



<p>5</p> <p>1 Q Do you have any notes, Doctor, that you 2 created as a result of your review in this case? 3 A No. 4 Q Is it your practice not to create notes 5 when you review or do a medical/legal review? 6 A Typically I would not. I might write in 7 the -- in the volumes that I've been given, but 8 not separate notes. 9 Q Okay. Let's talk about your medical/legal 10 experience. How long have you been reviewing 11 cases? 12 A Oh, a dozen years. 13 Q And approximately how many -- what -- how 14 many per year would you review? 15 A I would say on average less than one. 16 Q Okay. And do you know how it was that you 17 were contacted on this case? 18 A No. 19 Q And have you ever worked for Beverly's law 20 firm before? 21 A Not that I know of. 22 Q Do you know Dr. Elkhairi? 23 A No. 24 Q Okay. Never met him? 25 A Never.</p>	<p>7</p> <p>1 Q Okay. You've been practicing for roughly 2 20 years? 3 A 14. 4 Q 14. 5 Could you define the term "incidental 6 finding." 7 A A finding that is happened to be found that 8 is not directly pertinent to what was -- the 9 test was being performed for. 10 Q Okay. I forgot to give you my standard 11 caveats. This is a question and answer session 12 under oath. It's important that you understand 13 the question that I ask you. If you don't 14 understand the question, you let me know, I'll 15 be glad to rephrase or restate the question. 16 Fair enough? 17 A Yes. 18 Q However, unless you indicate otherwise, I'm 19 going to assume you have fully understood the 20 question that I've posed and you have given me 21 your best and most complete answer today. 22 Fair enough? 23 A Yes. 24 Q Now, we were talking about an incidental 25 finding or what it is. What you're saying is</p>
<p>6</p> <p>1 Q Okay. 2 A Not that I know of. 3 Q Okay. I looked at a deposition of yours. 4 It appears that you have maybe reviewed 12 to 5 15 cases; is that fair? 6 A That seems a little high to me, but it 7 could be right. 8 Q Have you ever reviewed a plaintiff's case, 9 on behalf of the patient? 10 A I have never been offered one. 11 Q Do you -- 12 A So no. 13 Q So the answer would be no, but is there 14 some kind of prohibition about doing plaintiff's 15 medical/legal work at this institution, to your 16 knowledge? 17 A Not that I know of. 18 Q Okay. We can agree that when you're acting 19 as a medical/legal expert, it's very important 20 to be fair, impartial and objective, fair 21 enough? 22 A I agree wholeheartedly. 23 Q Have you ever acted as an expert on behalf 24 of a fellow employee of the Cleveland Clinic? 25 A Not that I know of.</p>	<p>8</p> <p>1 it's a finding that -- when one doesn't 2 anticipate, runs a test, but it's not 3 anticipated? 4 A Correct. 5 Q Okay. Could you tell me approximately how 6 many times on average per year, in your 7 experience, in your preoperative testing that 8 your patients -- in your patients you might have 9 an incidental finding that could be suspicious 10 for cancer? 11 A Well, I'm personally referred those cases 12 almost every day. 13 Q You're referred those cases -- 14 A Yes. 15 Q -- almost every day? 16 A Um-hum. So it's a common situation. 17 Q So it would be other physicians referring 18 patients, their patients, to you for further 19 investigation? 20 A Correct, because -- because I have a 21 particular interest in cysts of the pancreas and 22 they are often found incidentally. 23 Q Okay. But what about in general, how about 24 in -- I understand you are a general surgeon, 25 correct?</p>

9

1 A Yes.

2 Q And as a general surgeon, have you ever had

3 a patient that had an abdominal CT or a chest

4 film in preparation for surgery and there was an

5 incidental finding?

6 A Yes.

7 Q Could you tell me, does that occur maybe

8 once a year to you, or how often would that --

9 A Oh, I would say once a month maybe,

10 something like that.

11 Q Once a month?

12 A Um-hum.

13 Q Okay.

14 A I see a lot of people with CAT scans or

15 order a lot of CAT scans, so --

16 Q Okay. Have any of those patients, when

17 there's been an incidental finding, had a

18 suspicious spot or lesion on a chest film or

19 CT scan that would be consistent with lung

20 cancer?

21 A Possibly. Now, these are patients that I'm

22 evaluating, correct?

23 Q Your patients.

24 A My patients --

25 Q Right.

10

1 A -- that I'm working up for a specific

2 complaint.

3 Q Right.

4 A Okay.

5 Q Not a specific complaint for the incidental

6 finding.

7 A Right, but -- right.

8 Q So how often would that occur? Once every

9 year or two years, maybe more than that?

10 A Once -- yeah, I would say a couple times a

11 year.

12 Q A couple times a year?

13 A Um-hum. I see a lot of people with

14 pancreatic cancer, so they get CAT scans and --

15 Q And when you see a suspicious finding on

16 the lungs, let's just kind of focus in on a spot

17 or a suspicious lesion on the lung, an

18 incidental finding, would you yourself arrange

19 for further testing or would you refer the

20 patient out?

21 A If I am the one who is ordering the -- it

22 depends, but if I'm ordering the test, I may

23 request another test or I might refer -- I might

24 do both.

25 Q Okay.

11

1 A It's rare that I actually find cancer in

2 the lung, even when it's an incidental finding.

3 Q But it's happened to your patients in the

4 past?

5 A I can't think of diagnosing a lung cancer

6 any time recently for that, in that scenario.

7 Q Well, would you actually be the one to

8 diagnose lung cancer or would you be someone

9 that would be referring the person --

10 A Well, even if I --

11 Q -- to a CT surgeon?

12 A Even if I referred the patient and it

13 subsequently came back lung cancer, that's been

14 very unusual --

15 Q Okay.

16 A -- in my practice.

17 Q Okay. When you have a suspicious finding

18 that is consistent with cancer, do you -- how do

19 you advise the patient of that finding?

20 A This is a patient I'm working up for

21 another reason, I myself?

22 Q Yes. Let's just deal with -- since we're

23 talking about --

24 A Because that's not the situation here

25 though.

12

1 Q Well, we're talking about an appendectomy,

2 so let's just use an appendectomy example. I'm

3 sure you do hundreds of appendectomies, correct?

4 A I don't do hundreds, no, but --

5 Q You do appendectomies?

6 A Yes, sir.

7 Q Okay. And in the course of doing

8 appendectomies --

9 A For append -- acute appendicitis, you mean?

10 Q Right. Right. And have you in fact had a

11 suspicious finding in the chest that could be

12 consistent with cancer?

13 MS. SANDACZ: Objection. Go

14 ahead.

15 A Have I seen that?

16 Q Yes.

17 A I haven't actually had that exact scenario.

18 Q Okay. If you had, what would -- let's deal

19 with your actual practice.

20 What kind of cancers, suspicious

21 lesions that could be cancerous, do you find in

22 incidental findings in your practice, not what's

23 referred to you?

24 A Right. So I deal a lot with pancreatic

25 cancer, so we're interested in metastatic

13

1 disease to the lung, so that's where -- most  
2 everything I'm going to be involved with.

3 Q Okay.

4 A Okay?

5 Q Where the -- where the cancer, the  
6 primary --

7 A Is already in the pancreas.

8 Q -- source is a pancreatic --

9 A Right.

10 Q -- cancer primary metastasized to the  
11 lungs?

12 A But I'm the one taking care of the  
13 pancreatic cancer.

14 Q Okay.

15 A So I'm trying to decide if the patient has  
16 disease going to the lung.

17 Q Okay. Can you give me any other examples  
18 of incidental findings besides pancreatic --  
19 lung cancers secondary to a pancreatic cancer  
20 patient?

21 A Not typically. I mean, it could be found  
22 on any CT scan for any reason, but that would be  
23 the most typical in my experience.

24 Q When you have a suspicious finding, can we  
25 agree that it's important to inform the patient

14

1 of the suspicious finding?

2 A Yes.

3 Q Okay. And how do you typically relay,  
4 impart that information to a patient?

5 A Well, it depends on the exact circumstance,  
6 but if it's part of an ongoing investigation,  
7 then I will tell the patient what has been found  
8 by a test that I ordered and what the next step  
9 is going to be, or what I would advise the next  
10 step going to be.

11 Q Okay. But if it's not part of an ongoing  
12 investigation, if it's truly an incidental  
13 finding, how would you impart that information  
14 to the patient?

15 A I would verbally tell them.

16 Q And you would -- would you then record that  
17 in your chart as a practice?

18 A It depends. I may, I may not.

19 Q Okay. Under what --

20 A I'm --

21 Q Can you give me some -- I don't mean to  
22 interrupt you. It's late in the day.

23 Can you give me some examples of when  
24 you might record that information?

25 A Well, part of it depends on if I'm doing

15

1 the eval -- if I'm working up a specific thing,  
2 and so it's part of that workup. So the typical  
3 example is a patient is referred for a mass,  
4 already a suspected cancer, and I find something  
5 in the lung. I would need to document that.  
6 That's part of the evaluation of the process, of  
7 the problem I'm dealing with.

8 Q Okay.

9 A If for some reason I don't think the  
10 patient may follow through, I may want to  
11 document it. Otherwise I can't think of a  
12 specific example. There are certainly times  
13 when I have recommended to patients that they  
14 follow up with their regular doctor for any host  
15 of problems that is not related to surgery, or  
16 my surgery.

17 Q Okay. And would you send a letter to the  
18 referring physician or --

19 A Sometimes yes, sometimes no. It -- it's --  
20 there isn't a specific criteria that I have that  
21 would dictate that.

22 Q You said that you would document it when  
23 you think the patient wouldn't follow up. What  
24 do you mean by that?

25 A If for some reason I thought the patient

16

1 was unreliable but I did want to document that I  
2 found something on a specific situation, then I  
3 might document that I found it.

4 Q Do you think you have a responsibility to  
5 insure that the patient follows up --

6 MS. SANDACZ: Objection. Go  
7 ahead.

8 Q -- to an incidental finding that might be  
9 suspicious for cancer?

10 A No. In an adult person, I convey the  
11 information and they can decide what they want  
12 to do with it.

13 THE WITNESS: Sorry.

14 Q Doctor, as you sit here today, can you  
15 think of any patients that you've advised them  
16 that they have a suspicious finding for cancer  
17 when they didn't know they had -- may have  
18 cancer and they didn't follow up?

19 A Yes.

20 Q Okay. What kind of example is that? What  
21 specifically?

22 A I remember a patient who had a -- an  
23 adrenal mass that was enlarging and I thought it  
24 was malignant and I recommended a biopsy and  
25 they decided not to have one.

17

1 Q Under those circumstances, did you rec --  
2 did you document your recommendation for a  
3 biopsy?

4 A That's what I was being -- the patient was  
5 referred for, and I -- for that problem, and I  
6 recommended a biopsy for them. Yes, that was  
7 documented.

8 Q Okay. Have you ever written a letter to a  
9 fellow physician, either within this -- the  
10 Cleveland Clinic family or outside in the  
11 community, where their patient has been sent to  
12 you for something and there was an incidental  
13 finding and you recommend follow-up by that  
14 physician?

15 A Yes.

16 Q Okay. Can you give me an example of that.

17 A I can't remember a specific example, but  
18 chances are that if I found something in  
19 testing, that I might find something, and if I'm  
20 writing the letter, let's say, to give them  
21 follow-up on what they sent the patient for,  
22 that I would, if I was already writing the  
23 letter, make a notation that such -- another  
24 incidental finding was found, yes. I can't  
25 think of a specific time that I did that, but --

18

1 Q Can we agree that an incidental finding of  
2 a spot or a lesion on the lung that is  
3 suspicious for cancer is certainly a potentially  
4 life-threatening condition?

5 A Yes.

6 Q Can we agree, Doctor, that a surgeon who  
7 becomes aware in an incidental manner of a  
8 potentially life-threatening condition has a  
9 responsibility to ensure that the patient fully,  
10 completely and accurately understands the  
11 condition?

12 MS. SANDACZ: Objection to  
13 "ensure." Go ahead.

14 A I think the patient needs to be told and be  
15 offered an opportunity to ask questions. If  
16 that satisfied being fully aware, I believe you  
17 said, of the -- of the problem, then, yes, I  
18 would agree with that.

19 Q Well, let me just read the question --

20 A Okay.

21 Q -- over again.

22 A Go ahead.

23 Q If you can answer it directly. If you  
24 can't, that's fine too.

25 MR. BECKER: Are we going to

19

1 listen to this --

2 MS. SANDACZ: I don't know. I  
3 don't know.

4 THE WITNESS: There's a -- there  
5 must be a conference right next door.

6 MR. TACKLA: Off the record.

7 -----  
8 (Discussion had off the record.)  
9 -----

10 BY MR. BECKER:

11 Q Let me just try that question again,  
12 Doctor.

13 Can we agree that a doctor, a surgeon  
14 who becomes aware in an incidental manner of a  
15 potentially life-threatening condition has a  
16 responsibility to ensure that the patient fully,  
17 completely and accurately understands the  
18 condition?

19 MS. SANDACZ: Objection. Go  
20 ahead.

21 A Yes.

22 Q Can we agree, Doctor, that a surgeon who  
23 becomes aware in an incidental manner of a  
24 potentially life-threatening condition has a  
25 responsibility to ensure that the patient

20

1 understands the need for follow-up?

2 MS. SANDACZ: Objection. Go  
3 ahead.

4 A Yes.

5 Q And can we agree, Doctor, that a surgeon  
6 who becomes aware in an incidental manner of a  
7 potentially life-threatening condition has a  
8 responsibility to actually ensure follow-up  
9 himself?

10 MS. SANDACZ: Objection.

11 A No.

12 Q Can we agree, Doctor, that there's kind of  
13 a compact or understanding in a  
14 physician/patient relationship that when a  
15 patient seeks health care from a physician and  
16 the physician violates the standard of care and  
17 causes harm to the patient, the medical provider  
18 should be held responsible for the harm caused  
19 by that violation?

20 MS. SANDACZ: Objection.

21 A If the standard of care is violated, yes.

22 Q And if the standard of care is violated,  
23 you have no problem that the physician should be  
24 held accountable?

25 A Correct.

<p style="text-align: right;">21</p> <p>1 MS. SANDACZ: Objection.</p> <p>2 Q Doctor, you are a Fellow of the American</p> <p>3 College of Surgeons?</p> <p>4 A Yes.</p> <p>5 Q And Dr. Elkhairi was a member of -- at</p> <p>6 least at the time he rendered care to</p> <p>7 Mrs. Richnafsky, of the American College of</p> <p>8 Surgeons.</p> <p>9 A I don't know that --</p> <p>10 Q Is that your understanding?</p> <p>11 A I don't know that for a fact, but --</p> <p>12 Q Okay.</p> <p>13 A I've never seen his CV.</p> <p>14 Q Okay. For purposes of many of my questions</p> <p>15 that follow, I want you to assume as true that</p> <p>16 he also is a -- is a Fellow of the American</p> <p>17 College.</p> <p>18 Can we agree that the American College</p> <p>19 of Surgeons establish certain statements and</p> <p>20 principles for their Fellows?</p> <p>21 A They may.</p> <p>22 Q And can we agree that there is a preamble</p> <p>23 to the statements and principles -- and I have</p> <p>24 copies for you, if you'd like to look at one,</p> <p>25 the preamble, which has been marked as</p>	<p style="text-align: right;">23</p> <p>1 A Yes.</p> <p>2 Q And what that means, sir, is that that --</p> <p>3 that a Fellow pledges to abide by, follow,</p> <p>4 adhere to the principles and to the statements</p> <p>5 of the College, correct?</p> <p>6 MS. SANDACZ: Objection.</p> <p>7 A Yes, but that doesn't have anything to do</p> <p>8 with standard of care again.</p> <p>9 Q Okay. We're going to talk about standard</p> <p>10 of care.</p> <p>11 A And we're not talking about sainthood,</p> <p>12 either.</p> <p>13 Q We're not what?</p> <p>14 A Talking about sainthood. I mean, they're</p> <p>15 not infallible.</p> <p>16 Q Okay. Now, also there is a prerequisite to</p> <p>17 entry as a Fellow that the physician must pledge</p> <p>18 to abide by the Code of Professional Conduct,</p> <p>19 correct?</p> <p>20 A Yes.</p> <p>21 Q And that Code of Professional Conduct</p> <p>22 states that: We treasure the trust that</p> <p>23 patients have placed in us, because trust is</p> <p>24 integral to the practice of surgery.</p> <p>25 Did I read that right?</p>
<p style="text-align: right;">22</p> <p>1 Plaintiff's Exhibit 1.</p> <p>2 A Okay. But I -- I don't think any of these</p> <p>3 principles necessarily apply to standard of</p> <p>4 care.</p> <p>5 Q Okay. We'll talk about that in a moment,</p> <p>6 but let's just deal with the preamble for a</p> <p>7 moment, and it says here that it's founded to</p> <p>8 provide opportunities for the continuing</p> <p>9 education of surgeons. The American College of</p> <p>10 Surgeons has a deep and effective concern for</p> <p>11 the improvement of patient care and for the</p> <p>12 ethical practice of medicine.</p> <p>13 Is that what it says?</p> <p>14 A That's what it says.</p> <p>15 Q And do you agree with that process?</p> <p>16 A Yeah, that's fine. That's a preamble.</p> <p>17 Q Now, in fact, Doctor, there is a fellowship</p> <p>18 pledge that each member, before he's inducted,</p> <p>19 must swear to, and the fellowship pledge, which</p> <p>20 is on the next two pages over on page 3 states</p> <p>21 as follows: I hereby pledge myself, as a</p> <p>22 condition of fellowship in the College, to live</p> <p>23 in strict accordance with the College's</p> <p>24 principles and regulations. Correct? Did I</p> <p>25 read that correctly?</p>	<p style="text-align: right;">24</p> <p>1 A Yes.</p> <p>2 Q And would you agree with that concept about</p> <p>3 trust and why patients --</p> <p>4 A Yes.</p> <p>5 Q -- place trust in their doctors?</p> <p>6 A Yes, I certainly do.</p> <p>7 Q It goes on to say: During the continuum of</p> <p>8 pre, intra and postoperative care, we accept</p> <p>9 responsibilities to serve as effective advocates</p> <p>10 of our patients' needs, be sensitive and</p> <p>11 respectful of the patients' understanding, their</p> <p>12 vulnerability during the perioperative period</p> <p>13 and fully disclose adverse events. Do you see</p> <p>14 that?</p> <p>15 A Yes.</p> <p>16 Q Do you agree with that concept?</p> <p>17 A Yes.</p> <p>18 Q Now, there's a section thereunder relative</p> <p>19 to informed consent. I think it's on page 5.</p> <p>20 In that it says that the surgeon must fully</p> <p>21 inform every patient about his or her illness</p> <p>22 and the proposed treatment, correct?</p> <p>23 A Correct.</p> <p>24 Q And you agree with that?</p> <p>25 A Yes. In this case as it applies to</p>

25

1     appendicitis.  
 2     Q     And it says: The information must be  
 3     presented fairly, clearly, accurately,  
 4     compassionately, correct?  
 5     A     Yes.  
 6     Q     And there's a section entitled Preoperative  
 7     Diagnosis and Care, and it says that the surgeon  
 8     is responsible for the patient's safety, the  
 9     patient's safety, throughout the preoperative,  
 10    operative -- preoperative, operative, and  
 11    postoperative period, correct?  
 12    A     Yes.  
 13    Q     And you agree with that?  
 14    A     Sure.  
 15    Q     And there's a section entitled Continuity  
 16    of Care, where it says that -- a section that  
 17    says a surgeon will ensure appropriate  
 18    continuity of care of that surgical patient,  
 19    correct?  
 20    A     Yes.  
 21    Q     And that means that if the patient is in  
 22    need of further care, that surgeon has a  
 23    responsibility to ensure it?  
 24    A     As it applies to the surgery.  
 25    Q     Okay. Now --

26

1                 MR. BECKER:         Off the record a  
 2     moment..  
 3                 - - - - -  
 4                 (Discussion had off the record.)  
 5                 - - - - -  
 6                 MR. BECKER:         Let's go back on  
 7     the record.  
 8     BY MR. BECKER:  
 9     Q     Doctor, I forgot to ask you a question  
 10    about incidental findings.  
 11    A     Yes.  
 12    Q     And although an incidental finding is  
 13    unrelated to the actual surgery, we can agree  
 14    that the new finding, since it was discovered  
 15    pre -- in preoperative testing, can be deemed a  
 16    potentially continuing problem associated with  
 17    the patient's surgical care?  
 18                 MS. SANDACZ:         Objection.  
 19    A     No --  
 20    Q     Is that fair?  
 21    A     Not necessarily, no. This lung nodule  
 22    didn't have anything to do with this patient's  
 23    surgical care of acute appendicitis.  
 24    Q     But if something was discovered in the  
 25    course of the patient's surgical care --

27

1     A     This was discovered before the surgical  
 2     care.  
 3     Q     But it was discovered in a preoperative  
 4     assessment, correct?  
 5     A     This was discovered for -- during a workup  
 6     of a complaint that led to surgery.  
 7     Q     Right.  
 8     A     Yeah.  
 9     Q     And it's something that the doctor,  
 10    surgeon, relied upon in his determination as to  
 11    whether the patient needed surgery.  
 12                 MS. SANDACZ:         Objection.  
 13    Q     Right?  
 14    A     It was part of what he used to make the  
 15    decision.  
 16    Q     In part.  
 17    A     Yes.  
 18    Q     Now, since it was -- it was discovered in  
 19    the preoperative testing, is it reasonable to  
 20    say that that is a potential continuing  
 21    problem --  
 22                 MS. SANDACZ:         Objection.  
 23    Q     -- that was discovered during the surgical  
 24    consultation?  
 25    A     No. This was ordered -- this wasn't even

28

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

29

1 Responsibility, correct? Is that the title?  
 2 A Yes.  
 3 Q And it states: When the time comes that  
 4 the surgeon will no longer be involved in the  
 5 follow-up of the patient, he or she is  
 6 responsible for ensuring appropriate long-term  
 7 follow-up for continuing problems.  
 8 A It says associated with the --  
 9 Q Associated with the --  
 10 A -- patient's surgical care.  
 11 Q -- patient's surgical care.  
 12 A So that applies only to the surgery, in  
 13 this case the appendectomy.  
 14 Q So it's your position, you're making the  
 15 distinction saying because this was discovered  
 16 preoperatively, although a bases for the  
 17 decision, that is the study, the CT scan, was a  
 18 bases for the decision to proceed with surgery,  
 19 that's -- and a problem was noted in that test,  
 20 that's not considered part of the patient's  
 21 surgical care, that finding?  
 22 A No.  
 23 Q So would it be fair for -- since it's not  
 24 part of the patient's surgical care, would it be  
 25 reasonable for Dr. Elkhairi to ignore it?

30

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

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

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



33

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

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

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

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

18 MS. SANDACZ: Objection. Go  
19 ahead.

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

25 Q To the referring physician?

34

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

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

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

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

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

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

24 A See the referring physician.

25 Q Okay.

35

1 A That would be the most common  
2 documentation.

3 Q Okay.

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

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

11 A No, I don't ever remember --

12 Q Explained to the patient --

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

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

17 A All right.

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

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

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

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

4 Q Okay.

5 A And so I might document that.

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

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

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

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

22 Q Right. I got that.

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

25 Q In your chart --

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1 A -- that something else was found.  
 2 Q -- you told the patient. And you told the  
 3 patient.  
 4 A I would say it's uncommon that I'm going to  
 5 document that I specifically told the patient  
 6 that I found that, because to me that's implied,  
 7 because I'm going to discuss the results with  
 8 the patient.  
 9 Q Well, would you --  
 10 A I wouldn't say: And I discussed this  
 11 incidental finding with the patient. It's -- I  
 12 would say it's rare that that's going to be --  
 13 that sentence is going to be there.  
 14 Q Would the sentence be that I discussed my  
 15 findings?  
 16 A I would say the test results were  
 17 discussed.  
 18 Q Okay.  
 19 A Something like that.  
 20 Q Would that normally be documented, the test  
 21 results were discussed with the patient?  
 22 A I would say commonly in my practice, yes.  
 23 Q When you document test results discussed  
 24 with patient, here is my question: Why do you  
 25 do it? Why do you write: Test results

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1 documented with patient?  
 2 A Because I'm writing a note and I'm  
 3 discussing a problem and that's part of the  
 4 problem.  
 5 Q So it is part of the problem, that  
 6 incidental finding?  
 7 MS. SANDACZ: Objection.  
 8 A We're talking about the results of any test  
 9 that I ordered.  
 10 Q Um-hum.  
 11 A So we'll discuss the results. If something  
 12 incidentally came up, I would discuss it with  
 13 them.  
 14 Q And it's part of the problem, because --  
 15 you're discussing it because it's part of the  
 16 problem?  
 17 A It may be, but it may not be. Again, if  
 18 it's something that's totally unrelated, I may  
 19 very well tell the patient to follow up with  
 20 their doctor about this -- whatever it is that  
 21 came up.  
 22 Q But you would think, Doctor, that if you're  
 23 not going to tell -- are you saying there's some  
 24 circumstances when you would simply refer the  
 25 patient for follow-up with the referring

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1 physician and not tell the patient at all --  
 2 A No.  
 3 Q -- about this?  
 4 A That's not what I said. I said I would  
 5 tell the patient. I -- it is not necessarily  
 6 true that I documented that I talked to the  
 7 patient about that problem, but that I told them  
 8 to follow up with their primary care physician.  
 9 Q Did you see any indication in this chart  
 10 where there's an entry by Dr. Elkhairi that the  
 11 test results were discussed with the patient?  
 12 A No.  
 13 Q Would you have expected to see some  
 14 indication in the chart -- I'm not talking about  
 15 standard of care now. I know you want to talk  
 16 to me about the standard of care --  
 17 A Right.  
 18 Q -- and we'll get to that. Hang on, okay?  
 19 Did you see any indication -- would  
 20 you have expected Dr. Elkhairi to have  
 21 documented, quote, test results doc -- discussed  
 22 with the patient?  
 23 A No.  
 24 Q Why?  
 25 A Because that's not necessarily standard of

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1 care.  
 2 Q Okay.  
 3 A It's not --  
 4 Q Now is your time --  
 5 A -- related to appendicitis.  
 6 Q -- to tell me what your definition of  
 7 standard of care is.  
 8 A My definition of standard of care is the  
 9 usual practice of a reasonable surgeon, in this  
 10 case, in the similar circumstance.  
 11 Q And where did you obtain that definition?  
 12 A That's my understanding of standard of  
 13 care. I can't --  
 14 Q Did some attorney tell you that --  
 15 A No.  
 16 Q -- or you read it somewhere, or --  
 17 A No.  
 18 Q You don't know?  
 19 A I don't -- I can't give you a specific  
 20 reference.  
 21 Q Okay.  
 22 A Whenever I've had standard of care  
 23 explained to me, that's the short, sweet  
 24 explanation for it.  
 25 Q Okay. Would you have expected a skillful

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1 and diligent surgeon to document test results  
2 discussed with patient?

3 MS. SANDACZ: Objection. Go  
4 ahead.

5 A Not necessarily. It depends on the  
6 circumstance, I would say.

7 Q Have you ever had any of your patients  
8 where there's been an incidental finding on a  
9 chest film of a -- of a spot or a one or two  
10 centimeter cancerous lesion diagnosed  
11 inadvertently or incidentally?

12 MS. SANDACZ: Objection. Asked  
13 and answered. Go ahead.

14 A Yes.

15 Q Okay. And --

16 A I think.

17 Q And is it those patients that are subject  
18 to a resection, based on your knowledge of the  
19 medicine?

20 A I don't know. I refer them to the people  
21 who do that.

22 Q Any of those patients have a resection of  
23 the lung, to your knowledge?

24 MS. SANDACZ: Objection.

25 Q Can you think of any of your patients?

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1 A I -- yes, I'm sure some have. I hope they  
2 have.

3 Q Okay. Any of those patients actually have  
4 a cancer diagnosed. Obviously, I guess they --  
5 they would have a biopsy confirming the cancer  
6 before they would have the resection; is that  
7 safe?

8 MS. SANDACZ: Objection. Go  
9 ahead.

10 A I don't know, actually. I don't --

11 Q Okay.

12 A I don't treat that, so I don't know if they  
13 all get biopsies or --

14 Q Okay. Do you treat -- you treat primary  
15 pancreatic cancer, you do not treat metastatic  
16 pancreatic cancer, that is where there's a  
17 primary source and it's spread to the pancreas,  
18 or do you treat both?

19 A I treat both. The latter is highly un --  
20 unusual. Usually unusual.

21 Q How unusual?

22 A Well, there -- you know, autopsy series are  
23 somewhat high, but the only practical tumors  
24 that go to the pancreas are from the kidney.

25 Q So to your knowledge the only primary

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1 cancer that spreads to the pancreas, at least in  
2 your experience, is kidney cancer; is that what  
3 you're saying?

4 A Pretty much. There aren't -- yes.

5 Q Okay. What about lung cancer?

6 A What about lung cancer?

7 Q Can it spread to the pancreas?

8 A Not that I know of.

9 Q What is the survival rate of pancreatic  
10 cancer?

11 MS. SANDACZ: Objection. Go  
12 ahead.

13 A With or without resection?

14 Q Well, give me both. Just give me a  
15 ballpark on both.

16 A Well --

17 MS. SANDACZ: Objection. Go  
18 ahead.

19 A The average length of life for people with  
20 pancreatic cancer is under -- around six months;  
21 but if they're resected, their median survival  
22 is about 24 months. That's median survival.

23 Q And when you say when they're resected,  
24 that is the cancer is --

25 A Removed.

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1 Q -- surgically removed.

2 A Um-hum. Yes.

3 Q So without resection, six months; with  
4 resection --

5 A Yeah, most are found in the late stage.

6 Q Okay. Where there is -- not amenable to  
7 resection?

8 A Yes.

9 Q Have you ever written or done lung cancer  
10 surgery, written on lung cancer surgery --

11 A No.

12 Q -- or --

13 A No.

14 Q -- engaged in lung cancer surgery?

15 A Not as a -- on staff, no. Not since I  
16 finished my --

17 Q Training?

18 A -- training. Um-hum.

19 Q Would you agree with this general  
20 principle, that with lung cancer, the earlier  
21 it's diagnosed, the greater the chance of cure?

22 MS. SANDACZ: Objection.

23 A Well, I'm not an expert in the area, but I  
24 would seem -- I would think that -- I would hope  
25 that that would be true.

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1 Q Is it true, Doctor, that, to your  
2 knowledge, that cancer, if permitted, if  
3 unaddressed, will ultimately spread to other  
4 parts of the body?

5 A Typically, yes.

6 Q And the longer it's permitted to stay  
7 unaddressed, the more harmful it may become in  
8 one's body?

9 MS. SANDACZ: Objection. If you  
10 know.

11 A Yes.

12 Q To your knowledge, Doctor, would a 19 month  
13 delay in diagnosing lung cancer likely be  
14 harmful to a patient?

15 MS. SANDACZ: Objection.

16 A I would say any delay of any cancer is  
17 harmful.

18 Q We can agree, Doctor, that, moving on to  
19 Susan Richnafsky and the care rendered by  
20 Dr. Elkhairi, that he clearly had multiple  
21 opportunities to sit down with her and explain  
22 this incidental finding that was suspicious and  
23 potentially life-threatening, correct?

24 A I don't know how many opportunities he had,  
25 truly. I know he looked at the report, it's

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1 initialed, so the most likely op -- single  
2 opportunity would have been in the post-op  
3 recovery visit.

4 Q Okay. At least a emergency room physician  
5 has given sworn testimony, told Dr. Elkhairi  
6 about it before surgery.

7 A And that's -- a follow-up was arranged for  
8 it. Correct.

9 Q Okay. And so if Dr. Elkhairi knew about it  
10 before surgery, he had an opportunity to talk to  
11 the patient pre-op, post-op, post-op day one,  
12 post-op day two, correct?

13 A Well, he -- the oppor -- he might view the  
14 opportunity as inopportune if the patient was  
15 under duress or inappropriately sedated or  
16 otherwise recovering, so that might not be an  
17 opportunity, even though there's a time  
18 opportunity.

19 Q Absolutely. Probably the most humane and  
20 most considerate opportunity to broach this may  
21 be in that office visit --

22 A That would be --

23 Q -- post-op?

24 A -- the most likely, I would say.

25 Q Okay. There's nothing documented -- we

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1 can -- just to recap this, there's nothing  
2 documented that Dr. Elkhairi told either Richard  
3 or Susan Richnafsky about this suspicious  
4 potentially life-threatening lesion in her right  
5 lower lung, correct?

6 MS. SANDACZ: Objection.

7 A He did not discuss the incidental finding  
8 on the CT scan, that is not documented.

9 Q And there's nothing documented that  
10 evidenced that Dr. Elkhairi took steps to insure  
11 that the patient -- the patient understood the  
12 need to follow up on this potentially  
13 life-threatening spot on her right lower lung,  
14 correct?

15 MS. SANDACZ: Objection. I  
16 didn't hear the full question. Could you  
17 repeat it?

18 THE WITNESS: Could you -- I  
19 would benefit from that, the question.

20 Q You need the question again?

21 A Please.

22 Q There's nothing documented to evidence that  
23 Dr. Elkhairi took steps to ensure follow-up on  
24 this potentially life-threatening spot?

25 A No. Yes, that's correct.

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1 Q And there's nothing documented that  
2 Dr. Elkhairi made it clear to the patient her  
3 need to follow up on this potentially  
4 life-threatening spot in her lower lung,  
5 correct?

6 A Correct. At the time it is an incidental  
7 finding. We don't know if it's life-threatening  
8 or not at the time. Could be.

9 Q Could be.

10 A Could be.

11 Q Right. I mean, one of the general  
12 principles in the statement of the College is  
13 you want to be treated as if you were the  
14 patient; treat the patient as if you were the  
15 patient, the same way that you would want to be  
16 treated. That's one of the principles I read  
17 about.

18 A I think it's a golden rule.

19 Q Okay. It's a great rule.

20 So, Doctor, if you or your loved one  
21 had a potentially life-threatening lesion in --  
22 or spot in her lung, you would want to know  
23 about that as soon as possible?

24 MS. SANDACZ: Object.

25 A I would definitely want to know about it,

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1 yes.

2 Q And if in fact there was any possibility  
3 that there was a misunderstanding about the  
4 significance of it, you would want the attending  
5 physician to either contact or write your  
6 referring physician or write you outlining the  
7 significance of the same?

8 MS. SANDACZ: Objection. Go  
9 ahead.

10 A Not necessarily. I just -- I would want to  
11 know about it.

12 Q Okay.

13 A As long as I knew about it, whichever way  
14 it's delivered, as long as I was comfortable  
15 with that --

16 Q Okay. You're not making any -- rendering  
17 any opinion as to whether she was told or not  
18 told about -- factually in this case, that is,  
19 "she" being Mrs. Richnafsky?

20 A I am saying I don't have documentation that  
21 she was.

22 Q Okay. And Dr. Elkhairi has no specific  
23 recollection that he told her, does he?

24 A That's true.

25 Q Can we agree, Doctor, that based on --

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1 assuming it's true, based on all the material  
2 you have reviewed, that Dr. Elkhairi failed to  
3 inform Susan Richnafsky of this potentially  
4 life-threatening condition and failed to ensure  
5 that she understood the need for follow-up, that  
6 Dr. Elkhairi's failures permitted Susan  
7 Richnafsky's lung cancer to go 19 months without  
8 a diagnosis?

9 MS. SANDACZ: Objection. Go  
10 ahead.

11 A I have no proof that he failed to inform  
12 the patient. I have -- I don't have evidence  
13 that he documented, but I have no evidence that  
14 he failed to inform her either.

15 Q Okay. Let's assume as true, let's start  
16 with this premise, and assume as true that  
17 Dr. Richnafsky failed -- assume it's true. Do  
18 you understand a hypothetical? I'm asking you  
19 to assume something is true.

20 A Dr. Elkhairi?

21 MS. SANDACZ: Yeah.

22 Q Right.

23 MS. SANDACZ: You said  
24 Richnafsky.

25 Q Assuming as true that --

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1 MR. BECKER: You're lucky I'm

2 not talking about vaginal prolapses, so --

3 THE WITNESS: They're on the  
4 ovaries now.

5 MR. BECKER: -- consider  
6 yourself lucky.

7 BY MR. BECKER:

8 Q Assuming it's true that Dr. Elkhairi failed  
9 to make Susan Richnafsky fully aware of this  
10 potentially life-threatening condition in her  
11 lower lung and to ensure that she appreciated  
12 the need for follow-up, can we agree that that  
13 failure, with that failure, Doctor, assuming  
14 it's true, Dr. Elkhairi deviated from the  
15 appropriate standard of care?

16 A If he failed -- yes, if that assumption is  
17 correct.

18 Q Okay. Continuing with that assumption,  
19 okay, assuming that he failed in that duty, can  
20 we agree that Susan Richnafsky's lung cancer  
21 went 19 months without a diagnosis?

22 MS. SANDACZ: Objection. If you  
23 know, based upon the medical records and  
24 everything that you have in front of you.

25 A Yeah, I -- I can't say that for sure. It's

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1 an assumption. That's another assumption.

2 Q The assumption is that that spot was in  
3 fact cancerous?

4 A Yes. Exactly.

5 Q Okay. Let's assume that that --

6 A Okay.

7 Q -- spot was in fact cancerous, as the  
8 defense causation expert will concede. Assuming  
9 that that is true, that that one spot in the  
10 right lower lobe was in fact cancerous, assuming  
11 it's true that he failed to advise this family  
12 of this potentially life-threatening condition,  
13 can we agree based on the chart and the history  
14 that developed here that her cancer, her lung  
15 cancer, went 19 months without diagnosis?

16 MS. SANDACZ: Same objection. If  
17 you know the answer, because you don't have any  
18 of the records that subsequently show her when  
19 she was diagnosed.

20 A Well, you know, those are two assumptions.  
21 If you can make those two assumption, then, yes,  
22 I'll agree with you.

23 Q Okay.

24 A I'm not saying that you can, but --

25 Q If in fact those two assumptions are

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1 correct, one, that this family was never told  
2 about this condition; two, that that was a early  
3 cancer spot in her right lower lobe.

4 A Well, you're adding a third assumption now,  
5 that it was an early cancer.

6 Q Okay.

7 A These are -- you're conceding these are  
8 assumptions that you want me to --

9 Q Yes.

10 A Okay.

11 Q Okay. Assume it's true that it was in  
12 fact -- let's start over. I'll remove the  
13 "early" assumption.

14 Let's assume as true that this family  
15 was never ever told about this life-threatening  
16 condition that Susan Richnafsky had; and assume  
17 as true that that was in fact a cancerous  
18 lesion, two centimeters, in her right lower  
19 lobe; and assume as true that it wasn't -- her  
20 cancer wasn't diagnosed until 19 months later;  
21 that the failure of Dr. Elkhairi to advise this  
22 family permitted the spread of her cancer and  
23 reducing her chances of survival and cure.

24 MS. SANDACZ: I'm going to make  
25 an objection. He cannot possibly know anything

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1 about this woman's cancer to render that; but  
2 go ahead, Doctor, if you -- based upon all  
3 those assumptions, in the absence of any  
4 information about the type of lung cancer,  
5 where it was located, otherwise, go ahead.

6 A I think it's the same question again, and  
7 so I'll say yes.

8 Q The answer to my question would be yes,  
9 assuming those things --

10 A Assuming those things --

11 Q -- the things that I've out -- that I've  
12 outlined.

13 A -- and based on this, what I have, but I  
14 don't know and I'm not an expert on lung cancer.

15 Q Okay. Well, let's further assume then that  
16 that month -- that 19 month delay led to her  
17 death. Assume that there was a failure to  
18 inform this family of this life-threatening  
19 condition; assume as true that there was a  
20 19 month delay before her diagnosis; assume as  
21 true that that 19 month delay led to her death.  
22 Everything assuming as true, we can agree,  
23 Doctor, that Dr. Elkhairi should be held  
24 accountable for this woman's death?

25 MS. SANDACZ: I'm going to

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1 object. He just said he's not a lung cancer  
2 expert and therefore cannot even render an  
3 opinion whether or not what was diagnosed or  
4 present in November of 2001 would have caused  
5 her death regardless of whether or not there  
6 was a delay. So I think it's an unfair  
7 question of -- asking this expert, who has  
8 clearly identified himself as not an expert in  
9 lung cancer. But go ahead, Doctor, and we'll  
10 deal with it with the Court if need be.

11 A I really can't comment on the cause of  
12 death other than he prevented her from dying  
13 from acute appendicitis.

14 Q Okay. Well, let's -- let's assume as true  
15 that he never told this family, which is borne  
16 out by the chart because there's no  
17 documentation of it; let's assume as true that  
18 he never told the family about this  
19 life-threatening condition; that it was in fact  
20 a cancerous lesion back in 2001; assume as true  
21 that there was a 19 month delay because of the  
22 failure to adhere to the standard of care and  
23 inform the patient, there was a 19 month delay  
24 in diagnosing the cancer; and assume as true  
25 that that 19 month delay played a part in her

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1 death. Assuming those four factors as true,  
2 Doctor, you would agree with me that  
3 Dr. Elkhairi should then be held accountable for  
4 this woman's death?

5 MS. SANDACZ: Objection.

6 A I am not holding Dr. Elkhairi responsible  
7 for her death.

8 Q That's apparent to me by your testimony.  
9 And you won't hold him accountable even under a  
10 hypothetical, will you?

11 A There are too many assumptions in your  
12 hypothetical to -- for me to then make this  
13 leap, is what I'm saying, and there's things  
14 about it I don't know.

15 Q Even if those assumptions are borne out by  
16 the defendant's own testimony, defendant  
17 expert's own testimony?

18 A Well, that's for the jury to decide.

19 Q And that's true. But have you ever seen a  
20 circumstance, Doctor, in your career where a  
21 physician -- in your career of 15 years -- I'm  
22 aging you more than I need to be.

23 A Well, it's better than 20, which you  
24 started with.

25 Q Okay. Have you ever seen --

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1 MR. BECKER: So he's younger  
2 than I thought.  
3 Q Have you ever seen a condition in your  
4 career of 15 years where a patient was not told  
5 of a -- made a claim that she was not told of a  
6 life-threatening condition?  
7 A And didn't follow through?  
8 MR. TACKLA: Off the record.  
9 - - - - -  
10 (Interruption in proceedings.)  
11 - - - - -  
12 MR. BECKER: On the record.  
13 BY MR. BECKER:  
14 Q Doctor, in your career have you ever  
15 experienced the circumstance, the clinical  
16 circumstance, where the patient claims that she  
17 was never informed of a life-threatening  
18 condition? That's my first question.  
19 A I -- I don't know.  
20 Q You can't think of one?  
21 A I -- I -- it's -- I don't -- I don't  
22 remember.  
23 Q Okay.  
24 A I can't think of a circumstance like  
25 that --

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

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1 not what he said.  
2 A Assuming your assumptions; is that what  
3 you're saying?  
4 Q Yeah.  
5 A No, I don't think he's -- he is not  
6 responsible for that. He's responsible for the  
7 care that he was called to deliver, and that's  
8 what he did.  
9 Q But he's -- let's go back to my question.  
10 MR. BECKER: Off the record.  
11 - - - - -  
12 (Discussion had off the record.)  
13 - - - - -  
14 (Question read as follows: We can agree that  
15 Dr. Elkhairi should be held accountable if the  
16 jury concludes that, one, he never told this  
17 patient, never told this family about this  
18 potentially life-threatening condition; and if  
19 the jury believes that there was a 19 month  
20 delay in diagnosis and that played a part in her  
21 death; can we agree under those circumstances of  
22 that question Dr. Elkhairi should be held  
23 accountable?)  
24 - - - - -  
25 MS. SANDACZ: Objection to the

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1 hypothetical. Multiple assumptions. Go ahead,  
2 Doctor.  
3 A Yeah, so the multiple assumptions, I  
4 believe I said that there were people more  
5 responsible for informing the patient. I've  
6 said that he is responsible for telling the  
7 patient, and so you've of course made the  
8 assumption that he failed to do that; so he  
9 would be partly responsible if he failed to tell  
10 the patient.  
11 Q Okay.  
12 A Okay?  
13 MR. BECKER: Thank you. I'm  
14 done.  
15 MS. SANDACZ: We're done.  
16 THE WITNESS: You're all done?  
17 MS. SANDACZ: We're all done.  
18 THE WITNESS: Okay. Fine.  
19 MS. SANDACZ: We'll read. You  
20 can send it to me. I'll have the doctor review  
21 it.  
22 THE NOTARY: Do you waive  
23 viewing of the videotape?  
24 MS. SANDACZ: Yeah, we don't need  
25 to view the videotape.





<p><b>A</b></p> <p><b>abdominal</b> 9:3</p> <p><b>abide</b> 23:3, 18</p> <p><b>above-refe...</b> 62:14, 18</p> <p><b>absence</b> 54:3</p> <p><b>Absolutely</b> 46:19</p> <p><b>accept</b> 24:8</p> <p><b>accountable</b> 20:24 54:24 56:3, 9 58:4 58:11, 22 59:15, 23</p> <p><b>accurately</b> 18:10 19:17 25:3</p> <p><b>acted</b> 6:23</p> <p><b>acting</b> 6:18</p> <p><b>action</b> 63:4</p> <p><b>actual</b> 12:19 26:13 32:15</p> <p><b>acute</b> 12:9 26:23 34:16 34:18 55:13</p> <p><b>adding</b> 53:4</p> <p><b>addition</b> 4:21</p> <p><b>additional</b> 31:25</p> <p><b>adhere</b> 23:4 55:22</p> <p><b>adjournment</b> 62:24</p> <p><b>adrenal</b> 16:23</p> <p><b>adult</b> 16:10</p> <p><b>adverse</b> 24:13</p> <p><b>advice</b> 30:13 30:23 32:6</p> <p><b>advise</b> 11:19 14:9 30:22 31:6, 8 33:2 33:9 52:11 53:21</p> <p><b>advised</b> 16:15</p> <p><b>Advisory</b> 28:11</p> <p><b>advocates</b> 24:9</p> <p><b>affixed</b> 63:8</p> <p><b>aforsaid</b> 62:13</p> <p><b>afternoon</b> 4:11</p>	<p>4:12</p> <p><b>aging</b> 56:22</p> <p><b>ago</b> 35:8</p> <p><b>agree</b> 6:18, 22 13:25 18:1, 6 18:18 19:13 19:22 20:5 20:12 21:18 21:22 22:15 24:2, 16, 24 25:13 26:13 44:19 45:18 49:25 51:12 51:20 52:13 52:22 54:22 56:2 58:3, 9 59:14, 21</p> <p><b>ahead</b> 12:14 16:7 18:13 18:22 19:20 20:3 30:16 33:6, 19 41:4 41:13 42:9 43:12, 18 49:9 50:10 54:2, 5 55:9 58:14 60:1</p> <p><b>al</b> 1:7, 12</p> <p><b>amenable</b> 44:6</p> <p><b>American</b> 21:2 21:7, 16, 18 22:9</p> <p><b>Andress</b> 2:12</p> <p><b>and/or</b> 33:16</p> <p><b>answer</b> 6:13 7:11, 21 18:23 33:7, 7 35:8 52:17 54:8</p> <p><b>answered</b> 41:13</p> <p><b>anticipate</b> 8:2</p> <p><b>anticipated</b> 8:3</p> <p><b>apparent</b> 56:8</p> <p><b>APPEARANCES</b> 2:1</p> <p><b>appears</b> 6:4</p> <p><b>append</b> 12:9</p> <p><b>appendecto...</b> 12:3, 5, 8</p> <p><b>appendectomy</b></p>	<p>12:1, 2 29:13 32:23 36:15</p> <p><b>appendicitis</b> 12:9 25:1 26:23 34:16 34:18 35:23 40:5 55:13</p> <p><b>applies</b> 24:25 25:24 29:12</p> <p><b>apply</b> 22:3</p> <p><b>appreciated</b> 51:11</p> <p><b>appropriate</b> 25:17 29:6 51:15</p> <p><b>approximately</b> 5:13 8:5</p> <p><b>April</b> 1:22 63:9, 14</p> <p><b>area</b> 44:23</p> <p><b>arm</b> 31:7</p> <p><b>arrange</b> 10:18</p> <p><b>arranged</b> 46:7</p> <p><b>Asked</b> 41:12</p> <p><b>asking</b> 50:18 55:7</p> <p><b>assessment</b> 27:4</p> <p><b>associated</b> 26:16 29:8, 9</p> <p><b>assume</b> 7:19 21:15 50:15 50:16, 17, 19 52:5 53:11 53:14, 16, 19 54:15, 17, 19 54:20 55:14 55:17, 20, 24</p> <p><b>assuming</b> 50:1 50:25 51:8 51:13, 19 52:8, 10 54:9 54:10, 22 56:1 59:2</p> <p><b>assumption</b> 51:16, 18 52:1, 1, 2, 21 53:4, 13 60:8</p> <p><b>assumptions</b> 52:20, 25 53:8 54:3</p>	<p>56:11, 15 59:2 60:1, 3</p> <p><b>attending</b> 49:4</p> <p><b>attorney</b> 40:14 63:2</p> <p><b>autopsy</b> 42:22</p> <p><b>Avenue</b> 1:24</p> <p><b>average</b> 5:15 8:6 43:19</p> <p><b>aware</b> 18:7, 16 19:14, 23 20:6 51:9</p> <p><b>B</b></p> <p><b>back</b> 11:13 26:6 31:10 32:20 34:20 36:1 55:20 59:9</p> <p><b>ballpark</b> 43:15</p> <p><b>based</b> 35:7 41:18 49:25 50:1 51:23 52:13 54:2 54:13</p> <p><b>bases</b> 29:16, 18</p> <p><b>Becker</b> 2:4, 5 3:5 4:10 18:25 19:10 26:1, 6, 8 51:1, 5, 7 57:1, 12, 13 59:10 60:13</p> <p><b>behalf</b> 2:3, 10 6:9, 23</p> <p><b>believe</b> 18:16 60:4</p> <p><b>believes</b> 58:7 59:19</p> <p><b>benefit</b> 47:19</p> <p><b>best</b> 7:21</p> <p><b>better</b> 56:23</p> <p><b>Beverly</b> 2:11</p> <p><b>Beverly's</b> 5:19</p> <p><b>biopsies</b> 42:13</p> <p><b>biopsy</b> 16:24 17:3, 6 30:23 31:8 42:5</p> <p><b>body</b> 45:4, 8</p> <p><b>borne</b> 55:15 56:15</p>	<p><b>broach</b> 46:20</p> <p><b>C</b></p> <p><b>C</b> 62:1, 1</p> <p><b>call</b> 30:25 31:9, 14</p> <p><b>called</b> 1:16 59:7</p> <p><b>cancer</b> 8:10 9:20 10:14 11:1, 5, 8, 13 11:18 12:12 12:25 13:5 13:10, 13, 19 15:4 16:9, 16 16:18 18:3 32:3, 24 42:4 42:5, 15, 16 43:1, 2, 5, 6 43:10, 20, 24 44:9, 10, 14 44:20 45:2 45:13, 16 50:7 51:20 52:14, 15 53:3, 5, 20, 22 54:1, 4, 14 55:1, 9, 24</p> <p><b>cancerous</b> 12:21 41:10 52:3, 7, 10 53:17 55:20</p> <p><b>cancers</b> 12:20 13:19</p> <p><b>caption</b> 62:23</p> <p><b>care</b> 13:12 20:15, 16, 21 20:22 21:6 22:4, 11 23:8 23:10 24:8 25:7, 16, 18 25:22 26:17 26:23, 25 27:2 28:14 28:17, 17 29:10, 11, 21 29:24 30:6, 8 33:10 34:15 39:8, 15, 16 40:1, 7, 8, 13 40:22 45:19</p>
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