And there's nothing documented that evidenced that Dr. Elkhairi took steps to insure that the patient -- the patient understood the need to follow up on this potentially life-threatening spot on her right lower lung, correct?
MS. SANDACZ: Objection. I didn't hear the full question. Could you repeat it?
THE WITNESS: Could you -- I would benefit from that, the question.
Q You need the question again?
A Please.
Q There's nothing documented to evidence that Dr. Elkhairi took steps to ensure follow-up on this potentially life-threatening spot?
A No. Yes, that's correct.

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Q And there's nothing documented that Dr. Elkhairi made it clear to the patient her need to follow up on this potentially life-threatening spot in her lower lung, correct?
A Correct. At the time it is an incidental finding. We don't know if it's life-threatening or not at the time. Could be.
Q Could be.
A Could be.
Q Right. I mean, one of the general principles in the statement of the College is you want to be treated as if you were the patient; treat the patient as if you were the patient, the same way that you would want to be treated. That's one of the principles I read about.
A I think it's a golden rule.
Q Okay. It's a great rule.
So, Doctor, if you or your loved one had a potentially life-threatening lesion in -- or spot in her lung, you would want to know about that as soon as possible?
MS. SANDACZ: Object.
A I would definitely want to know about it,

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yes.
Q And if in fact there was any possibility that there was a misunderstanding about the significance of it, you would want the attending physician to either contact or write your referring physician or write you outlining the significance of the same?
MS. SANDACZ: Objection. Go ahead.
A Not necessarily. I just -- I would want to know about it.
Q Okay.
A As long as I knew about it, whichever way it's delivered, as long as I was comfortable with that --
Q Okay. You're not making any -- rendering any opinion as to whether she was told or not told about -- factually in this case, that is, "she" being Mrs. Richnafsky?
A I am saying I don't have documentation that she was.
Q Okay. And Dr. Elkhairi has no specific recollection that he told her, does he?
A That's true.
Q Can we agree, Doctor, that based on --

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assuming it's true, based on all the material you have reviewed, that Dr. Elkhairi failed to inform Susan Richnafsky of this potentially life-threatening condition and failed to ensure that she understood the need for follow-up, that Dr. Elkhairi's failures permitted Susan Richnafsky's lung cancer to go 19 months without a diagnosis?
MS. SANDACZ: Objection. Go ahead.
A I have no proof that he failed to inform the patient. I have -- I don't have evidence that he documented, but I have no evidence that he failed to inform her either.
Q Okay. Let's assume as true, let's start with this premise, and assume as true that Dr. Richnafsky failed -- assume it's true. Do you understand a hypothetical? I'm asking you to assume something is true.
A Dr. Elkhairi?
MS. SANDACZ: Yeah.
Q Right.
MS. SANDACZ: You said Richnafsky.
Q Assuming as true that --

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MR. BECKER: You're lucky I'm not talking about vaginal prolapses, so --
THE WITNESS: They're on the ovaries now.
MR. BECKER: -- consider yourself lucky.
BY MR. BECKER:
Q Assuming it's true that Dr. Elkhairi failed to make Susan Richnafsky fully aware of this potentially life-threatening condition in her lower lung and to ensure that she appreciated the need for follow-up, can we agree that that failure, with that failure, Doctor, assuming it's true, Dr. Elkhairi deviated from the appropriate standard of care?
A If he failed -- yes, if that assumption is correct.
Q Okay. Continuing with that assumption, okay, assuming that he failed in that duty, can we agree that Susan Richnafsky's lung cancer went 19 months without a diagnosis?
MS. SANDACZ: Objection. If you know, based upon the medical records and everything that you have in front of you.
A Yeah, I -- I can't say that for sure. It's

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an assumption. That's another assumption.
Q The assumption is that that spot was in fact cancerous?
A Yes. Exactly.
Q Okay. Let's assume that that --
A Okay.
Q -- spot was in fact cancerous, as the defense causation expert will concede. Assuming that that is true, that that one spot in the right lower lobe was in fact cancerous, assuming it's true that he failed to advise this family of this potentially life-threatening condition, can we agree based on the chart and the history that developed here that her cancer, her lung cancer, went 19 months without diagnosis?
MS. SANDACZ: Same objection. If you know the answer, because you don't have any of the records that subsequently show her when she was diagnosed.
A Well, you know, those are two assumptions. If you can make those two assumption, then, yes, I'll agree with you.
Q Okay.
A I'm not saying that you can, but --
Q If in fact those two assumptions are

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correct, one, that this family was never told about this condition; two, that that was a early cancer spot in her right lower lobe.
A Well, you're adding a third assumption now, that it was an early cancer.
Q Okay.
A These are -- you're conceding these are assumptions that you want me to --
Q Yes.
A Okay.
Q Okay. Assume it's true that it was in fact -- let's start over. I'll remove the "early" assumption.
Let's assume as true that this family was never ever told about this life-threatening condition that Susan Richnafsky had; and assume as true that that was in fact a cancerous lesion, two centimeters, in her right lower lobe; and assume as true that it wasn't -- her cancer wasn't diagnosed until 19 months later; that the failure of Dr. Elkhairi to advise this family permitted the spread of her cancer and reducing her chances of survival and cure.
MS. SANDACZ: I'm going to make an objection. He cannot possibly know anything

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about this woman's cancer to render that; but go ahead, Doctor, if you -- based upon all those assumptions, in the absence of any information about the type of lung cancer, where it was located, otherwise, go ahead.
A I think it's the same question again, and so I'll say yes.
Q The answer to my question would be yes, assuming those things --
A Assuming those things --
Q -- the things that I've out -- that I've outlined.
A -- and based on this, what I have, but I don't know and I'm not an expert on lung cancer.
Q Okay. Well, let's further assume then that that month -- that 19 month delay led to her death. Assume that there was a failure to inform this family of this life-threatening condition; assume as true that there was a 19 month delay before her diagnosis; assume as true that that 19 month delay led to her death. Everything assuming as true, we can agree, Doctor, that Dr. Elkhairi should be held accountable for this woman's death?
MS. SANDACZ: I'm going to

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object. He just said he's not a lung cancer expert and therefore cannot even render an opinion whether or not what was diagnosed or present in November of 2001 would have caused her death regardless of whether or not there was a delay. So I think it's an unfair question of -- asking this expert, who has clearly identified himself as not an expert in lung cancer. But go ahead, Doctor, and we'll deal with it with the Court if need be.
A I really can't comment on the cause of death other than he prevented her from dying from acute appendicitis.
Q Okay. Well, let's -- let's assume as true that he never told this family, which is borne out by the chart because there's no documentation of it; let's assume as true that he never told the family about this life-threatening condition; that it was in fact a cancerous lesion back in 2001; assume as true that there was a 19 month delay because of the failure to adhere to the standard of care and inform the patient, there was a 19 month delay in diagnosing the cancer; and assume as true that that 19 month delay played a part in her

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death. Assuming those four factors as true, Doctor, you would agree with me that Dr. Elkhairi should then be held accountable for this woman's death?
MS. SANDACZ: Objection.
A I am not holding Dr. Elkhairi responsible for her death.
Q That's apparent to me by your testimony. And you won't hold him accountable even under a hypothetical, will you?
A There are too many assumptions in your hypothetical to -- for me to then make this leap, is what I'm saying, and there's things about it I don't know.
Q Even if those assumptions are borne out by the defendant's own testimony, defendant expert's own testimony?
A Well, that's for the jury to decide.
Q And that's true. But have you ever seen a circumstance, Doctor, in your career where a physician -- in your career of 15 years -- I'm aging you more than I need to be.
A Well, it's better than 20, which you started with.
Q Okay. Have you ever seen --

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MR. BECKER: So he's younger than I thought.
Q Have you ever seen a condition in your career of 15 years where a patient was not told of a -- made a claim that she was not told of a life-threatening condition?
A And didn't follow through?
MR. TACKLA: Off the record.
- - - - -
(Interruption in proceedings.)
- - - - -
MR. BECKER: On the record.
BY MR. BECKER:
Q Doctor, in your career have you ever experienced the circumstance, the clinical circumstance, where the patient claims that she was never informed of a life-threatening condition? That's my first question.
A I -- I don't know.
Q You can't think of one?
A I -- I -- it's -- I don't -- I don't remember.
Q Okay.
A I can't think of a circumstance like that --

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Q All right.
A -- exactly.
Q We can agree that Dr. Elkhairi should be held accountable if the jury concludes that, one, he never told this patient, never told this family about this potentially life-threatening condition; and if the jury believes that there was a 19 month delay in diagnosis and that played a part in her death; can we agree under those circumstances of that question Dr. Elkhairi should be held accountable?
A No.
MS. SANDACZ: Objection. Go ahead.
A Not he himself. There were plenty of opportunities, including the ER physician, those people that he communicated with, that could have been responsible for those incidental findings and not for which Dr. Elkhairi was consulted.
Q So is that a yes, that he should have been held -- he should be held accountable, in conjunction with other people? Is that what I heard?
MS. SANDACZ: Objection. That's

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not what he said.
A Assuming your assumptions; is that what you're saying?
Q Yeah.
A No, I don't think he's -- he is not responsible for that. He's responsible for the care that he was called to deliver, and that's what he did.
Q But he's -- let's go back to my question.
MR. BECKER: Off the record.
- - - - -
(Discussion had off the record.)
- - - - -
(Question read as follows: We can agree that Dr. Elkhairi should be held accountable if the jury concludes that, one, he never told this patient, never told this family about this potentially life-threatening condition; and if the jury believes that there was a 19 month delay in diagnosis and that played a part in her death; can we agree under those circumstances of that question Dr. Elkhairi should be held accountable?)
- - - - -
MS. SANDACZ: Objection to the

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hypothetical. Multiple assumptions. Go ahead, Doctor.
A Yeah, so the multiple assumptions, I believe I said that there were people more responsible for informing the patient. I've said that he is responsible for telling the patient, and so you've of course made the assumption that he failed to do that; so he would be partly responsible if he failed to tell the patient.
Q Okay.
A Okay?
MR. BECKER: Thank you. I'm done.
MS. SANDACZ: We're done.
THE WITNESS: You're all done?
MS. SANDACZ: We're all done.
THE WITNESS: Okay. Fine.
MS. SANDACZ: We'll read. You can send it to me. I'll have the doctor review it.
THE NOTARY: Do you waive viewing of the videotape?
MS. SANDACZ: Yeah, we don't need to view the videotape.

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(Deposition concluded at 5:54 p.m.
Signature not waived.)

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RICHARD MATTHEW WALSH, M.D.

C E R T I F I C A T E

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

I, David J. Collier, Registered Professional Reporter, Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named witness, RICHARD MATTHEW WALSH, M.D., was by me first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by the above-referenced witness was by me reduced to stenotypy in the presence of said witness; afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony so given by the above-referenced witness.

I do further certify that this deposition was taken at the time and place as in the foregoing caption specified, and was completed without adjournment.

I do further certify that I am not a relative, counsel or attorney for either party, or otherwise interested in the outcome of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, this 19th day of April, 2006.

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David J. Collier, RPR,
Notary Public/State of Ohio.
Commission expiration: April 26, 2006.