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IN THE
Supreme Court of Virginia
AT RICHMOND

RECORD NO. 940416

HING-HAR LO, M.D.

and

MONTGOMERY RADIOLOGY ASSOCIATES, INC.,

Appellants,

v.

JAMES F. BURKE, Executor of the Estate of
MARY HUTCHESON BURKE, Deceased

Appellee.

JOINT APPENDIX

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Counsel for Appellee

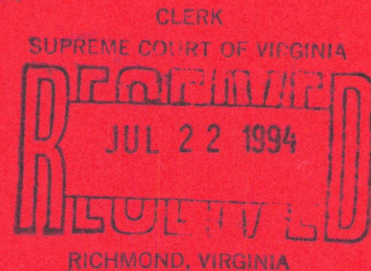
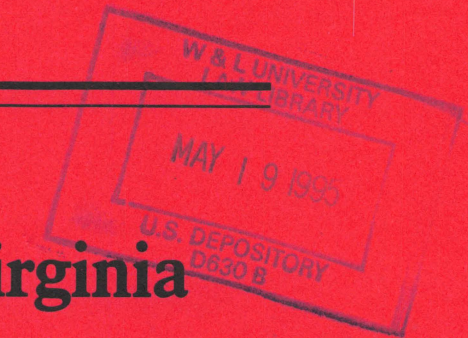


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VIRGINIA: IN THE CIRCUIT COURT OF MONTGOMERY COUNTY

JAMES F. BURKE, Executor of the)
Estate of MARY HUTCHESON BURKE,)
Deceased,)

Plaintiff,)

v.)

MOTION FOR JUDGMENT

V-7791

DR. HING-HAR LO)
Montgomery Radiology Associates,)
Inc.)
2001 South Main St.)
Blacksburg, Virginia 24060;)

AND)

MONTGOMERY RADIOLOGY ASSOCIATES,)
INC.)
2001 South Main St.)
Blacksburg, Virginia 24060,)

Defendants.)

TO THE HONORABLE JUDGES OF SAID COURT:

COMES NOW the Plaintiff and respectfully alleges
as follows:

1. During the summer and fall of 1988,
Plaintiff's decedent, Mary Hutcheson Burke, underwent various
diagnostic imaging procedures under the service of the
Defendants.

2. Notwithstanding the duties which the
Defendants owed to the Plaintiff's decedent, the Defendants were
negligent in that the care and treatment then afforded was not in
keeping with that degree of care, skill and diligence ordinarily
and customarily practiced and exercised by like physicians and
health care providers under like circumstances in the
Commonwealth of Virginia in that, among other things, on more

10:01 O'clock A M
Teste:
ALLAN C. BURKE, Clerk
Mary F. Hing-Har, D.C.
FLEX \$ 25.00
fe 100.00
Fees 2.00
Total Paid \$ 127.00

LAW OFFICES
YOUNG, HASKINS,
MANN & GREGORY
60 WEST CHURCH ST.
MARTINSVILLE, VA.

September 1, 1988, the Defendants negligently reported to Plaintiff's decedent's treating physicians that the pancreas was within normal limits. In truth and fact a suspicious three centimeter cyst was clearly visible upon x-ray, which the Defendants negligently failed to see and/or report.

3. As a result of your failing to recognize the existence of the cyst, and/or failing to report the existence of the cyst to Plaintiff's decedent's treating physicians, the cyst was neither discovered nor treated by attending physicians until April 29, 1991. When the cyst was finally discovered in 1991, it was determined that the cyst was caused by a cancer which was malignant, a condition which did not exist in 1988.

4. As a direct and proximate result of the negligence aforesaid, the Plaintiff's decedent, Mary Hutcheson Burke, died of metastatic pancreatic cancer on November 8, 1991.

WHEREFORE, Plaintiff moves the Court for judgment against the Defendants for compensatory damages on behalf of the decedent and/or beneficiaries, as their interests may appear, as set out in Section 8.01-52 of the Code of Virginia, in the sum of One Million (\$1,000,000.00) Dollars, prejudgment and other interest as may be appropriate, and the costs in this behalf expended.

A TRIAL BY JURY IS REQUESTED.

JAMES F. BURKE, Executor of the Estate of
MARY HUTCHESON BURKE, Deceased

By: 

Of Counsel

ROBERT W. MANN, ESQUIRE
G. CARTER GREER, ESQUIRE
YOUNG, HASKINS, MANN
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VIRGINIA:

IN THE CIRCUIT COURT OF MONTGOMERY COUNTY

JAMES F. BURKE, Executor of the
Estate of MARY HUTCHESON BURKE,
Deceased,

Plaintiff,

v.

DR. HING-HAR LO

and

MONTGOMERY RADIOLOGY ASSOCIATES,
INC.,

Defendants.

Law No.:

DEFENDANTS' MOTION TO AMEND THEIR
GROUND OF DEFENSE

Comes now the defendants, by counsel, and respectfully
move this Honorable Court for an Order granting them leave
to amend their Grounds of Defense to expressly assert the
following affirmative defense:

AFFIRMATIVE DEFENSE

These defendants affirmatively aver that plaintiff's
action is barred by the applicable statute of limitations.

FILED IN CLERK'S OFFICE
Circuit Court of Montgomery County
9th DAY OF October 19 92
AT 11:35 O'CLOCK A M
ALLAN C. BURKE, CLERK
Carol K. Brackley D.C.

HING-HAR LO, M.D. and
MONTGOMERY RADIOLOGY
ASSOCIATES, INC.

By John S. Brackley
Counsel

Robert S. Brewbaker, Jr.
VSB No. 18793
Rilee, Cantor & Russell, P.C.
P. O. Box 561
Richmond, Virginia 23204-0561
804/644-1400

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing Motion to Amend Grounds of Defense was mailed, postage prepaid, this 7th day of October, 1992, to:

Robert W. Mann, Esquire
G. Carter Greer, Esquire
Young, Haskins, Mann & Gregory, P.C.
P. O. Box 72
Martinsville, VA 24114-0072

Rob. S. Brewbaker

TWENTY-SEVENTH JUDICIAL CIRCUIT
OF VIRGINIA

KENNETH I. DEVORE, JUDGE
MONTGOMERY COUNTY COURTHOUSE
P. O. BOX 388
CHRISTIANSBURG, VIRGINIA 24073
(703) 382-2222

CIRCUIT COURT FOR THE COUNTIES OF:
BLAND, CARROLL, FLOYD, GILES,
GRAYSON, MONTGOMERY, PULASKI AND WYTHE
CIRCUIT COURT FOR THE CITIES OF:
GALAX AND RADFORD

COMMONWEALTH OF VIRGINIA

November 12, 1993

Mr. Brewster S. Rawls
Russell, Cantor, Arkema & Edmonds
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Richmond, Virginia 23204-0561

Mr. Robert W. Mann
Young, Haskins, Mann & Gregory
A Professional Corporation
400 Starling Avenue
P. O. Box 72
Martinsville, Virginia 24114-0072

Re: James F. Burke, Executor of the Estate of Mary
Hutcheson Burke, Deceased
v.
Dr. Hing Har Lo
and
Montgomery Radiology Associates, Inc.

Gentlemen:

This matter is before the Court on the defendant's
Plea of the Statute of Limitations. The Court thanks each
of you for your very thorough Memoranda and your arguments
heard by the Court on November 4, 1993.

On September 1, 1988, defendant, Dr. Hing Har Lo,
read and interpreted a CT Scan of Mary Hutcheson Burke's
abdomen. At that time, her treating physicians suspected

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a liver problem. Dr. Lo's report included a broader evaluation among other organs and she noted that the pancreas was normal. Two years and seven months later, on April 24, 1991, Dr. Lo interpreted an ultrasound where she observed a cystic mass at the tail of the plaintiff's pancreas. A followup CT Scan five days later revealed a five centimeters cystic mass at the tail of the pancreas. As part of her interpretation of the second CT Scan, Dr. Lo reviewed the earlier scan and saw a three centimeter lesion in the pancreas with a similar appearance. In her report on the second scan, she clearly noted the existence of the cyst in the first scan and its subsequent change in size.

Initially, Mrs. Burke's physicians thought that the lesion was benign and surgery was not performed until almost six weeks after the second CT Scan. The lesion was found to be malignant. Mrs. Burke died on November 8, 1991, as a result of the metastasis from her pancreatic cancer. Notice of claim for Mrs. Burke's wrongful death action was given on February 19, 1992. Her Motion for Judgment was filed on June 24, 1992. The defendants filed a Plea of the Statute of Limitations.

Virginia Code Section 8.01-143 A is as follows:

"Unless otherwise provided in this section or by other statute, every action for personal injuries, whatever the theory of recovery, and every action for damages resulting from fraud, shall be brought within two years after the cause of action accrues."

It is fundamental that a Trial Court may enter summary judgment only if no material fact is genuinely in dispute and only if it clearly appears that the defendants are entitled to judgment based on the pleadings and the parties' admissions.

The defendant argues that the plaintiff's injury accrued on or about a few weeks after September 1, 1988, and rely very heavily on the plaintiff's expert. The expert states if Dr. Lo had properly read the scan, the lesion would have been closely watched for 30/45 days or immediately removed by an aggressive doctor. The plaintiff argues that Dr. Lo was negligent on September 1, 1988, when she misread the CT Scan and reported that the decedent's pancreas was normal. The defendant concedes that the three centimeter lesion was not malignant on September 1, 1988. The defendant contends that the statute of limitations barred any claims because it was not brought within two years of the date of neglect. However, the plaintiff argues that the

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CT Scan was lodged within the sole custody and province of the defendants until April 24, 1991, at which time the existence of lesion in the first CT Scan was found and made known to the plaintiff's decedent.

Virginia Code Section 8.01-243 2 is as follows:

"In cases in which fraud, concealment or intentional misrepresentation prevented discovery of the injury within the two-year period, for one year from the date the injury is discovered or, by the exercise of due diligence, reasonably should have been discovered."

This Court is of the opinion that there are material facts genuinely in dispute and that the motion should be overruled. A cause of action does not accrue when there is neglect. It accrues when the neglect causes an injury. An appropriate notice of claim was given on February 19, 1992, and well within two years of the date when the lesion became cancerous and thereby caused any injury. The injury of which the plaintiff complains is that the defendants' neglect allowed a benign lesion to become cancerous, thus causing her untimely death. There was no injury, and, therefore, no cause of action until such time as the benign lesion became cancerous. The plaintiff argues that the plaintiff's evidence is expected to be that this type of cancer, when it becomes malignant, grows very fast and that it is most likely that the injury occurred, or cancerous state occurred, in very close proximity to when the lesion was disclosed in April, 1991. The burden is on the defendant who makes the plea to prove when the lesion becomes cancerous and that such time was prior to the two year period proceeding the death of the plaintiff's decedent. This would have to be made, if it can be made, by medical evidence.

The Court feels that this case is governed by the recent case of Renner v. Stafford, an opinion by Justice A. Christian Compton on April 16, 1993, 245 VA at 352.

Section 8.01-243 of the Code of Virginia was amended by the General Assembly and they added Subsection C which provides that the two year statute of limitations period prescribed in Subsection A shall be extended in actions for malpractice "In cases in which fraud, concealment or intentional representation prevented discovery of the injury within the two-year period, for one year from the date the

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injury is discovered or, by the exercise of due diligence, reasonably should have been discovered." This language of Subsection C clearly tolls the statute of limitations if fraud is involved whether intentionally or unintentionally. The Court says unintentionally because the General Assembly had it intended that only actual fraud would suffice to toll the statute of limitations, then it would only have had to have mentioned intentional misrepresentation in Subsection C.

The Court is a great believer that every person is entitled to their day in Court and would, therefore, overrule the motion. You gentlemen get together on a sketch of an order, saving exceptions.

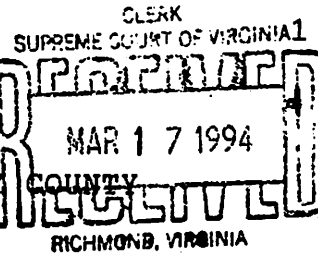
Very truly yours,


Kenneth I. Devore

KID:lhc
cc: Mr. Allan C. Burke, Clerk

CAVALIER REPORTING

940416



V I R G I N I A:

IN THE CIRCUIT COURT OF MONTGOMERY COUNTY

JAMES F. BURKE, Executor of the
Estate of MARY HUTCHESON
BURKE, deceased,

Plaintiff,

-vs-

DR. HING-HAR LO and
MONTGOMERY RADIOLOGY
ASSOCIATES, INC.,

Defendants.

CASE NO. V-7791

FILED IN CLERK'S OFFICE

Circuit Court of Montgomery County

104th DAY OF February 1994
AT 10:00 O'CLOCK A.M.

ALLAN C. BURKE, CLERK

Henry F. [Signature] D.C.

PROCEEDINGS BEFORE:

THE HONORABLE KENNETH I. DEVORE

DECEMBER 6, 1993

CHRISTIANSBURG, VIRGINIA

9:00 A.M. - 5:00 P.M.

C A V A L I E R

R E P O R T I N G

CORPORATE HEADQUARTERES:

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TOLL FREE:

1-800-972-1993

REPORTED BY: JANELLE A. MUNDY

10



1 Doctor Hall, because that is their proof. That is
2 their only proof of the claim that Doctor Lo did
3 cause the death of Mr. Burke's wife. That is it.

4 Now, ladies and gentlemen, as I said at the
5 start, I'm not going to stand up here and deny
6 the grief of this family. It is real. It may
7 affect you very much. It may even affect some of
8 the parties here at trial. But please, ladies
9 and gentlemen, pay careful attention to the
10 medical facts in this case. Pay careful attention
11 to exactly what they are claiming caused the
12 harm here. I feel confident that after you have
13 considered the testimony that you will hear, that
14 you will find that they have not made a case to
15 show that Doctor Lo's error was the cause of
16 Mrs. Burke's death.

17 I trust that you will be fair, and I thank you
18 for your time.

19 THE COURT: There is a stipulation among the
20 parties. If you will listen to this and along with
21 the other evidence that you will hear in this
22 matter.

23 MR. MANN: Thank you, Your Honor.

24 Ladies and gentlemen, there is a stipulation
25 or an agreement, meaning that the following facts

1 are not contested. You can assume these as proven
2 facts in the case.

3 On September 1, 1988, Mary Hutcheson Burke
4 underwent a CT scan at Montgomery Regional Hospital.
5 The scan was ordered by her personal physician,
6 Ray Dyer, M.D. Doctor Dyer ordered the CT scan
7 because he suspected a hemangioma on Ms. Burke's
8 liver. A hemangioma is a benign tumor.

9 Hing-Har Lo, M.D., a radiologist and employee
10 of Montgomery Radiology Associates, Inc., read the
11 CT film on the same day. In this capacity she was
12 acting as the agent of her employer.

13 In her written report, Doctor Lo found and
14 reported a cyst on the left lobe of Ms. Burke's liver
15 measuring approximately two centimeters in diameter
16 (slightly less than one inch). Doctor Lo also
17 reported that Ms. Burke's kidneys, pancreas, and
18 retroperitoneal area were within normal limits.
19 However, the pancreas was not within normal limits
20 as it contained a three centimeter cyst.

21 On April 24, 1991, Ms. Burke underwent an
22 ultrasound of her gallbladder. This study was
23 ordered by Doctor dyer because of Ms. Burke's
24 gastrointestinal problems. Doctor Lo performed
25 the study herself. In her report, Doctor Lo

1 described a cyst on Ms. Burke's pancreas. In
2 comparing the ultrasound with the 1988 CT,
3 Doctor Lo found that the 1988 study showed a
4 smaller cyst in the same place on Ms. Burke's
5 pancreas.

6 In her April 24, 1991, written report,
7 Doctor Lo recommended another CT study. Doctor Dyer
8 concurred and another CT was done on April 29,
9 1991. Doctor Lo read this study as well. The study
10 showed that the pancreatic cyst has grown from
11 three centimeters to five centimeters between
12 1988 and 1991.

13 Doctor Lo admits that on September 1, 1988,
14 she inadvertently failed to report to the
15 attending physician, Doctor Dyer, the existence of
16 the three centimeter pancreatic cyst. She also
17 admits that her failure to report was a breach of
18 the standard of care for radiologists practicing in
19 the Commonwealth of Virginia and was therefore
20 negligent. The standard of care required that the
21 cyst be reported to the attending physician.

22 Except with regard to the September 1, 1988,
23 CT scan, the parties agree that on all other
24 occasions pertaining to Ms. Burke when studies were
25 performed and/or films read, the conduct of

1 Doctor Lo and/or other employees of Montgomery
2 Radiology Associates, Inc., was within the standard
3 of care for radiologists practicing in the
4 Commonwealth of Virginia.

5 Your Honor, maybe we should have this marked
6 for identification.

7 THE COURT: All right, sir.
8 (Plaintiff's Exhibit 1; marked for identification.)

9 MR. MANN: Your Honor, could we have about
10 five minutes recess to get set up for the
11 next witness. It will require some props and
12 all.

13 THE COURT: All right, the Jury may be
14 excused.

15 (Recess)

16 MR. MANN: Your Honor, please, we call
17 Dr. William B. Hall to the Stand.

1 WILLIAM B. HALL, M.D.

2 was duly sworn and testified as follows:

3 DIRECT EXAMINATION

4 BY MR. MANN:

5 Q Doctor Hall, would you please tell the
6 ladies and gentlemen and His Honor on the Bench your
7 full name and your address and your occupation.

8 A My name is William Bruce Hall, Jr., M.D.
9 I live in Critz, Virginia. That's Route 1,
10 Post Office Box 155 in Patrick County. And, my
11 occupation is that I am a retired surgeon, consulting
12 in the medical field of quality surgeons for the
13 Joint Commission on Hospital and Accreditation. And,
14 that covers about 6,400 hospitals here in the United
15 States. And, also, I have my own personal consulting
16 business out of Critz..

17 Q Would you just trace for us briefly your
18 educational experience, commencing with medical studies.

19 A After I graduated from Randolph Macon, I went
20 to the Medical College of Virginia and attended four
21 years of medical school there. And then, following
22 that, I went to Akron, Ohio, and spent five years
23 specializing in general and thoracic surgery. And, then
24 following that, I entered private practice in
25 North Carolina and spent 25 years doing primarily

1 general and pediatric and thoracic surgery.

2 Then in 1981, I became disabled due to a
3 polio condition which changed my career. And, because
4 I was paralyzed in the lower extremities, I could not
5 stand up in the operating room. I became a
6 consultant, at that time, with the Joint Commission.
7 And then I have been with the Joint Commission since
8 that time, up until the present time.

9 As a part-time faculty member of the Joint
10 Commission because I teach other surveyors, and I also
11 am a consultant on the quality of care. The degree
12 in which care is being provided patients across the
13 country. And, I have also served as an individual
14 consultant for a hospital on how to prepare for a
15 survey to be accredited by the Joint Commission.

16 Q What exactly is the Joint Commission?

17 A Well, the Joint Commission is an organization
18 made up of all specialties of medicine today.
19 Primarily we start with the American College of
20 Surgeons, and that is a voluntary organization. It's
21 not a federal government-organized service. But it's
22 a volunteer organization that accredits hospitals
23 for the degree of quality provided patients in all
24 areas of medicine.

25 Q And since your retirement as a surgeon, have

16

1 you also in any capacity continued to see patients,
2 and, if so, how and when?

3 A Well, yes. In two capacities as a member of the
4 Joint Commission, naturally I see patients in practically
5 every hospital that I go to. Especially I do see the
6 medical records, and I do see some patients.

7 In addition to that, I have some activities that
8 allow me to see patients in Tulsa, Oklahoma, which I had
9 three years of hospital appointments in Oklahoma prior to
10 my sickness with the polio virus.

11 Q Have you taught in medical schools as well
12 as practiced medicine and surgery?

13 A Yes, I was a member of the Duke University
14 faculty up until 1979, and all of these surgical
15 students at the Duke University Medical Center had to
16 rotate through my service, during this curriculum
17 in the United States.

18 Then, in 1979 from that particular period on,
19 I taught at the Oral Roberts University School of
20 Medicine in Tulsa, Oklahoma. And there I taught not
21 all the medical students, but also taught residents in
22 the field of surgery.

23 Q Now, are you Board-certified or were you
24 Board-certified in any specialty. And, if so, what?

25 A Yes, I am Board-certified in general surgery.

1 Q What is the significance of Board-certified
2 in general surgery?

3 A Board-certification means that you have reached
4 a benchmark of competency. Competency meaning whether you
5 are knowledgeable in the field of general surgery and
6 can perform and operate and take care of a disease process
7 a patient may have within that specialty with a
8 degree of competency that is acceptable throughout these
9 United States.

10 Q Now, do medical students and doctors before they
11 become certified in a specialty, do they also study such
12 things as oncology and pathology?

13 A Yes. Before surgeons become certified in that
14 particular specialty, they have to go through all of
15 the subspecialties; radiology and neurosurgery and
16 orthopedic and urology and some internal medicine, yes.

17 Q Is this a current copy of your Curriculum
18 Vitae?

19 A Yes.

20 MR. MANN: Your Honor, please, we would like
21 this marked as Plaintiff's Exhibit Number 2
22 for identification.

23 THE COURT: I assume there is no
24 objection?

25 MR. RAWLS: No objection. Not for

1 identification, Your Honor.

2 (Plaintiff's Exhibit 2; marked for identification.)

3 BY MR. MANN:

4 Q How many years did you actually practice
5 surgery?

6 A Approximately 25 years.

7 Q In your capacity as a surgeon, did you have
8 any opportunities to examine pancreatic lesions and
9 determine whether or not they should be removed or
10 what mode of treatment should be given to pancreatic
11 lesions?

12 A Yes, it was a part of my practice of
13 general surgery.

14 Q Can you give us any idea as to how frequent
15 that type of occurrence comes up?

16 A Well, no, because even though I did -- I did
17 keep a record all those years of how many operations I
18 performed a year. Basically it was about equivalent to
19 1,000 operations a year. So, I did about 25,000
20 operations in the hospital.

21 I'm not speaking now of minor surgical procedures
22 which I would do in the ER room or in my own office
23 clinic. But out of the 25,000, I did not keep a list of
24 the pancreatic lesions I operated on because it is
25 an infrequent operation.

1 Q Since your retirement as a surgeon and in
2 your capacity with the Joint Commission and in consulting
3 in clinical work that you have been doing, have you
4 kept abreast of the field of surgery? And particularly
5 abreast of the field of surgery as it relates to
6 pancreatic lesions?

7 A I have maintained my status as far as
8 continued medical education. I belong to the Physicians
9 Recognition Award which is given by the AMA on a
10 three-year basis. If you reach a certain amount of
11 continued education to keep abreast.

12 I have attended the various surgical society
13 meetings, here in Virginia.

14 I am still a member of the Virginia Surgical
15 Society, and I attend that on an annual basis. And,
16 I have attended other surgical meetings, such as the
17 Southern Medical Association as part of my continued
18 education. Plus, the fact that since I have to review
19 hospitals and have done so now in some 37 states. A
20 large portion of that is a reviewing of surgical medical
21 records.

22 So, I have to keep abreast because of that,
23 also.

24 Q Do you review those records with respect to
25 determining mortality and morbidity and causes thereof?

1 A That is the primary reason that I review
2 medical records in hospitals is to determine the cause
3 of death; what is the cause of death primarily, and
4 I use basically a four, five criteria to determine.
5 And, when looking at the medical records, why the
6 patient died and those criteria is to just see if the
7 diagnosis was missed or was there an error in judgment
8 by a physician who operated on the patient. Was there
9 a complication that could occur as a result of the use
10 of blood or of the use of medications or the actual
11 complication as a result of inappropriate surgery.

12 MR. MANN: Your Honor, I move Doctor Hall
13 as a qualified medical expert.

14 MR. RAWLS: Might I voir dire him briefly.

15
16
17
18 EXAMINATION

19 BY MR. RAWLS:

20 Q Doctor Hall, let me make sure, you have not
21 practiced surgery since 1981?

22 A That is correct, sir.

23 Q And your actual hands-on medical practice
24 involved in the diagnosis and treatment of patients
25 since that time has been limited, I believe, you' 21

1 mentioned three or four weeks a year in Tulsa practicing
2 with a Doctor Richter out of there, is that correct?

3 A Not exactly. That is not exactly correct.
4 Because I would say, on an average, I will see two or
5 three or four consultations a month in Patrick County,
6 which I refer to the University of Virginia to follow up
7 or Duke University Medical Center. So, out of the
8 Patrick County, because of my reputation, I still see
9 consultations.

10 Q You don't have an office in Patrick County for
11 seeing patients, do you?

12 A No.

13 Q Are these mostly friends and acquaintances of
14 yours?

15 A They happen to be acquaintances, and a lot of
16 them are friends.

17 Q But you have not practiced surgery since 1981,
18 is that correct?

19 A That is true.

20 Q You have never practiced oncology or pathology?

21 A That is not my specialty.

22 Q Your training on that was in medical school?

23 A No, my training on that was in the residency
24 program. But that is not my specialty.

25 Q And your training on that in the residency

1 was back after you graduated from college, was that
2 1954?

3 A 1954 through 1959.

4 Q So that was 34 years ago, is that
5 correct?

6 A That is true.

7 MR. RAWLS: Your Honor, at this point I would
8 object to the qualifications of Doctor Hall to
9 testify with regard to the areas of surgery.
10 To testify with regard to oncology or pathology.
11 I think he has plainly admitted that he is not
12 qualified and has not practiced in that since over
13 seven years before the time in question here.

14 THE COURT: Mr. Mann?

15 MR. MANN: If Your Honor please, I think that
16 the Record and the testimony of the doctor speaks
17 for itself. He is being intended as a causation
18 witness.

19 He is qualified as an expert by anyone
20 who has been to medical school, at least someone
21 who has been to medical school and practiced surgery
22 and then spent the time he practiced surgery
23 going around with the Joint Commission to determine
24 the cause of death.

25 THE COURT: Your objection is overruled.

DIRECT EXAMINATION CONTINUED

BY MR. MANN:

Q Doctor Hall, before getting into your testimony, perhaps it would be helpful to define some terms so the Jury would, and myself would be better able to follow some of your testimony.

Tell us first of all exactly what is the pancreas. Where is it located? And what is its function?

A The pancreas is a glandular organ in the stomach. It lies just below the stomach, and also to the right of the left kidney and spleen and to the left of the right kidney.

It is kind of behind the liver. It is an elongated glandular organ. Many of you who have had a chance of killing hogs and that sort of thing, we used to call the pancreas the sweetbread. But the pancreas has two dual functions. One, the pancreas secretes a liquid substance for the purpose of digestion, and that can vary from just a few ounces to as much as five or six thousand CCs in a period of a day. So that's one function of the pancreas.

The other function of the pancreas is to produce insulin so that insulin can help us burn the glucose that we eat and maintain a level of body functions

1 that support our life.

2 So, in a simplistic way, we have an organ that
3 not only secretes juices out of a little duct into the
4 first portion of the small intestine just after it leaves
5 the stomach, but we also have an organ producing a
6 hormone that goes right into the body stream based upon
7 our needs. Based upon our needs of insulin to support
8 how much sugar or carbohydrate we eat.

9 Q Could you define for the Court and myself
10 and the ladies and gentlemen, what physicians refer to
11 when they refer to a cyst?

12 A Well, the cyst is nothing more than a sac. It's
13 usually filled with some type of fluid. And a cyst
14 means a sac, like an envelope and the cyst can vary
15 with various sizes, depending upon how much pressure
16 or how much fluid is inside that sac.

17 Q What is a benign cyst?

18 A Well, basically the word cyst, itself, denotes
19 that it is benign. It means that there are no cells
20 within that cyst that are cancerous.

21 Q Are there more than one type of benign cyst?

22 A Yes, there are multiple types of benign cysts.
23 And the most common types that you see in the pancreas
24 are those cysts that are filled with mucin, which is kind
25 of a thick saliva-like juice. It is very rich in .

1 nitrogen. And then the other type of cyst which is not
2 as quite as common is the serous cyst, which is kind of
3 a clear to yellow fluid cyst.

4 And, then there are other retention cysts in
5 the pancreas. There are congenital cysts --

6 Q What is a cystadenoma?

7 A Well, the cystadenoma primarily is an
8 adenoma, which is a benign tumor in the presence of a
9 cyst. So, the two occupy the same space.

10 Q So a cystadenoma is benign?

11 A Yes, sir.

12 Q Now, what is a pseudocyst?

13 A A pseudocyst means primarily that it has the
14 characteristics of a cyst, but is not a true cyst. A
15 true cyst has an epithelial lining that encloses the
16 contents of the cyst, which is very strong and built up
17 by the nature to wall off the contents of the cyst.

18 Whereas the pseudocyst is usually common as
19 a result of a trauma or a possible diabetes. And these
20 pseudocysts do not have an epithelial or a true-like
21 that covers them. And, usually, as a result most often
22 of trauma and quite frequently are filled with blood.

23 Q But it, too, is benign?

24 A Yes.

25 Q Is it common to have pseudocysts and

1 cystadenoma about the pancreas?

2 A No, it is not common to have a cyst of the
3 pancreas. But a pseudocyst probably is more common to
4 the average general surgeon than the other cyst.

5 Q All right, sir, what is a cancer or malignancy?

6 A Well, the cancer word itself, as you probably
7 know, is from the word crab, which means it is a claw-like
8 growth that has the ability to encompass and to actually
9 freeze whatever tissue it comes in contact with. It
10 means that the cells of that particular cancerous growth
11 are becoming abnormal, and they may resemble a little
12 of the parent origin from which they came. Which the
13 cancer, itself, cells have grown so rapidly and become
14 so wild in their pattern of growth that they are able
15 to do like the crab does. Come in and take over and
16 destroy the function of the normal cell.

17 Q Do you make the distinction in discussing things
18 between cancer and malignancy?

19 A No, the terms are synonymous.

20 Q But what is metastasis?

21 A Well, metastasis means that primarily the
22 cancer has, itself, has spread beyond its local
23 habitat. It started out, whether it would be a skin
24 cancer or pancreatic cancer, it started out looking a lot
25 like the skin or the pancreas, or whatever the cancer

1 started from. And then it begins as it grows, it gets so
2 out of line with your body functions that it begins to
3 spread and it can spread in many different ways.

4 Once it spreads beyond the normal confines of
5 the organ, itself, or the original tumor, itself, then it's
6 considered a metastasis.

7 Q Can you just break down, perhaps not all, but
8 maybe the two or three most common mechanisms or areas in
9 which a cancer might normally be expected to metastasize?

10 A Well, it's always some cancers are very prone to
11 metastasize. By the blood immediately they gain entrance
12 into the bloodstream and then it's carried throughout the
13 body from the top of one's head to the bottom of the feet.

14 Every cellular structure is engrossed with the
15 cancer, and then others are much slower because they only
16 spread by direct extension. That means if they come
17 close to the colon, then the cancer will spread to the
18 colon that is from the pancreas.

19 Another common way that cancer spreads is through
20 the lymphatic and the lymphatic system, and the body
21 system is a very dense network and the cells get into
22 there and then carry to the lymph nodes. The kernels
23 that you might say that you frequently see in our neck.

24 Then, another way they can spread is along the
25 nerves. The nerves that are adjacent to an organ, the

1 cancer is spread along those nerves what is called a
2 barrier around the nerve involvement and they transmit
3 those cancer cells along the nerve structure.

4 Q So you can have a cancer that would be
5 restricted to one location or you can have a cancer which
6 is metastasized in some other area of the body?

7 A That is correct.

8 Q What, and perhaps you did define this, but before
9 we start talking specifically about Mrs. Burke's situation,
10 what is your definition of the so-called perineurial area?

11 A Well, the perineurial area means that there is a
12 rich nerve network. Just almost like a nerve center for a
13 telephone for an entire city behind the pancreas. And,
14 in that nerve center, the cancer can spread along those
15 nerves and become perineurial, meaning, around the
16 nerve involved.

17 Q All right, Doctor, at my request, have you
18 reviewed the medical records pertaining to Mrs. Burke
19 and, in particular, have you reviewed Doctor Lo's
20 records, Doctor Asrani's records, some records from the
21 Montgomery Regional Hospital, records from Doctor Davidson,
22 pathology reports from Mrs. Burke, records of
23 Doctor Redkin and Doctor Dyer's office records? Have you
24 reviewed those records with a view toward determining
25 the cause of Mrs. Burke's death?

1 A Yes, I have.

2 Q Now, Your Honor, please, may I have Exhibit 1.
3 I believe it is for identification.

4 Rather than reading this again, Doctor, prior
5 to your coming to Court today, this document that I have
6 in my hands marked Deposition Exhibit Number 1
7 for identification has been read to the Court and to the
8 Jury. And, you may consider the facts in this
9 document to be facts. You may consider them to be things
10 that are not disputed and things that are proven in this
11 case.

12 So as a practical matter for your testimony,
13 I would ask you to read this to yourself.

14 Doctor, are the type of records which you have
15 reviewed in this case, are they the type of medical
16 records which ordinarily and customarily were reviewed by
17 you as a surgeon and now are ordinarily and customarily
18 reviewed by you as a treating doctor? And also the type
19 of records which are ordinarily and customarily reviewed
20 and studied by you in your work with the Joint Commission
21 on determining mortality and morbidity?

22 A They are.

23 Q What I would like you to do first is to explain
24 to us generally the mechanism of Mrs. Burke's death.
25 In other words, the mechanism, physiology, whatever that

1 was taking place within her body that actually caused
2 her death.

3 Can you do that, and in so doing, would these
4 models -- you have seen these before, I believe?

5 A Yes.

6 Q Would this model here be of help to you in
7 giving that explanation to the Court and to the Jury?

8 A Well, I think it would probably make the
9 discussion more real and imagine so that one could
10 understand the terminology and how the process of the
11 cancer caused Mrs. Burke's death. Yes, I do.

12 Q All right, sir. Can the ladies and
13 gentlemen see this? Would you just come up here then,
14 Doctor, and make that explanation using whatever might
15 be of help to you.

16 A This represents a model that we basically use
17 in, not only in medical school, but certainly in the
18 nurses' classes today to teach the anatomy. And, this
19 particular specimen is not a full size as you can
20 recognize. And, what we have done, what the artist has
21 done here is to show the muscles overlying the chest
22 and abdomen. If you will allow me to take that off
23 briefly as we would much like you would during an
24 operation, then what we have left here, of course, is
25 the patient's right lung and left lung and heart, as

1 seen in the chest.

2 And, then just below the diaphragm which has been
3 cut away here to allow you to see a right lobe of the
4 liver and a left lobe of the liver. Then we have in
5 addition here a small cutaway to show the inside of the
6 stomach and showing the stomach, how it fits underneath
7 the liver.

8 And, then as we look further down, you can see
9 the colon, the transverse colon lying underneath the
10 colon and then this represents the small intestines. The
11 colon is the large intestine. And, as you can see here,
12 it's much larger, almost three times as large as the
13 small intestine. There are four feet of colon.

14 Q You are talking about the bowel?

15 A Yes, and it runs all the way down here and all
16 the way up to the liver. Across the liver to the spleen,
17 and then down to the left side of the body and ends up in
18 the rectum. This is what source the food takes after it
19 has been digested.

20 The small intestine, in contrast, is about
21 20 feet in length, and it has -- its sole purpose is
22 absorbing food and water, chemicals of all nature into
23 the system to help us digest and burn our food so that
24 we can live.

25 Now, overlying this whole thing, cut away here,

1 is this yellow portion, which is what we call the
2 good Samaritan. If you go back to the biblical terms
3 that this represents the good Samaritan, because this
4 whole envelope of tissue, and it is cut away here just
5 so that you can see how this is done, but it's cut
6 away here. But basically, the reason we call it the
7 good Samaritan is because it protects us from injury and
8 infection because it's like a blanket. It covers the
9 vital organs.

10 Now, behind that transverse colon, and in
11 this particular space here is where I will further
12 show you is how the pancreas is situated. So, what we
13 will do is just basically remove the liver from the
14 patient, and then you can see the way that the stomach
15 is situated. Here it is coming down the esophagus. Comes
16 down here and feeds the stomach, and then goes down into
17 what we call the first portion of the small intestine,
18 which is the duodenum. That's about four inches from
19 here to there. This is about four inches of small bowel,
20 which is the area on most of us sometimes when we have an
21 ulcer we can relate.

22 So, if we can take away then this stomach and
23 you can immediately say as we have taken away from the
24 stomach, you can immediately say that the patient has a
25 right kidney here and a spleen on the opposite side where

1 the kidney is somewhat hidden behind it.

2 Now, right across then of the mid portion of
3 that abdomen, and if you are looking at the --

4 Q You mean the belly button?

5 A Yes. You can almost see the pancreas here as it
6 really fits into this nice group formed by the first portion
7 of the small intestines, as I labeled the duodenum.

8 But, you can see then the body of the pancreas
9 and a small portion of the tail of the pancreas that has
10 been removed in order to give you visibility of the spleen.

11 Q Now, before you leave that point, just to make
12 sure we understand exactly which of those organs is
13 the pancreas.

14 A It is the white organ here that fits into this
15 little nest, as you can see. Here is the duodenum, and
16 here on the distal end and the far end is the pancreas.
17 It is between here and it goes all the way across the
18 right side of the abdomen here, over to the left side of
19 the abdomen.

20 Q And do I further understand you to say that in
21 that body they cut off part of it so you can see?

22 A Yes, so you can really better look at this.
23 If I remove the colon now and the small intestine, and
24 now we have a better look at this, because we see in
25 relationship to the backbone here is the blood vessels

1 and nerves supplying the right leg and blood vessels
2 and nerves supplying the left leg. And here is the
3 pancreas, then, along directly over the spine.

4 The spine is just behind these major blood
5 vessels. Blue represents the veins, of course. The
6 red represents the arteries. And, the white represents
7 the little nerves that supply the body. And these
8 little green things represent lymph nodes and lymphatics.

9 Q Doctor, before we do that, and again I apologize
10 for interrupting you, but essentially a segment of that
11 pancreas is cut off. Could you perhaps look at this and
12 explain here what that is?

13 A This is a far better representation of what
14 the pancreas looks like because of the drawing and the
15 coloring. The yellow being the pancreas showing the
16 duct here that goes through the pancreas to drain into
17 the intestines, and showing the relationship here.

18 As I mentioned, this whole thing goes
19 around to the stomach and represents the four
20 inches or so which is called the duodenum,
21 and that represents the head of the pancreas.
22 This represents what we call the body of the pancreas.
23 And this represents what we call the tail of the
24 pancreas.

25 Q Now, I believe you indicated, and it's pretty

35

1 obvious without your saying so, but this is slightly
2 smaller than the body?

3 A Yes.

4 Q I take it that the things in there are pretty
5 much to scale?

6 A Yes, the best you can do for demonstration
7 purposes, yes.

8 Q And how would this drawing compare as far as
9 the size of the actual pancreas is concerned?

10 A This pretty much represents the size of the
11 pancreas. I think that the artist may have made it
12 just a little more prominent in this dimension here
13 than you would see in actual life of the patient.

14 Q But for all practical purposes, that's about
15 the length of it?

16 A Yes.

17 Q And about what it looks like?

18 A Yes.

19 Q All right, sir. Now, I'll let you go ahead
20 and explain what happened to her that shut her system
21 down. And I will try not to interrupt you again.

22 A Well, the cancer which involved both the
23 body and tail of the pancreas at the time when she was
24 operated on looked like it was confined to the pancreas.
25 When, in actuality, what caused Mrs. Burke's death was

1 that the tumor was not confined to the pancreas, but
2 had also involved this portion of the intestine, which
3 sat like that. As you recall, which involved and
4 blocked the intestine here.

5 It also blocked the small bowel intestine as
6 it fed the colon, so the cancer had spread to the colon.
7 Had spread to the intestine, and it had spread also to
8 the nerves.

9 As we take away the pancreas, you can see
10 very readily here that this is a very rich -- and this is
11 just an artist's conception, because there are far greater
12 in number. These little white connecting lines represent
13 the nervous system. It's far greater in number than we
14 have here, but as a cancer fixed itself against the
15 nerves and grew up and down, it -- it grew into the blood
16 vessels, but it also grew into the intestine causing
17 blockage. And, because of the nerve structure, as I said
18 earlier, it's almost like cutting a wire on a telephone
19 because no more signals can transpire through that nerve
20 once the cancer has taken over the body of the nerves.

21 So, we have done several things to the patient.
22 We have prevented the absorption of any food and liquids
23 and any nutrients from this 20 feet of small intestines,
24 as I just mentioned to you earlier. We prevented that
25 from getting back into the patient's system because of

1 the blockage of the center. Because of the extension,
2 we have actually had some decrease in return of the
3 blood supply. We have these vessels back to the system,
4 which were causing a blockage from the cancer. And,
5 thirdly, because of the cancer involving the intestinal
6 tract, even though she had some surgery for that, the
7 cancer had blocked already two portions of the
8 intestinal tract as a result of its direct extension of
9 that. So, the cancer had not only had direct extension
10 into tissues that were vital to live, but the cancer
11 spread along this area of the space that is protected
12 and very limited.

13 This is a very limited space that the pancreas
14 is in, and things cannot grow either up or down because
15 there is no place for it to grow without causing danger
16 to another organ. So, as a result, we had direct
17 extension into the adjacent structures. And also
18 direct extension into the liver. Direct extension into
19 the liver, which overlies that.

20 So, it was in every vital organ that that patient
21 had at the time of the second surgery. Plus, the fact
22 that we had direct extension preventing the flow of blood
23 and nutrients from the intestines back into the system.
24 So, we had a shutdown. A total collapse of the organs.

25 Q So the cancer shut her system down, and that's

1 what caused her death?

2 A Yes.

3 Q All right, you may resume your seat.

4 Now, as you have indicated, in addition to the
5 medical records that you reviewed, the evidence which has
6 been stipulated into Court in which I previously read
7 to the ladies and gentlemen and to the Judge, and the
8 document which I asked you to read to yourself, we know
9 from that document that in September of 1988 that there
10 was a three centimeter cyst on Mrs. Burke's pancreas,
11 which was not reported to her treating physician,
12 Doctor Dyer. In which it was negligence not to report
13 that the existence of that three centimeter cyst on the
14 pancreas to Doctor Dyer.

15 Now, at my request have you taken some clay
16 and attempted to fashion what a three centimeter cyst
17 would look like?

18 A Yes, I have.

19 Q Is this what you have done?

20 A Yes, it is.

21 Q So, as far as you can do with a piece of
22 clay, is that what a three centimeter cyst looks like?

23 A That represents three centimeters in size, both
24 if you looked at it from a longitudinal and horizontal
25 appearance. And it pretty much reflects the actual

1 appearance of a three centimeter cyst, yes.

2 Q Now, what portion generally, if you can show us
3 from the records, where would the cyst have been on this
4 lady's pancreas?

5 A This cyst is reported in the tail of the
6 pancreas, which is, and we are looking at here --
7 basically this is the vertebral column of the backbone.
8 In other words, as we would apply the anatomy to it,
9 it is to the left of the vertebrae.

10 Q Would it have been outside of the pancreas?

11 A It started on the inside, but naturally it
12 can't grow because the pancreas can't accommodate a
13 growth of that size inside. So, naturally it has to
14 expand to the outside.

15 Q Now, we also know from the document which
16 you read that by 1991, the spring of 1991, that that
17 had grown from approximately three centimeters to
18 approximately five centimeters. Did you, at my request,
19 fashion out of some yellow clay the approximate size
20 of the five centimeter cyst?

21 A Yes.

22 Q Is this what you have done for us?

23 A Yes, it is. It takes 2.5 centimeters to be
24 an inch, so this is a little more than two inches.

25 Q Now, taking into consideration the medical

1 records that you have reviewed, and the stipulation
2 which you read, do you have an opinion with a reasonable
3 degree of medical certainty as to whether or not
4 Mrs. Burke would be alive today if the three centimeter
5 cyst that was existing in September of 1988 had been
6 properly reported to her treating physician?

7 A Yes, in my opinion Mrs. Burke would have been
8 alive today.

9 Q Do you hold that opinion within a reasonable
10 degree of medical certainty?

11 A I do.

12 Q Would you explain to us the basis for your
13 opinion, please.

14 A Most of the pancreatic cysts that I have had
15 experience with, and not only in teaching, but in
16 doing the actual surgery, myself, have been cysts
17 that were found incidentally. Meaning that you really
18 didn't expect to find a cyst.

19 But, because of the work-up on the patient, you
20 uncovered a cyst. And, surgeons are taught around the
21 world, when you have a cyst, you take it out. If it's
22 a true cyst now -- if it's a pseudocyst of the pancreas,
23 there are other ways to handle it other than surgical
24 removal. So, as a result of it, the patients that are
25 alive today that I know of are the patients that had an

1 incidental finding, either at the time of surgery one
2 would feel around in the abdomen and most surgeons do,
3 and the hand would generally come across the pancreas
4 and there you would feel, you know, a cyst. A small
5 cyst like this and/or if you were x-raying a patient for
6 something else, and by chance did X-rays of the pancreas,
7 then the cyst would show up. So your best chance of
8 survival is, in my opinion, is based upon the fact that
9 these things have been found at an incidental study of
10 the patient to which turned up a cyst which may not
11 have been causing the patient's symptoms. But at least
12 prevented the cyst from later on developing into a
13 cancer.

14 Q When you say an incidental finding, we know
15 that Doctor Dyer ordered this work-up because he was
16 concerned about a benign tumor on the liver. And we
17 know the stipulation in which you had read that
18 Doctor Lo reported this lady's pancreas as normal when,
19 in fact, it was not normal. It contained a cyst this
20 size.

21 Would that be what you described as an
22 incidental finding?

23 A Yes, I would have -- I would consider that an
24 incidental finding.

25 Q From the medical records that you have reviewed,

1 where did the cancer that ultimately took this lady's life
2 come from?

3 A Well, there again I am having to review the
4 medical records and take the opinion of the pathologist
5 at Roanoke Memorial Hospital, but he said --

6 MR. RAWLS: Your Honor, I am going to
7 interpose an objection to the hearsay on this,
8 if he is going to quote out of there.
9

10 BY MR. MANN:

11 Q Well, based on the medical records, do you,
12 yourself, have an opinion as to where the cancer came
13 from that took this lady's life?

14 A Yes, I do.

15 Q What is that opinion?

16 A It came from the cystic structure that was
17 described in the X-rays.

18 Q So the five centimeter lesion that was
19 cancerous grew out of the three centimeter lesion?

20 A Yes.

21 Q Based on the medical records you reviewed
22 and your study of this case, do you have an opinion as
23 to whether the original three centimeter lesion that was
24 present in 1988 and not reported as to whether or not
25 it was cancerous?

1 A Would you rephrase that, please?

2 Q Based on the records that you have reviewed,
3 based on the stipulation in the records that you have
4 reviewed, do you have an opinion as to whether the
5 three centimeter cyst that was existing in September of
6 1988 and was not reported, do you have an opinion as to
7 whether it was benign or whether it was cancerous?

8 A In 1988, my personal opinion is that it was
9 benign.

10 Q And, of course, the five centimeter cyst that
11 was present in 1991, was it cancerous or was it benign?

12 A It was cancerous.

13 Q And not only was it cancerous, it spread?

14 A It had metastasized to the various organs,
15 yes.

16 Q Now, I'm going to ask you a hypothetical
17 question inasmuch as it was not reported. But, first
18 of all before I ask you the hypothetical question, in
19 your experience, not only as a surgeon but as a treating
20 physician, and in your experience with the Joint
21 Commission on the accreditation of hospitals, when a
22 treating physician orders an X-ray or a CAT scan study,
23 does he rely on what the radiologist reports to him?

24 A Yes, he must rely.

25 Q Does he have any duty or obligation to go 44

1 back and look at the X-rays themselves and to determine
2 what they see?

3 A He does not have credentials to read X-rays
4 by the hospital. So, he has no responsibility to go back,
5 other than naturally most of us will talk with the
6 radiologist as to what they found. And, not only do
7 we read the report, but we usually discuss it with him
8 personally. But, he has no obligation to read the
9 X-rays, because he is not credentialed to do so.

10 Q So, in short, he relies on what the radiologist
11 tells him?

12 A Yes.

13 Q If the radiologist says that the pancreas is
14 within normal limits, he is justified in assuming that
15 the pancreas is within normal limits?

16 A Absolutely.

17 Q Now, for the hypothetical question: If this
18 three centimeter benign cyst had been properly reported
19 September 1, 1988, what would be the expected mode of
20 treatment at that time? In other words, what would
21 the physicians have done? How would competent physicians
22 have handled the knowledge that a three centimeter
23 cyst existed on that lady's pancreas?

24 MR. RAWLS: Your Honor, I'm going to interpose
25 an objection here. First, the hypothetical assumes

1 facts that are not in evidence. Second of all,
2 what really is being asked here of this doctor
3 is speculation about what Ray Dyer would have done,
4 and that's exactly what the issue is here. And
5 he has been asked to speculate on that.

6 And, Your Honor, that's just plainly
7 inadmissible.

8 MR. MANN: I don't think there is any
9 speculation, either.

10 THE COURT: I think it's a proper question.
11 I overrule your objection.

12 THE WITNESS: The responsibility of any
13 physician, once told that the patient has a cyst,
14 is to get a consultant in who is knowledgeable on
15 making a diagnosis of that cyst.

16 So, Doctor Dyer could have called in a
17 surgeon or he could have called in a
18 gastroenterologist if there was one in this area.
19 Or, he could have called one in from the Roanoke
20 area.

21 BY MR. MANN:

22 Q In your capacity of a surgeon, were you
23 often called in to make such diagnoses?

24 A Very frequently.

25 Q And what would have been the acceptable mode

1 of treating, had the surgeon realized that this cyst
2 was there for diagnosing and treating it?

3 A Well, you know there are really basically,
4 I might say, two approaches that a surgeon could take
5 that has been told that the patient has a cyst.
6 Particularly pancreas. One could take the aggressive
7 approach and immediately say to the patient that this
8 is a cyst. It needs to come out, and leads to operating,
9 and the sooner the better.

10 The second approach would be to say that let's
11 be more conservative with the cyst. And let's do some
12 diagnostic work-ups, and get a needle biopsy, and plan
13 our procedure. And see if we can maybe come up with a
14 lesser procedure than maybe the surgery would require.

15 So, there would be the two possibilities and
16 both are accepted. In my opinion, in this country today
17 there is a very aggressive approach and a conservative
18 approach which will allow you to take a little more time
19 like four or five weeks in determining.

20 Q Suppose in four, five weeks the surgeon determines
21 that this was a pseudocyst, you have already told us what
22 a pseudocyst is. But maybe you ought to refresh our
23 recollection.

24 A As we talked about that earlier, a pseudocyst
25 is not a true cyst. It's a traumatic type of cyst, usually

1 filled with some serum that contains the enzymes of the
2 pancreas and blood and they do not become malignant. So,
3 you can drain those.

4 There are two ways of draining. One certainly
5 means going into the intestine, and the second way you
6 can drain externally with a catheter. So there are
7 methods to drain a cyst which is a pseudocyst that does
8 not require an operation.

9 Q Do we know from the pathology in this case
10 whether or not she had a pseudocyst?

11 A We know from the pathology that she did not
12 have a pseudocyst.

13 Q What did she have?

14 A She had a cystadenoma.

15 Q If the existence of a cystadenoma had been
16 known -- now, going back to the hypothetical question,
17 you have an aggressive-type surgeon who senses that he
18 would recommend an operation. He would go in and take
19 it out. Then, would you have one who would follow it
20 for a few weeks to determine whether or not it was a
21 cystadenoma or a pseudocyst. And, if it was a
22 pseudocyst, he would drain it.

23 What if he determined it was a cystadenoma,
24 what would he do?

25 A If it was a cystadenoma, then his

1 responsibility was to do a total removal of the cyst
2 from the pancreas.

3 Q Even though it's benign?

4 A Yes, because it's a very bad actor if left
5 in.

6 Q And how do you know that?

7 A Well, we know that from all of the teachings
8 that is in the literature from surgeons for the past
9 50 years. All the literature indicates if a benign cyst
10 is left in, they are potentially cancerous. And,
11 unfortunately we don't know when the benign cyst becomes
12 a malignancy.

13 Q Suppose the patient said, I know it's a
14 benign cyst in there, I know that I have got this
15 three centimeter lesion on my pancreas and you tell
16 me it's benign. But, I'm not keen on an operation. I
17 don't want you to take it out.

18 What does the doctor say to that patient
19 under those circumstances?

20 MR. RAWLS: I am going to object. That's
21 speculation.

22 THE COURT: Sustained.

23 BY MR. MANN:

24 Q Have you, yourself, been in that position?

25 A Yes, I have been in that position.

1 MR. RAWLS: I am going to object, Your
2 Honor.

3 THE COURT: Well, if he had been in that
4 position, I don't see anything wrong with it.

5 MR. RAWLS: His being in that position is of
6 no relevance in this, Your Honor.

7 MR. MANN: It's relevant to his experience
8 in how surgeons view the dangers of the cyst.

9 THE COURT: I can understand that objection.
10 Overruled.

11 THE WITNESS: The reason that one would have
12 to sit down with the patient and say simply that
13 here I have had experience, whether it's five years
14 or whether it's 35 years, in treating patients.
15 And some of those patients have had cysts of the
16 pancreas. And, I know this is a potential harm to
17 you and it's a bad actor.

18 So, therefore if you can't take my advice
19 and have this cyst removed, then you and I must
20 come to an understanding that you need another
21 doctor.

22 So, I would immediately recommend another
23 doctor. Another surgeon or have a letter sent to
24 the patient that I am no longer responsible for the
25 patient's care because the patient has not acted

1 in the best judgment of his or her health by not
2 following good clinical advice.

3 BY MR. MANN:

4 Q So if the patient followed the clinical advice,
5 that the benign lesion would have come out in 1988?

6 A Yes, sir.

7 Q And if the benign lesion would have come out
8 in 1988, could a cancerous lesion have grown out of it
9 to be present in 1991?

10 A Would you rephrase that, please.

11 Q Well, I guess the question is -- but for the
12 Record I just need to get it in: If the benign lesion
13 had been removed in September of 1988, could it have
14 caused this lady's cancer in 1991?

15 A No.

16 MR. RAWLS: Objection for lack of foundation,
17 Your Honor.

18 MR. MANN: We have been laying a foundation
19 ever since he started testifying.

20 THE COURT: I think so, too. Objection
21 overruled.

22 BY MR. MANN:

23 Q Doctor Hall, we have all heard, ever since we
24 could read and listen, the early detection of lesions
25 are important in cancer. How would you characterize the

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1 incidental finding that was available in September of
2 1988?

3 In other words, knowing that there was this
4 three centimeter benign cyst, and knowing that as an
5 incidental finding, how would you characterize that as
6 being early detection or middle detection or late or
7 what?

8 A Well, if you go back and look at the cyst that
9 we have here in clay, I would say that in my own personal
10 experience, that is about as early as I have ever seen
11 the detection of a pancreatic cyst done. And, because
12 of that, when you have been able to make the diagnosis
13 early, you expect an excellent result.

14 MR. MANN: That is all that I have.

15 MR. RAWLS: Your Honor, my Cross Examination
16 will probably be a while. I don't know if the
17 Court wants to take its lunch break now.

18 THE COURT: All right. We are going to go
19 to lunch. I ask that you be back at 1:45. You all
20 have a nice lunch and come back to the jury room.

21
22 (The luncheon recess was from 12:20 p.m. to 1:45 p.m.)
23
24
25

CROSS EXAMINATION

BY MR. RAWLS:

Q Doctor Hall, what I think you told us on your Voir Dire is that you had not practiced surgery since 1981, is that correct?

A That is correct.

Q And since that time your practice has been limited to, I think, you told us three or four weeks a year primary care work, plus a few referrals out of Henry County?

A Not of Henry County, but Patrick County and North Carolina.

Q And that's been the extent of your hands-on medical practice in the last twelve years in terms of treating patients, is that correct?

A Yes.

Q And the last position you actually held where you were a treating physician functioning as a surgeon is when you were on the faculty out at Oral Roberts out in Tulsa?

A No, it was on the staff at St. John's Medical Center in Tulsa.

Q You were there after you were at Oral Roberts?

A No, jointly.

Q It was part of the Oral Roberts Medical School?

1 A No, it's entirely separate.

2 Q But is that the same time you were doing that?

3 A Jointly, yes.

4 Q You haven't done that since 1981?

5 A Right.

6 Q The fact that your Curriculum Vitae, which
7 was marked for identification in this, if you read that
8 you would believe that you had ceased your hands-on
9 practice in 1981, is that correct? It makes no mention
10 of your work for Doctor Richter or your other practice?

11 A That is probably correct.

12 Q Now, Doctor, you mentioned that you are a
13 consultant or a surveyor for the Council Commission on
14 Accredited Hospitals, is that correct?

15 A Yes.

16 Q And basically you go back and look through a
17 sample of cases after they are going or after they have
18 gone to determine certain facts about it, isn't that
19 correct?

20 A That's probably ten percent correct.

21 Q What is it then, Doctor?

22 A Well, the other part is that I interviewed
23 doctors as to their mode of assessment of patient care
24 as to the standard of care they are practicing.

25 Q And you look for basically differences and

1 changes in it throughout the country?

2 A I look for complications in a particular,
3 hospital. Not throughout the country.

4 Q You look for trends?

5 A The hospital looks for trends, and I particularly
6 do not look for trends, no.

7 Q But you are part of the whole survey team,
8 which is a managing accrediting hospital?

9 A That is correct.

10 Q Now, your consulting practice is where you
11 sell your consulting services to a hospital in order to
12 prepare them to pass that inspection, if you will, is
13 that correct?

14 A Or to evaluate the progress, either one.

15 Q And I think you told us before that you had
16 an agreement with those hospitals, if they hired you as
17 a private consultant, you would not come back and
18 survey them for the Joint Commission, is that correct?

19 A That's true.

20 Q So that basically protects that hospital from,
21 if you will, you do private consulting for them in one
22 sense, if you will, Doctor?

23 A It doesn't protect them from me, but protects
24 them from the discovery of problems they have when the
25 Joint Commission does come back.

1 Q But you are not going to be the surveyor when
2 they do come back?

3 A No, I will not be.

4 Q You are not a pathologist?

5 A No.

6 Q You don't hold yourself out as one?

7 A Never have.

8 Q And, in this case, you have not actually reviewed
9 the pathologist slides pertaining to Mrs. Mary Burke?

10 A I have never had credentials to do that.

11 Q You are not a medical oncologist?

12 A That is correct.

13 Q Likewise, you are not a radiologist, are you,
14 Doctor?

15 A I don't think I have had any training along
16 those lines, no.

17 Q In that regard, you have not even read the
18 films with regard to Mrs. Burke?

19 A I have never had credentials to read films.
20 I read the reports.

21 Q You have not actually looked at the film
22 pertaining to Mrs. Burke?

23 A I have not.

24 Q You would rely on what the radiologist says?

25 A Yes.

1 Q You wouldn't look at the films, yourself?

2 A In my practice, it depends upon the quality of
3 the radiologist as to whether I would look at the films
4 or not.

5 Q Doctor, in all your practice, isn't it true
6 that you typically would have looked at the film of this
7 sort and the CT scan before you would have actually
8 operated on a patient?

9 A I would have had a consultation with the
10 radiologist and the radiologist would have shown me the
11 films.

12 Q There would have occurred a consultation, one
13 on one?

14 A I would not have looked at the films, myself.

15 Q Ever?

16 A Ever.

17 Q And you are saying that's the standard practice?

18 A That is the standard practice. Now, I wouldn't
19 say that I wouldn't look at the films, myself. But you
20 said --

21 Q Now, Doctor, is there evidence in this record
22 that Doctor Davidson, the surgeon, conferred with the
23 radiologist about the reading of those films?

24 A I cannot answer that.

25 Q What do you mean, you can't answer that?...

1 A Because I don't --

2 MR. MANN: Your Honor, please, I object to
3 that question. It is totally irrelevant.
4 Doctor Davidson didn't see the patient until
5 1991, and he is the doctor who operated on her
6 after they determined by the second CAT scan
7 that the lesion had grown.

8 Doctor Davidson is the one that got in and
9 attempted to take out the malignant cancer. So
10 that's totally irrelevant. And, it far exceeds
11 the scope of my Direct Examination and anything
12 that this witness testified to.

13 MR. RAWLS: Your Honor, it does not exceed
14 the scope. He talks about reliance upon the
15 radiologist, and that means common practice on
16 it.

17 THE COURT: How would it be relevant?

18 MR. RAWLS: Your Honor, Doctor Hall is
19 trying to claim that no one other than the
20 radiologist ever looks at X-rays. And, that
21 just simply is not the case. We don't believe
22 it is, anyway. And, if he says it is, he can
23 stand by that. But, I am testing his knowledge
24 in that regard, Judge.

25 THE COURT: I think it's irrelevant. Proceed.

1 BY MR. RAWLS:

2 Q Now, Doctor Hall, you also have a practice
3 of consulting with lawyers in terms of the review of
4 cases, isn't that correct, Doctor?

5 A I don't know how to answer that. What does
6 the practice mean?

7 Q Do you review cases for attorneys?

8 A Occasionally I do.

9 Q I think you told us you had done approximately
10 200 over the last ten years?

11 A Two hundred, but not for all attorneys. Some
12 of them are for other hospitals as well.

13 Q And for that you charged \$200 an hour?

14 A That is true.

15 Q And over the last ten years or so you have
16 also done 15 for Mr. Mann or his firm, haven't you?

17 A Less than -- I think it was less than 15.

18 Q And you told us you had done less than ten
19 for Mr. Mann, himself?

20 A Yes.

21 Q About ten then, maybe?

22 A Less than ten.

23 Q And about five others for other people in his
24 firm?

25 A Less than five.

1 Q But you would agree in your deposition, it was
2 about 15, isn't that correct, Doctor Hall?

3 A For a total of less than 15.

4 Q You can't say how much less, can you?

5 A I can't.

6 Q And five or ten were figures you used in the
7 deposition?

8 A They were.

9 Q Now, Doctor Hall, I take it you believe that
10 this cyst which existed in 1988 was at least in whole or
11 part the cause of some of the symptoms that Mrs. Burke
12 was having at that point, isn't that correct?

13 A Without another diagnosis that I would have to
14 assume that, yes.

15 Q And the other diagnosis would be gallbladder
16 problems, for an example?

17 A That is one of the ten possibilities.

18 Q That was ruled out, wasn't it?

19 A Yes, that was ruled out.

20 Q And an ulcer was ruled out, wasn't it?

21 A The second thing out of ten was ruled out.

22 Q And Doctor Asrani examined her colon and
23 you didn't believe that the diverticulum in there were a
24 problem in there, did you?

25 A I do.

1 Q They were part of the problem?

2 A Yes.

3 Q But you also believe that the pancreatic cyst
4 at that time was most likely a part of the problem, is
5 that correct?

6 A No, that is not correct.

7 Q You don't believe it was a part of the problem
8 at all?

9 A I believe it would be a part if there were no
10 other diagnoses.

11 Q Was there any diagnoses?

12 A Yes.

13 Q What was that?

14 A Hiatal hernia, one. Two, diverticulitis of the
15 colon. Three, diabetes. Four, obesity. Five, reflux
16 esophagitis.

17 Q Was the diabetes ruled out at that time,
18 Doctor?

19 A No, it wasn't.

20 Q How so did Doctor Dyer not take the steps
21 necessary to rule that out?

22 A No, he treated the diabetes.

23 Q In May of 1989, isn't that correct?

24 A I think Doctor Dyer went back in 1976 and started
25 treating.

1 Q So she had diabetes at the time, and that could
2 have been a problem?

3 A I can't say it could have been a problem, but
4 she did have diabetes.

5 Q But you believe that this cyst -- you can't rule
6 out the fact that this cyst was a part of the problem
7 at that time, can you?

8 A If I could rule out all of the other
9 possibilities, I could say, yes, it could have been a
10 part of the problem.

11 Q So what you are saying now, you don't know
12 whether it was part of the problem? Or it probably was?
13 Or you just can't say?

14 A Well, I know I can't say it was part of the
15 problem.

16 Q Doctor, do you recall your deposition?

17 A I do.

18 Q And you sworn to tell the truth at that
19 time?

20 A I was.

21 Q Okay. I take it you did tell the truth?

22 A I did.

23 Q Now, Doctor, on page 13 of your deposition,
24 you were asked the question, starting on line ten,
25 "Do you or do you not believe there was a link between

1 the cyst and her symptomology." And, you answered,
2 "Without any positive findings, I would certainly have
3 to rule out the symptoms being related to the pancreatic
4 cyst. I sure would."

5 Question: "Does that answer my question or
6 not, Doctor?" Answer: "It answers your question, but it
7 doesn't put me in a box to say that was her only
8 symptom, you see."

9 Question: "I'm not trying to put you in a
10 box, Doctor. What I want to know is whether in whole or
11 in part there was a link between her symptomology in
12 the summer and fall of 1988 and the cyst that existed
13 on her pancreas?" Answer: "But I think that's
14 hypothetical, because you don't know what other things
15 she may have had. So, therefore, the answer seems
16 hypothetical because we don't know the disease process."

17 Question: "With all due respect, Doctor, I am
18 asking the questions today." Answer: "I know that."

19 Then we asked the question again and you
20 answered at the bottom of page 13, line 19, "My answer
21 is I'm not trying to be hard to understand. I'm just
22 trying to say that I can't. Does a very long-practicing
23 physician give you an answer dogmatically states that
24 there is a link. But, based upon the fact that I have no
25 other diagnostic possibilities, I certainly will consider

1 that the most common reason for her mid-epigastric
2 abdominal distress."

3 Didn't you say that?

4 A I did.

5 Q And you told the truth at that time?

6 A Yes.

7 Q And you thought it was the most common reason
8 for her distress in 1988?

9 A I cannot say that without qualifying that
10 statement.

11 Q That's what you said in that deposition, Doctor?

12 A I said in the deposition that without knowing
13 what other diagnosis that patient could have had that
14 would be, and we know now that she had a cyst then that
15 would be the most likely, yes.

16 Q Thank you, Doctor. Now, Doctor, when we are
17 talking about a cyst, we are talking as, I take it,
18 about really several types of cysts plus a pseudocyst,
19 is that correct?

20 A That is true.

21 Q But the two that we would be talking about today
22 primarily in terms of consideration would be a cystadenoma.
23 Or, the other possibility would be a pseudocyst, isn't
24 that correct?

25 A I think you are narrowing your definition of

1 cyst too narrowly.

2 Q Okay, Doctor. This cyst, when it was looked
3 at in 1991, it was considered to be either a cystadenoma
4 or a pseudocyst, is that correct?

5 A Those were the two possibilities, yes.

6 Q And that was Doctor Davidson, the surgeon's
7 possibilities, is that correct?

8 A Yes.

9 Q And, in fact, the radiologist who did the CT
10 at Montgomery Regional Hospital in Christiansburg when
11 Mrs. Burke was admitted in June of 1991, he didn't even
12 raise the possibility of a cystadenoma? He called it
13 a pseudocyst, didn't he?

14 A Yes.

15 Q So somebody looking at this film could have
16 considered the logical cystadenoma or pseudocyst?

17 A You could say that. But you asked me my
18 opinion, and my opinion was no. I said that was too
19 narrow.

20 Q Now, Doctor, a surgeon relying upon the reports
21 in this case would have had a choice of a cystadenoma or
22 a pseudocyst, isn't that correct?

23 A Yes.

24 Q And we have agreed that the other readings of
25 the films in there were appropriate, haven't we? So we

1 are not criticizing Doctor Lo's report on April 24th.

2 Now, Doctor, if I might ask you something here
3 about a cystadenoma. Really, those aren't one whole
4 category, are they? There are serous cystadenomas, and
5 mucinous cystadenomas. Now, the serous cystadenoma is
6 one that there is very little likelihood -- in fact,
7 it's almost unheard of, the likelihood of a serous
8 cyst becoming cancerous?

9 A Yes, the literature bears that out.

10 Q And the bad actor you refer to is the mucinous
11 cystadenoma?

12 A Correct.

13 Q And you would expect to find mucin in that cyst,
14 wouldn't you?

15 A Yes.

16 Q You could find mucin all along in that tumor,
17 isn't that correct?

18 A If the tumor had been removed in total, yes.

19 Q You would have found mucin in 1988?

20 A No.

21 Q You would not have found mucin in the tumor in
22 1988?

23 A You can't say that.

24 Q Are you saying it was a serous cystadenoma in
25 1988?

1 A You can't say what it was in 1988.

2 Q Now, Doctor, are you saying it can convert from
3 a serous to a mucinous cyst?

4 A I'm not saying that. I'm saying that we
5 do not have any good experimental or practical advice to
6 show what the inception of the cyst was. Whether it
7 was mucinous, retention, dermoid, congenital or serous.
8 And how that transformation goes into a final cancer.
9 We don't know that.

10 Q Doctor, you would agree with me though that
11 serous cystadenomas that size, there is very little
12 history of malignancy with serous cystadenomas?

13 A That is correct.

14 Q Whereas it is those that turn mucinous or
15 are mucinous that are the bad actors, in your word?

16 A That is correct.

17 Q Now, have you read the records in this case,
18 in this particular case?

19 A Yes.

20 Q And have you read the pathologist record
21 from Roanoke Community Hospital?

22 A Yes.

23 Q And in the description of that, the pathologist
24 found that there was no mucins on it. Did you
25 read that?

1 A Yes.

2 Q And also in the pathologist diagnosis, he
3 said the features suggestive of a musigenous cyst
4 adenomacarcinoma are not identified, didn't he?

5 A Yes.

6 Q And that was the diagnosis of the pathologist
7 who looked at the pancreas taken out of Mrs. Burke in
8 1991, isn't that correct?

9 A Yes.

10 Q And what that says, he didn't find any
11 mucin in there, did he?

12 A That is right.

13 Q So this would not appear to be a musigenous?

14 A That doesn't rule out, because the diagnosis
15 there is a very difficult diagnosis, and missed by a
16 large percentage of pathologists across the country.

17 Q So, you are critical of the doctors across
18 the country?

19 A No, I am just stating a fact.

20 Q You are placing your knowledge above that
21 pathologist's knowledge?

22 A No, I am placing the literature and throughout
23 the United States in every literature it says that the
24 pathologist often makes the mistake in the diagnosis.

25 Q But you have no independent pathology examination

1 that you have done yourself, Doctor, on it?

2 A No.

3 Q So, you are just taking issue with regard to
4 the pathologist here just simply because you don't
5 agree with it?

6 A That is not true at all. I am taking issue
7 upon the best surgeons in this country saying you cannot
8 depend totally upon the pathologist.

9 Q Have you any reason to think that that
10 pathologist is wrong?

11 A Other than the literature and as a high degree
12 of error on the pathologist's diagnosis in these tumors.

13 Q Now, Doctor, the treating oncologist in this
14 case thought this was a very unusual presentation of a
15 pancreatic cyst, didn't he?

16 A Yes.

17 Q He thought it was very unusual?

18 A Yes.

19 Q And would you agree with it being an unusual
20 presentation?

21 A I don't know what you mean by unusual
22 presentation.

23 Q You have reviewed the medical records,
24 Doctor?

25 A Yes.

1 Q And in Doctor Kennedy's report, he refers to
2 it as an unusual presentation?

3 A Yes.

4 Q But you don't know what that really means, so
5 you don't agree or disagree with him?

6 A No.

7 Q You have no reason to think he is wrong, do
8 you?

9 A No apparent reason.

10 Q Now, Doctor, in fact, the pathology report in
11 this referred to an adenomacarcinoma in-situ, is that
12 correct?

13 A That is correct.

14 Q There is an adenomacarcinoma of ductile
15 origin, isn't that correct? That was the pathologist's
16 diagnosis.

17 A Yes.

18 Q Not a cystic adenomacarcinoma?

19 A That is correct.

20 Q And, I take it, you disagree with that finding
21 as well?

22 A I don't disagree with the finding. I am just
23 saying that from the world literature, that the
24 pathologists have a hard time making a diagnosis. That's
25 all I'm saying.

1 Q Now, Doctor, would you agree if you read the
2 pathology report in block D where it says, "Shows
3 polyploid papillary excrescence exhibiting cellular
4 dysplasia and focal architectural complexity and
5 cytologic atypia which appears to represent adenomacarcinoma
6 in-situ. The wall of the cyst is focally calcified
7 and chronically inflamed. The underlying fibrous cyst
8 wall shows atrophic pancreatic acini and islets
9 with chronic inflammation and dilated ducts."

10 Do you recall that statement in the pathology
11 report?

12 A I do.

13 Q Doctor, would you agree with me that it is
14 possible to have a cyst and have an adenomacarcinoma
15 that are not necessarily related to each other?

16 A Would you please read the pathology report
17 again.

18 MR. MANN: Your Honor, please, perhaps he could
19 show the pathology report and let me see which one
20 he is talking about.

21 THE WITNESS: When the pathologist read this,
22 and this is the reason I asked you for a copy of
23 this. He says the wall of the cyst. The wall of
24 the cyst. So, we have demonstrated that this was
25 a cyst. The wall of the cyst which appears to

1 represent -- which to me he is hedging because he
2 basically is not dogmatically sure. He says ,
3 which appears to represent. It wasn't obvious.

4 But, to the best of his knowledge he says
5 which appears to represent, and that's the reason
6 I am basing my whole statement. That he doesn't
7 absolutely dogmatically say that this is A, B,
8 C or D, but it appears to represent.

9 BY MR. RAWLS:

10 Q Doctor, carcinoma in-situ means a very localized
11 place of it?

12 A Yes.

13 Q And that's what the pathologist was referring
14 to in a few lines above that, isn't that correct?

15 A That is correct.

16 Q And referring to that separately about talking
17 about the wall of the cyst --

18 A I'm reading from the report, sir.

19 Q That is what I am asking you, Doctor.

20 A Yes, fine.

21 Q Now, Doctor, there was another possibility
22 that we could have had in here and that is that somebody
23 could have looked at this and called it a pseudocyst,
24 isn't that correct?

25 A I would say that would be a very erroneous

1 diagnosis in this case.

2 Q I am talking about a surgeon's differential
3 diagnosis could have considered it a pseudocyst,
4 couldn't he?

5 A Yes.

6 Q And, in fact, on the films it appears to look
7 something like a pseudocyst because it's a fairly simple
8 structure, isn't that correct?

9 A I would disagree, because on the films there
10 was a small area within the cyst that appeared to be
11 solid.

12 Q But there was only one structure of the cyst?

13 A That is true.

14 Q There was not a multiple structure?

15 A Pseudocyst means frequently are not multiple.

16 Q Doctor, originally everybody agrees that a
17 radiologist looking at that might have put that in the
18 differential than a surgeon considering it would have
19 considered it?

20 A Yes.

21 Q And part of what you would do is you might
22 watch it for a few weeks to see if it reabsorbed, to see
23 if it gets larger or becomes infected? Complications
24 developed or something else? Or just doesn't go away
25 at all, isn't that correct?

1 A I don't think you can say that about the
2 pseudocyst alone.

3 Q But those are the criteria for thinking about
4 operating on a pseudocyst, isn't that correct?

5 A Yes.

6 Q And part of the reason is that a pseudocyst
7 very often reabsorbs itself?

8 A Not often.

9 Q It will reabsorb itself, isn't that correct?

10 A Yes.

11 Q And sometimes if it doesn't grow any larger,
12 you might just watch it for awhile?

13 A No, I would not.

14 Q That is because it can cause some complications,
15 too?

16 A Yes.

17 Q Nausea, vomiting and pain?

18 A Depending upon the size, it can cause nausea,
19 vomiting, pain. And, only pain now if the size displaces
20 another organ.

21 Q It is also sometimes associated with
22 pancreatitis?

23 A Occasionally you will find pancreatitis
24 associated with that.

25 Q And, I think you mentioned earlier, you have a

1 higher incidence with diabetics, too?

2 A Yes.

3 Q And Mrs. Burke was diabetic. Now, Doctor,
4 you are aware, I take it, that the pancreatic cyst was
5 picked up by Doctor Lo in April of 1991. April 24th,
6 she picked that up on ultrasound, is that correct?

7 A Yes.

8 Q And the ultrasound in 1988 was an accepted
9 means of examining the pancreas, I take it?

10 A I haven't been very impressed by ultrasound
11 for diagnosing the pancreas, because there is so much
12 gas frequently overlying the pancreas that I can't
13 always get a true picture.

14 Q Well, you didn't actually do the ultrasound
15 yourself, did you?

16 A No, I am not credentialed to do that. I
17 am talking about ordering the ultrasound. The surgeon
18 or the physician orders the ultrasound and the
19 radiologist does it.

20 Q Now, Doctor, do you know who Andy Warshaw is,
21 a surgeon at Massachusetts General?

22 A I have read some of Doctor Warshaw's work,
23 yes.

24 Q And he is a noted expert on pancreatic lesions?

25 A Yes, he is one of the recognized surgeons on

1 pancreatic lesions.

2 Q Would you agree with Doctor Warshaw's
3 statement, which was placed in the February 1992
4 article in the New England Journal of Medicine on
5 page 456. Where he said, and I quote, "Ultrasonography
6 and CT are the most frequent methods used to confirm a
7 clinical suspicion of pancreatic cancer. Both can detect
8 pancreatic masses as small as two centimeters, and
9 occasionally smaller."

10 Would you agree with that statement?

11 A I think that's a very nice statement. All he is
12 saying is that most doctors use those two modalities to
13 make the diagnosis, and either one can pick it up. And
14 you can go down to two centimeters.

15 Q Would you agree with that statement?

16 A Sure.

17 Q You would agree with me that on July 28th, 1988,
18 Mrs. Burke had an ultrasound, didn't she?

19 A Yes.

20 Q She also had an upper GI. Now, that ultrasound
21 is silent as to the pancreas. It doesn't say anything one
22 way or the other?

23 A I think that is true.

24 Q There is another ultrasound done on December 15th,
25 1988, isn't that correct?

1 A That is correct.

2 Q That was done at the request of Doctor Asrani,
3 isn't that correct?

4 A That is correct.

5 Q And that ultrasound that was done showed the
6 pancreas as normal, didn't it?

7 A Yes.

8 Q It did not show any evidence of a cyst on there,
9 did it?

10 A But neither did he ask for a particular diagnosis
11 of the pancreas, either.

12 Q That was true on April 24th, 1991, too, wasn't
13 it?

14 A That is true. That is why it is incidental.

15 Q He didn't ask for a diagnosis of the kidney,
16 do they? It's often reported?

17 A Right.

18 Q And in the December 15, 1988 report, another
19 doctor, not Doctor Lo, reported the pancreas -- reported
20 a number of areas normal region of the pancreas. And
21 you have no reason to think that's incorrect, Doctor,
22 do you?

23 A I would not rely upon the ultrasound if I
24 was suspicious of a lesion when I have got a better tool
25 to make the diagnosis. You can't rely upon that when

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1 the patient's life is at stake now.

2 Q So, you then disagree with Doctor Warshaw,
3 the expert on talking about ultrasound?

4 A Doctor Warshaw stated that in this country
5 there are two modalities to making diagnoses. You are
6 really misinterpreting it, sir. You are misinterpreting
7 the fact that one is good as the other, when the book
8 says that is absolutely not the case.

9 Q It says that they are both commonly used --

10 A Yes, that is correct.

11 Q The September 1, 1988 CT looking back at it
12 showed a three centimeter, isn't that correct?

13 A That is correct.

14 Q Now, Doctor, it's possible, isn't it, if there
15 was no cyst on the pancreas on December 15, 1988, that
16 what was seen on that first CT, was, in fact, a
17 pseudocyst?

18 A Absolutely not. You can't say that.

19 Q You can't even say that as a possibility,
20 Doctor?

21 A Yes, I would say a possibility.

22 Q You would say it's a possibility in your mind?

23 A Yes.

24 Q Thank you, Doctor. Now, the primary care
25 physician -- you understand, of course, that Doctor Lo

1 is not a primary care physician, isn't that correct?

2 A I'm not aware of the position that Doctor Lo
3 has.

4 Q A radiologist is not a primary care physician?

5 A By the textbook in this case it would not.

6 Q In this case it would be a Doctor Dyer is
7 one specialty of primary care physician. And, in fact,
8 from your review of the records, it appears to you that
9 Doctor Dyer was functioning as Mrs. Burke's primary
10 care physician from 1988 really through the time she came
11 under the care of Doctor Kennedy?

12 A I think it goes back earlier than 1988.
13 1986 and 1985.

14 Q But in the times and question in this case,
15 he was her primary care physician?

16 A That is correct.

17 Q Now, at that time, Mrs. Burke back in the
18 summer and fall of 1988 was having some fairly significant
19 gastrointestinal problems, isn't that correct?

20 A Yes.

21 Q For which Doctor Dyer referred her to
22 Doctor Asrani, for which Doctor Dyer ordered certain
23 tests? And he never, Doctor Dyer, never came up with
24 a diagnosis as to what the cause of those stomach
25 problems were in 1988, isn't that correct?

1 A No, I don't think that's correct for at least
2 from my interpretation of Doctor Dyer's medical records
3 and personal communications.

4 Q What was his determination, Doctor?

5 A Well, he treated Mrs. Burke, as you recall,
6 very nicely in his chart and got excellent results.

7 Q For what?

8 A Once he treated her for gastritis. He treated
9 her for hiatal hernia. And, he treated her for diarrhea.
10 And, he treated her for the right lower quadrant pain,
11 and he got good results.

12 Q He treated the symptoms, isn't that correct?

13 A What else can he treat?

14 Q He never found a cause, isn't that correct?

15 A Well, you can't say that he did not. If the
16 patient responds, wouldn't you be satisfied?

17 Q Doctor, what I asked you is if he ever determined
18 a cause of those problems.

19 A I think Doctor Dyer did determine the cause of
20 those problems, sir, because she got good results. And
21 she continued full employment. The record shows that.

22 Q His record does not reflect any indication that
23 he determined a cause of her epigastric problems. He
24 treated the problems, and the problems went away.

25 A That is not correct, sir.

1 Q Doctor, his record contains no reference of
2 what the cause of that was.

3 A It reflects these things that he was treating
4 her for. Now, I agree because the diagnosis was missed
5 on the X-ray he ordered, and the ultrasound, and the CT.
6 He wasn't privy to know that, and you can't expect a man
7 to treat something that the diagnosis has been missed.

8 But, he treated Mrs. Burke and enabled her to
9 continue full employment.

10 Q Nobody is criticizing Doctor Dyer for what he
11 would have missed in the CT.

12 A He didn't miss anything.

13 Q But you would let me finish my question, I could
14 get to it. And the CT wouldn't have given him a diagnosis.
15 It would have just shown a cyst, if it was reported?

16 A Well, the cyst is the diagnosis.

17 Q And it would have been up to other physicians
18 to determine what to do about that cyst, isn't that
19 correct?

20 A There is only one thing you can do about the
21 cyst, sir, and that is grilled in every physician.
22 And, that's to either remove it or drain it. There is
23 no equivocation about that.

24 Q If it would have been a pseudocyst?

25 A I wouldn't watch it any longer than I would a

1 pseudocystadenoma.

2 Q And a pseudocyst might go away?

3 A In my personal experience, I have never had a
4 pseudocyst go away.

5 Q If I read your literature that many of them
6 spontaneously resolve, would you necessarily disagree with
7 it?

8 A No, I think that would be lovely. I said
9 personally in my own experience in my many years have
10 never had one go away.

11 Q But you would not disagree with the
12 literature --

13 A I would not.

14 Q Doctor, my point is that Doctor Dyer, we
15 mentioned, never determined the cause of the six months
16 of epigastric problems on Mrs. Burke in 1988, did he?

17 A I think Doctor Dyer did, sir.

18 Q But you are basing that on the treatment?

19 A And the patient responded beautifully. What
20 else could you expect Doctor Dyer to do? And I have
21 asked him the question. I'm using that as a matter of
22 statement. I'm not asking you a question, please.

23 Q Now, Doctor, you would agree with me there is
24 no report in his record here what we think the cause of
25 that was, isn't that correct? Whether it was gallbladder

1 or whatever? It's not there, is it?

2 A I think Doctor Dyer wanted to do the best for
3 his patient. And, unfortunately, he was misled because
4 the diagnosis was missed and he treated what he had left.
5 And, he treated it well.

6 Q Now, she did undergo another ultrasound,
7 didn't she, at the request of Doctor Asrani?

8 A Yes, but she had another ultrasound, sir, for
9 whatever reason. Because she had a problem with her liver.
10 See, that's the reason she had it.

11 Q Actually, Doctor, if you will look at the
12 record you will find that he suspected the gallbladder
13 problems?

14 A She also had a diagnosis of an angionoma of
15 the liver. And that caused the pain.

16 Q And that's a cyst on the liver, isn't that
17 correct?

18 A It is not a cyst. It is a blood vessel tumor
19 of the liver.

20 Q Now, Doctor, if we turn to January of 1991,
21 you would agree at that time that Mrs. Burke's problems
22 came back, didn't they?

23 A No, I would not agree with that statement
24 all, sir.

25 Q Doctor, are you aware that she came to

1 emergency room in January at that time complaining of
2 vomiting?

3 A Yes, I'm aware that she came to the emergency
4 room at that time.

5 Q And she was seen by Doctor Dyer a number of
6 times in that period in January with regard to
7 epigastric pain?

8 A January of 1991?

9 Q Yes.

10 A I agree with that, but you said, sir, that the
11 symptoms came back. And, I said I do not agree with
12 that terminology.

13 Q Were they very similar symptoms?

14 A She had symptoms at this time far more severe
15 than she had had, because she was in Doctor Dyer's
16 presence and documented 28 separate visits in 1990.

17 Q And those visits don't contain information as
18 to any gastrointestinal problems in 1990, except for
19 one around July, do they?

20 A They showed that she had discomfort and had
21 diarrhea. And occasionally was nauseated and sometimes
22 had constipation. It showed a multitude of symptoms
23 that Mrs. Burke came to see Doctor Dyer for.

24 Q And, Doctor, also in January 1991, Mrs. Burke
25 lost about ten to fifteen pounds of weight, isn't it.

1 that correct?

2 A That is correct.

3 Q And that weight never came back, did it?

4 A No, it had no reason to come back.

5 Q Now, Doctor, would you agree with me that
6 one of the signs -- one of the first signs of pancreatic
7 cancer is unexplained weight loss, is that correct?

8 A That is correct, sir. And she weighed 184
9 in 1988, and in 1990. And, in 1991 she dropped down
10 to 175.

11 Q And in January 1991, there was no explanation
12 for that weight loss, was there, by Doctor Dyer?

13 A There was some explanation for the weight
14 loss, yes. There was because she had nausea and vomiting
15 which is a very common denominator in weight loss.

16 Q But if that were the case, you would expect
17 the weight to come back, wouldn't you?

18 A Yes.

19 Q And it did not with Mrs. Burke, did it?

20 A Right.

21 Q Now, in January of 1991, Doctor Dyer -- and
22 this is over the two years of the last round of tests --
23 Doctor Dyer did not send Mrs. Burke out for any
24 ultrasound studies at that time, did he?

25 A In January of 1991, he had about six or eight

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1 personal consultations with Mrs. Burke, and 28 visits.
2 But he did not -- I agree, he did not send her out in
3 January of 1991.

4 Q He did not send her out in January of 1991
5 for an ultrasound or a CT or referral to anyone else
6 at that time, did he?

7 A That is correct.

8 Q Doctor, was no explanation for that weight
9 loss other than the nausea and vomiting you mentioned
10 already?

11 A Which is approximately -- it's not ten to fifteen
12 pounds loss in January. It's only about five to eight
13 pounds loss in January. As time progresses, the loss
14 gets more severe.

15 Q So it's actually about ten pounds?

16 A Yes. And, Doctor Kennedy when he later
17 examined Mrs. Burke at Community, he is the one that
18 referred to the ten or fifteen pound weight loss. That
19 did not come back. Doctor Dyer's chart reflects the
20 weight loss.

21 Q And that was a weight loss that was
22 unexplained?

23 A No, it was explained.

24 Q But the weight never came back?

25 A The weight didn't have a chance to come back

1 because Mrs. Burke had surgery, you recall. She had
2 no chance to come back.

3 Q But talking about January 1991 and the end of
4 April 1991, the weight did not come back, did it?

5 A You cannot say at the end of April because
6 Doctor Davidson who operated on the patient said
7 basically the past four weeks Mrs. Burke is feeling very
8 well.

9 Q The information on Doctor Kennedy's chart is
10 that she had that weight loss in January and it never
11 came back, isn't that correct?

12 A That is correct.

13 Q And, based upon that and Doctor Dyer's chart,
14 you have no reason for that weight gain, did she?

15 A She had no choice, sir. She had surgery.

16 Q She had for four months an unexplained weight
17 loss in here, didn't she?

18 A Well, in the time that she started to vomiting
19 in January of 1991, I would say she had actually possibly
20 two-and-a-half months to three months before she was
21 referred then to Doctor Davidson. Because it takes
22 awhile. You just don't get a consultation overnight.
23 So, it took awhile.

24 Q From the time you started, Doctor, in early
25 January of 1991, it was, in fact, not until the end of

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1 April, April 24th, 1991, that Doctor Dyer sent Mrs. Burke
2 for another CT scan, isn't that correct?

3 A That is correct.

4 Q Then it was another month after that before
5 Mrs. Burke was seen by the surgeon, Doctor Davidson,
6 isn't that correct?

7 A That is correct.

8 Q So there is a total transpiring in here of
9 almost five months from the time of the onset of the
10 symptoms to the time she is finally seen by a surgeon,
11 isn't that correct?

12 A You need to put in there June 11th when she
13 had surgery that Doctor Davidson, himself, gave
14 Mrs. Burke the elective of when she would have surgery.
15 Knowing fully well that she had some weight loss, but
16 he did not see the need of needed surgery. So, he
17 waited another two-plus weeks, giving her the option
18 as to when she should want the surgery.

19 Q So by then we are over five months past the
20 start of the symptoms?

21 A Right.

22 Q Now, Doctor, when Doctor Davidson operated --
23 just to make sure we have this clear -- when he operated
24 on Mrs. Burke in June of 1991, he got out of there what
25 they call clean margins? He thought he had a resectable

1 tumor?

2 A Based on what?

3 Q Based on his operative note and the pathology
4 report.

5 A That is exactly right. Based upon the pathology
6 report.

7 Q And based upon his observations?

8 A But pathology is microscopic eyes. And there are
9 far more deeper involved than are personal eyes. So,
10 based upon the microscopic report, Doctor Davidson did
11 agree. He thought he got the tumor out.

12 Q And that microscopic report which -- there is
13 actually a gross report by the pathologist there, too?

14 A Yes.

15 Q What he looks at and what he sees and what he
16 looks at under the microscope?

17 A Yes.

18 Q And they had sampled some other area in there
19 too, hadn't they?

20 A Yes.

21 Q And they found the lymph node to be free of
22 cancer, isn't that correct?

23 A Well, the pathologist said that she had no
24 metastasis, is what he said. That is what he thought
25 at the time.

1 Q I take it you differ with him?

2 A I'm just trying to show -- and four weeks
3 later the woman -- the metastasis is everywhere.

4 Q My point is, Doctor, that when you looked at
5 this, the surgeon looking at it at the time and the
6 pathologist looking at it at the time, there was no
7 gross or to this estimation microscopic indication of
8 metastasis at that time, isn't that correct?

9 A Gross, you can't tell metastasis, sir.

10 Q He didn't see anything abnormal in there other
11 than what he took out?

12 A I agree with that.

13 Q You say it was three months, six weeks later
14 on that she was operated on?

15 A Somewhere in that time frame.

16 Q When she was operated on three months later,
17 Doctor Davidson found obvious problems before he ever
18 sent it to the pathologist, didn't he?

19 A She had metastasis in every organ in the
20 abdomen as if it had been going on for a long period of
21 time.

22 Q It was apparent to him when he looked at
23 that in surgery?

24 A Well, she had intestinal obstruction, sir.

25 Q It was obvious when Doctor Davidson looked

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1 at it there was extensive metastasis? That's not
2 something he needed a pathologist for?

3 A That is correct.

4 Q That was not the case back in June?

5 A I would have to think that she had
6 metastasis in June.

7 Q But there is no evidence of it in the record?

8 A True.

9 Q So it probably just started to spread,
10 Doctor?

11 A No.

12 Q It hadn't spread near as much the three months
13 following?

14 A Everything grows, sir. It hadn't spread as
15 much. But I think it was evident in this patient on
16 6-11-91.

17 Q But the surgeon and the pathologist didn't
18 pick it up?

19 A Because you go back to the thing on the top of
20 your chart, sir. The ten, fifteen pound weight loss
21 shows basically cancer metastasis then or taking
22 place.

23 Q So you saying that it metastasized by then?

24 A I didn't say that. I'm saying that the
25 weight loss shows a very definite pattern. We are all

1 quite aware of the facts of cancer on the body, and that's
2 one of them.

3 Q Whether before or after, it metastasized?

4 A Mostly after it has metastasized. It's hard to
5 say the alpha from the omega in these particular cases,
6 because we don't have a way to tune in any particular
7 point in time.

8 Q Now, Doctor, I think you told me once in the
9 deposition that pancreatic cancer is a very fast-acting
10 cancer?

11 A It is.

12 Q And it typically moves very rapidly?

13 A Yes.

14 Q In a matter of a few months, I think what you
15 told me?

16 A Yes.

17 Q Now, help me out here, Doctor. When
18 Doctor Kennedy looked at her, they thought they had a
19 tumor that they had resected and gotten all the tumor?

20 A Based upon the pathologist report, you are
21 right.

22 Q They thought they had from this appearances it
23 looked treatable?

24 A You can't look at it. You have got to look
25 under the microscope. And, based upon that alone, they

1 said we have got a good result here.

2 Q And based upon their experience, treating
3 patients and Doctor Davidson's experience treating
4 patients?

5 A I don't think experience comes into it. You
6 have got to have dogmatic evidence of tissue involving
7 cancer.

8 Q But they thought then they had a clean result
9 then?

10 A They sure did, based upon the microscopic root.

11 Q Which is to say that if somebody had looked
12 at it four months earlier, it probably would have looked
13 even better then?

14 A That's speculation. I think it's good
15 speculation.

16 Q Now, Doctor, the surgery that you say
17 Mrs. Burke would have needed to remove this cyst, you say
18 that would have been needed, under your theory she would
19 have needed surgery regardless?

20 A Yes.

21 Q She would have required additional
22 pancreatotomy, isn't that correct?

23 A Yes.

24 Q And that is not a minor operation, is it?

25 A That is a major operation, yes.

1 Q And anytime as a surgeon, I think you would
2 agree that anytime you operate on the pancreas, you do at
3 times have a significant morbidity and mortality rate,
4 isn't that correct?

5 A I would have to disagree with that. The
6 literature in large numbers because this is a very, as
7 I said, area -- since 1930 we have had a 300 percent
8 increase in these cystic tumors and tumors of the
9 pancreas in these United States. And especially in
10 Japan, as you probably know. That is a very common
11 thing or not a common thing, but a very frequently rising
12 thing. Now, to say that we have had a chance to know
13 exactly what the rate of metastasis or greater growth is,
14 I can't say because we don't know what risk factors are
15 acting in Mrs. Burke's life to cause this to grow, do
16 we?

17 Q Doctor, what I was asking about -- let's say
18 under your theory had been reported and surgery had been
19 performed, it was essentially the same sort of surgery
20 that she ended up having two years later, isn't that
21 correct? They would have removed the end of her pancreas?

22 A But less tissue. If she had had the cyst
23 removed in 1988, it could have been a very simplistic
24 operation comparing to five centimeters. As you can see
25 here from my model, it is far more serious that size

1 tumor than in 1988. But to answer your question about the
2 complications in good hands, in good surgeons and good
3 medical sceptors, the basic complications I have seen as
4 many as 40 and 50 and 100 patients operated on with zero
5 complications. So, it depends where you go and who does
6 your operation.

7 Q You also see where there were a number of
8 complications?

9 A I don't know how to equate a number.

10 Q Doctor, you have come across instances of
11 high rate of complications with regard to pancreatic
12 operations, too, haven't you?

13 A I really haven't, sir.

14 Q Doctor, would you agree that a Whipple
15 procedure --

16 MR. MANN: Your Honor, please, Whipple procedure
17 doesn't have anything to do whatsoever with this.
18 This was not a Whipple procedure, and a Whipple
19 procedure would not have been needed in 1988. A
20 Whipple procedure was not done, and it's a totally
21 irrelevant question. It's just a smokescreen.

22 MR. RAWLS: If Mr. Mann would let me finish
23 my question, perhaps his objection would have been
24 alleviated.

25 THE COURT: Finish the question then.

1 MR. RAWLS: I should say finish the line of
2 two questions.

3 BY MR. RAWLS:

4 Q You would agree that in some of those
5 operations, which is not the operation, this was not a
6 Whipple procedure?

7 A A Whipple procedure is an entirely different
8 operation altogether.

9 Q But in some of those cases there is a mortality
10 of ten percent reported, isn't that correct?

11 A That is correct, because you are not operating
12 on the pancreas. You are operating on the liver, the
13 gallbladder, the stomach and the intestines. You have
14 got four operations compared to the pancreas as only being
15 one. You have got four particular operations you are
16 operating on in the Whipple.

17 Q And in this, you are working in the same area
18 and you still have the risk, Doctor, of pancreatic fistulas
19 developing?

20 A No, because you are taking off the tail, sir.
21 You have fistulas, you operate on the body and the head.
22 But in the tail of the pancreas, no, sir, a good surgeon
23 should have no fistulas.

24 Q Now, Doctor Davidson reported that the cyst
25 was in the body and tail of the pancreas, isn't that

1 correct?

2 A That is true.

3 Q So it was partly in both?

4 A The growth had occurred, sir, and apparently in
5 1991 that no longer could it stay confined to the tail,
6 but reached over into the body, that is true.

7 Q But it was on the edge to begin with,
8 wasn't it?

9 A It was closer to the beginning of the tail than
10 it was the tail, itself.

11 Q Was it right near the dividing line in the
12 body, wasn't it?

13 A Yes.

14 Q And Mrs. Burke -- basically what they did in
15 1991 was they cut off the two-thirds of the end of the
16 pancreas, isn't that correct?

17 A And some adjacent tissue with it.

18 Q And what would have happened in 1988 would
19 have been essentially the same thing, only they could
20 have cut off less, isn't that correct?

21 A Yes.

22 Q And you would have had the same risk obligation
23 at the same time?

24 A No, a smaller tumor. A smaller complication,
25 sir.

1 Q The cost before would have been there, too?

2 A I would say the cost of surgery 1988 should
3 be probably one-third of what it was in 1991, because
4 of the size.

5 Q And the size would require a hospital stay,
6 wouldn't it?

7 A Yes.

8 Q It would have required pathology to look at
9 it?

10 A Yes.

11 Q And anesthesia?

12 A Yes.

13 Q And all of those would have run up costs?

14 A Yes.

15 Q Even under your theory, there would have been
16 some fairly significant medical costs incurred in this
17 case, isn't that correct, to remove that tumor?

18 A Much more in 1991 than it would have been in
19 1988.

20 Q If you would just answer my question. Under
21 your theory to remove the tumor, there would have been
22 significant costs involved, wouldn't there?

23 A Well, please clarify significance.

24 Q You would have had surgeons' charge. You would
25 have had how many days she was in the hospital. And,

1 anesthesia charges. Pathology charges. Probably X-ray
2 charges, wouldn't you have had all of those?

3 A Yes.

4 Q And also associated with this operation, there
5 are also some gastrointestinal problems in terms of
6 managing her diabetes, having lost part of her pancreas,
7 isn't that correct?

8 A Basically that is not correct, sir.

9 Q The Lord made us so that the pancreas can take
10 over with a very small portion left and provide us with
11 enough insulin and digestive enzymes to make life quite
12 comfortable. So you would not have anticipated, unless
13 the tumor spread so far into the body of the pancreas,
14 that we lose some pancreatic tissue. And, if that be
15 the case, your answer would be yes? And also the fact,
16 Doctor, wasn't Mrs. Burke already a diabetic?

17 A Yes.

18 Q She was not insulin-controlled at that point,
19 but she was borderline, wasn't she?

20 A She was not a diabetic, but she was borderline.
21 And she was fairly well controlled.

22 Q So removing half or a third of her pancreas
23 could have had some effect on her diabetes?

24 A I don't think so, sir. I don't think the
25 literature has shown that when patients have diabetes

1 and the tail of the pancreas is removed that it does not
2 cause the diabetes to be worse.

3 Q You are saying that's true on long-term
4 diabetics?

5 A I am not saying on a long-term basis.

6 MR. RAWLS: Thank you, Doctor. I have no
7 further questions.

8
9
10
11 REDIRECT EXAMINATION

12 BY MR. MANN:

13 Q Doctor, I just want to address some of the
14 points that Mr. Rawls has illustrated in his Cross
15 Examination. And, I am not going to do so in any
16 particular order. I'm not going to start where he
17 started. In fact, I think one of my first questions will
18 be one of the last questions he was asking you concerning
19 what Doctor Dyer may or may not have done in January of
20 1991.

21 What Doctor Davidson may or may not have done
22 in the spring of 1991. He asked you this question: When
23 you consider the information that was available to
24 Doctor Dyer in January of 1991, the information that was
25 available to Doctor Davidson and Doctor Kennedy in the

1 spring of 1991, and when you consider the fact that they
2 were not privy to a CAT scan which showed a three centimeter
3 cyst to be existing in 1988, they didn't know about that.
4 Is there anything, sir, in your opinion that Doctor Dyer
5 or anyone else could have done to have saved this lady's
6 life in the January to April period of 1991? By then
7 was it too late?

8 A Well, basically I can't say that by January of
9 1991 it was too late. But we do know that cancers of the
10 pancreas are very bad actors and they spread rapidly.
11 But, I don't know in looking at all the records and the
12 many times that Mrs. Burke was seen by Doctor Dyer. His
13 repeated efforts to try to make a diagnosis on everything,
14 including the GI tract. The liver. The pancreas, and the
15 region of the hiatal hernia. And, in his efforts to try to
16 make that diagnosis, it appeared the man had done a very
17 thorough workup and was devoted to his patient.

18 I can't see anything else he could have done,
19 because he was naturally steered away from the true
20 diagnosis, because it wasn't revealed to him. And, he
21 was constantly working to see what he could do to make
22 Mrs. Burke feel better. He was able to accomplish that
23 up until the first quarter of 1991. At that time, the
24 situation got tremendously worse. And, of course, he
25 had to turn her over to someone else.

1 Q Of course, if it had been made known to
2 Doctor Dyer in September of 1988 like it should have been,
3 you never would have gotten to these problems in 1991,
4 would you?

5 A That is true. If we had had the diagnosis,
6 there would have been a very excellent favorable case of
7 removing a pancreatic cyst.

8 Q Now, Mr. Rawls asked you a question to the
9 effect of it concerned Doctor Kennedy's report, which I
10 believe is dated June 18th, 1991. Doctor Kennedy is
11 a treating oncologist there in Roanoke. I believe Mr.
12 Rawls asked you a question, didn't Doctor Kennedy
13 say that she had an unusual presentation of pancreatic
14 carcinoma in June of 1991? I believe your answer was to
15 the effect that you didn't know what he meant by that,
16 and I don't believe he showed you the report at that
17 time.

18 I would like to show you that record and ask you
19 to read to the Jury what Doctor Kennedy said after he made
20 his comment. Just read them. That whole paragraph right
21 there, and down.

22 A Doctor Kennedy in his consultative note said,
23 "Mrs. Burke obviously has an unusual presentation of
24 the pancreatic carcinoma. It appears that the
25 adenomacarcinoma has arisen within a preexisting pancreatic

1 cyst. And, the cyst is said to have been present on the
2 CT scan in 1988. And, I would doubt that it was
3 malignant at that time, especially in the light of the
4 poorly and differentiated histology."

5 Q Mr. Rawls asked you a number of questions
6 concerning a deposition that you gave that was taken by him,
7 I believe, on the 15th day of October, 1993. Do you
8 remember him asking you those questions?

9 A Yes, sir.

10 Q And do you remember the questions that he asked
11 you concerning his attempts, and I believe he read a long
12 listing of questions and answers that you gave back in
13 October, a couple of months ago, concerning the possible
14 cause of the symptoms Mrs. Burke was having back in 1988.
15 Back in September and December and January of 1988.

16 Do you remember Mr. Rawls asking you those
17 questions?

18 A Yes, sir.

19 Q And they were repeated questions, and you
20 didn't give him an answer except that you would have to
21 rule out other things? And then you finally conceded
22 that if you don't rule out other things, that you will
23 consider that that was maybe a common cause. Do you
24 remember that question and answer sequence?

25 A Yes.

1 Q At the time he was asking you those questions,
2 had you seen Doctor Dyer's office records? Doctor
3 Dyer's office chart on that lady?

4 A No, I had not.

5 Q Did you have occasion to see it after he asked
6 you those questions?

7 A Yes, I did.

8 Q Based on what you saw in Doctor Dyer's
9 records, based on your experience, do you have an
10 opinion now as you sit here as to whether or not in
11 September of 1988 and January of 1989, whether or not
12 the symptoms that this lady had at that time, were
13 they related, in your opinion, to the placing of this
14 cyst? Or were they related to the hiatal hernia and
15 some other problems that she had?

16 MR. RAWLS: I'm going to object to the leading
17 form of the whole line of questioning.

18 THE COURT: Overruled. Go ahead.

19 THE WITNESS: I would say that the three
20 centimeter cyst that was demonstrated on the CT scan
21 in 1988 did not represent the symptoms that
22 Mrs. Burke was having. Simply because she was
23 responding to medication. And, cancer we all know
24 does not respond to medication. I mean, you can
25 give all types of medications when the patient has

1 a cancer. And regardless of what you are doing,
2 unless you knock the patient out totally, they
3 are not going to respond. And, Mrs. Burke responded
4 quite well to medications both in 1988 and in 1991
5 and 1990. So obviously there can't be any
6 relationship with the pain and the discomfort and
7 the symptomology that she was treated for to the
8 small three centimeter pancreatic cyst.

9 BY MR. MANN:

10 Q So you referred to this as a small cyst. Of
11 course, to a lay person such as myself, it looks pretty
12 big. But to medical people, that's a small cyst?

13 A That is the smallest we usually see.

14 Q Now, how would you refer to that?

15 A Well, you know that is considered a large
16 size cyst because if you take all of the literature of
17 all the pancreatic-type operations in this country, the
18 average patient when he comes in for surgery has a
19 cancer will have a cyst five to six centimeters. So
20 that's a large cyst.

21 MR. MANN: Let the Record show, if Your Honor
22 please, that what I am referring to is the yellow clay
23 that the witness has made of the demonstrated size of
24 this lesion in 1991.

25 THE COURT: The Record will so reflect.

1 BY MR. MANN:

2 Q He asked you a number of questions relating to the
3 fact that there was a sonogram or ultrasound done in July of
4 1988, which was just a couple of months before the CAT scan
5 that was missed. Then he also referred and asked you a
6 number of questions concerning another ultrasound, which
7 was done by Doctor Lo in December of 1988.

8 MR. RAWLS: Your Honor, it was not Doctor Lo
9 performing it. It was one of the other physicians.

10 MR. MANN: Excuse me. I misspoke that, and I
11 apologize to Doctor Lo.

12 BY MR. MANN:

13 Q There was one in July of 1988 by another
14 radiologist, and it doesn't matter because no one contends
15 that they missread those. But you remember him asking
16 you questions about a sonogram that was done in 1988
17 that didn't show anything wrong with the pancreas? And
18 another sonogram that was done in December of 1988 that
19 didn't show anything wrong with the pancreas?

20 A Yes, sir.

21 Q And the inference being that there wasn't
22 anything wrong with the pancreas at that time. As a
23 surgeon, as a treating physician, as one who reviews
24 records to determine mortality and morbidity, which would
25 be more definitive in making a diagnosis? A CAT scan

1 such as the one that was done in September of 1988 and
2 showed on it a three centimeter cyst, which we all know
3 now was not probably reported? Or the ultrasounds that
4 were done the month before and the month after that
5 didn't show anything? Which would be the better
6 evidence?

7 A Well, I think it's quite obvious that the CAT
8 scan is and the ultrasound missed the diagnosis.

9 Q That doesn't mean anybody misread it?

10 A It is just that this is not the most accurate
11 way to make a diagnosis of a cyst of the pancreas.

12 Q Is there any way, sir, to determine precisely
13 when this benign lesion represented by the red clay had
14 grown out of it a cancerous lesion? Is there any way
15 to determine when that happened?

16 A No, there is no way, simply because each
17 patient's own growth pattern determines and risk factors
18 determine the growth of the cyst or the tumor. And,
19 what may happen in one patient may be twice as fast to
20 grow in the second patient. So, there is no way to
21 set a standard saying X number of months represents X
22 number of centimeters of growth. There is no way to do
23 that.

24 Q Did I understand your testimony correctly that
25 once it becomes cancerous, then a cancer of the pancreas

1 moves very quickly?

2 A Once the diagnosis of cancer or once the patient
3 has cancer of the pancreas, they frequently have two
4 predominating symptoms. That is, gastric pain and weight
5 loss. And, basically, it does grow very, very fast.

6 Q And is there any way to determine when after the
7 lesion has become cancerous, is there any way to determine
8 in Mrs. Burke's case when it actually metastasized?

9 A No, because you know I think Mrs. Burke had
10 excellent staff operating on her. And, based upon the
11 knowledge that they had that she had no metastasis at
12 that time -- and yet a matter of 90 days later she was
13 terminal. So there is no way of knowing.

14 MR. MANN: Your Honor, at this point I would
15 ordinarily put this into evidence at this time.
16 But inasmuch as we did do some questions of this
17 witness about it, I would like to introduce another
18 exhibit and at least read a portion of it.

19 THE COURT: Any objections?

20 MR. RAWLS: Your Honor, what has been
21 stipulated here to is the damages on it in a sense
22 of the medical bills. Now what has not been
23 stipulated is that it was cause all this in that
24 connection to which there has been no testimony on
25 it. Certainly the medical bills were incurred and

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1 those bills were reasonable in the treatment of
2 pancreatic cancer.

3 THE COURT: Didn't you go into it?

4 MR. RAWLS: I did, but the causal relationship
5 has not been stipulated on it.

6 MR. MANN: Hopefully I can clear it up. Maybe
7 this witness can help us, and maybe he can't.

8 Ladies and gentlemen, you recall earlier when
9 we read the other stipulation concerning the things
10 that are admitted. What I am about to read to you
11 now is likewise admitted. There is no dispute with
12 what I am about to read to you, and you may consider
13 it as evidence in this case.

14 It is stipulated that the following costs were
15 incurred in the treatment of Mrs. Burke's pancreatic
16 cancer, and were reasonable and necessary for the
17 treatment of said condition. It is further stipulated
18 that the funeral expenses listed here were incurred
19 and were reasonable.

20 Now, I'm not going to read to you all of the
21 sub parts and totals of that, but the total cost of
22 the funeral bill was \$4,690. And the total cost of
23 the funeral bill plus the medical expenses that were
24 incurred in 1981, in regard to treating her cancer,
25 was \$96,124.24.

1 Doctor Hall, you may or may not be able to
2 speak to these points. So, if you can't, fine,
3 and if you can, fine.

4 In your work now with the Joint Commission
5 and based on your knowledge and so forth of
6 surgical costs and things of that nature, would you
7 be able -- perhaps I had better show you something
8 before I ask you a question about it.

9 If you can assume, sir, that what is in the
10 paper that I have now handed you is agreed to be
11 the costs that were incurred and what they were
12 incurred for in 1991 to remove this yellow size
13 lesion, which by that time had grown into the
14 body of the pancreas. The operation that
15 Doctor Davidson had to do and it incurred those
16 costs.

17 Are you in a position to say approximately
18 what the costs would have been in 1988 to have
19 gone in and taken out a non-cancerous lesion of the
20 tail of the pancreas such as represented by this
21 red ball?

22 THE WITNESS: Well, sir, based upon the
23 document that you have handed me, it would appear
24 that the total anesthesia bill for this particular
25 lady on the day of operation was \$620 and the

1 radiologist or -- excuse me, the oncologist charged
2 \$140. And that Doctor Davidson, in doing the two
3 surgeries, he did charge a little over \$6,800. And
4 the Radiologist Associates of Roanoke that is
5 charged Mrs. Burke \$130. And then the pathologist
6 looking at the tissue and one time he charged \$620.
7 Another he charged \$255.

8 So the bulk of the cost was \$60,000 at
9 Roanoke Memorial Hospital. So that's where the
10 cost of this whole procedure ended up. Then there
11 was a \$12,000 roughly at Community Hospital of
12 Roanoke, and then here in Montgomery Regional
13 Hospital there was a \$1,400 bill.

14 The only thing that I can say about this,
15 I personally would say that the fees for the doctors
16 would look like to me from my own personal
17 experience is about what you would expect. Maybe
18 a five, six-percent increase from 1988 until
19 1991.

20 But, if she didn't have to go to Roanoke
21 Memorial and had the cyst removed locally, I think
22 that's where you could have saved \$50,000 or
23 \$60,000 of the bill. And, that's the closest I
24 can do for you, sir.

25 MR. MANN: Those are all the questions that I

1 have.

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5 RECROSS EXAMINATION

6 BY MR. RAWLS:

7 Q Doctor Hall, just to clear up perhaps one
8 misunderstanding and Mr. Mann asked you about Doctor
9 Davidson and Doctor Kennedy being unaware of the
10 September 19, 1988 cyst. Do you recall that?

11 A Yes.

12 Q In fact, they were aware of that, weren't they?

13 A Well, they were aware of it after the fact,
14 yes.

15 Q They were aware of it when they treated
16 Mrs. Burke and it's reflected in there, isn't that correct?

17 A Yes.

18 Q Now, Mr. Mann -- just to make sure we are
19 straight on it, one of the reasons, wouldn't you agree
20 that Doctor Kennedy called this tumor to have an
21 unusual presentation on it was the fact that there was no
22 mucin in it at the time?

23 A I think one of the reasons he said it had an
24 unusual presentation after Mr. Mann showed me the report
25 represented the fact that it had been present since,

1 at least since November of 1988. That was my impression,
2 yes.

3 Q And he also commented on a very poorly
4 differentiated histology?

5 A Right. Poorly differentiated means its fast
6 and aggressively growing, yes.

7 Q Now, Doctor, you also mentioned back when talking
8 about what went on in 1988 that medicine wouldn't have
9 controlled cancer, I believe is what you told us?

10 A Yes, that is what I said.

11 Q You are saying that the cyst at that time was
12 not cancerous, is that correct?

13 A I think I echoed Doctor Kennedy on that.

14 Q That it was a cystadenoma?

15 A It was a cyst, yes.

16 Q Which by definition is not malignant, is
17 that correct?

18 A Yes.

19 Q Although there may be a few malignant cells in
20 a mucinous tumor, is that correct?

21 A You don't know when the transformation takes
22 place. That's true.

23 Q We know for a fact that in September 1988 the
24 tumor was not probably malignant or insignificantly so?

25 A I think it doesn't take a rocket scientist to

1 prove that. In 9-88, she couldn't have lived from
2 9-88 with a cancer of that magnitude.

3 Q But a cystadenoma, Doctor, it can cause
4 symptoms too, can't it?

5 A It can cause symptoms, but primarily due to
6 its expansion and the pushing on other organs, yes.

7 Q So pushing into the ducts of the pancreas?

8 A If it's in the head of the pancreas, yes.

9 Q So, at the time you told us that it was the
10 most common cause of her problems, that was the information
11 that you thought it was, wasn't it? That was your
12 opinion at the time of the deposition?

13 A No, I think you are misleading me or trying
14 to there. For the simple reason, I said if you had no
15 other diagnosis, then naturally I would have to talk
16 about a pancreatic cyst. And I have tried to repeat that,
17 sir, for you.

18 Q And, at that time, you thought quite possibly that
19 a three centimeter cyst would have been the most common
20 cause of her problem, is that what you said then?

21 A If I had no other diagnosis, and I ruled
22 out every other thing, is exactly what I said. I would
23 have to put my money on the cyst.

24 Q And Mr. Mann at that time had not furnished
25 Doctor Dyer's records to you, had he?

1 A That is true.

2 Q He furnished them to you after the deposition,
3 didn't he?

4 A Yes.

5 Q And Doctor Dyer never comes up with a
6 definitive diagnosis in his records, either?

7 A He doesn't because he never got the right
8 report, sir. He was misled.

9 Q He did other tests? He had nothing which
10 told him the cause of this gastrointestinal problems?

11 A He sure didn't.

12 Q He treated the symptoms?

13 A He had nothing else to do. He treated them
14 well.

15 Q He didn't order any follow-up studies in
16 January of 1991, did he?

17 A Yes, he did. He had follow-up to be seen
18 by a surgeon and an oncologist and so forth.

19 Q That was in May, April of 1991, wasn't it?

20 A Well, the things that happened, I think in
21 his last three or four months of Mrs. Burke's life
22 happened very rapidly. A tremendous downhill course.

23 Q And, in January of 1991, he didn't order any
24 further CT, ultrasound or studies of that sort, did he?

25 A No, he did not.

1 MR. RAWLS: Thank you, Doctor.

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5 REDIRECT EXAMINATION CONTINUED

6 BY MR. MANN:

7 Q Doctor, one short question: I originally
8 asked you to do this. I asked you to determine whether
9 or not, in your opinion from the records, Mrs. Burke
10 would be alive if that three centimeter cyst had been
11 called to the attention of the doctors in 1988. Now,
12 did you need Doctor Dyer's office charts to address the
13 question that I asked you to address?

14 A No, I did not.

15 Q You don't need to address the question that
16 Mr. Rawls asked you at your deposition?

17 A That is true.

18 MR. MANN: That is all I have.

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22 RECROSS EXAMINATION CONTINUED

23 BY MR. RAWLS:

24 Q Your Honor, since that door has been opened --
25 Doctor, at the time of your deposition I showed you the

1 Interrogatory Answers identifying you in the case?

2 A Yes.

3 Q You told me that it was accurate at the time,
4 didn't you?

5 A What was accurate?

6 Q The Interrogatory identifying your opinion.

7 A Yes.

8 Q And that was before you had seen Doctor Dyer's
9 notes, wasn't it?

10 A Yes.

11 Q And in that Interrogatory Answer, it says
12 a more aggressive surgeon may well have operated to
13 remove the cyst because of a pre-cancerous potential.
14 The more conservative approach would have been to follow
15 for 30 or 45 days in order to rule out gastric,
16 esophageal, gallbladder or other possible causes. If
17 the other possible causes were not eliminated, then
18 it would be likely that any surgeon would have
19 operated in the time frame to remove the lesion based
20 on the symptom, isn't that correct?

21 A Yes.

22 Q That was an accurate answer at the time?

23 A Yes.

24 MR. RAWLS: Thank you, Doctor.

25 THE COURT: All right, Doctor, thank you very

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1 much. You may be excused.

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3 X X X X X X X X X X

4 WITNESS STOOD ASIDE

5 X X X X X X X X X X

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7 (The following took place in Chambers and out
8 of the presence of the Jury.)

9
10 MR. RAWLS: Judge, Mr. Mann has shown me a number
11 of photographs of the decedent.

12 THE COURT: Is this today?

13 MR. RAWLS: I have seen them today. There is
14 no surprise in it. I believe one is at a class
15 reunion in June of 1991, showing Mrs. Burke dancing
16 and things like that.

17 Your Honor, I do not have the case in front of
18 me right now, but I believe there is authority in
19 effect that showing pictures of the decedent is
20 inflammatory. It is not calculated to lead to the
21 damages at issue in this case.

22 And, I would move that the photographs be
23 excluded.

24 THE COURT: Well, I don't know what case you
25 are talking about, but I always do it and have done

1 * * *
2 that under his theory, Mrs. Burke would have had
3 some of these costs regardless.

4 MR. MANN: I agree with that, and that is a
5 matter of argument.

6 THE COURT: I am going to allow it to go to
7 the Jury. All right, what else now?

8 MR. MANN: Well, I agree with the Court. I think
9 all of these things were in evidence with the
10 exception of what Mr. Rawls objected to, and the
11 Court either took under advisement or sustained.
12 I am making an all-inclusive Motion at this time,
13 because I think all of the evidence is relative
14 and material and the Jury should be entitled to see
15 it.

16 THE COURT: Well, I'm going to allow all of it
17 in except the last two balls, whatever they are.

18 MR. RAWLS: Your Honor, at this time I would
19 also have a Motion to make as well.

20 MR. MANN: Your Honor please, I do rest.

21 MR. RAWLS: Your Honor, I have a Motion to make.
22 My Motion is to fold in all of this. And, first,
23 I would renew our Motion to with regard to the
24 statute of limitations, Your Honor. The unequivocal
25 testimony, I am not sure it was unequivocal. But the
26 testimony of Doctor Hall was that this was present

1 in 1988. That something should have been done in
2 1988. And, that the failure to do so was a cause
3 of harm to her.

4 He also gave testimony to the effect that it was
5 the most common, perhaps the most common source of
6 her symptoms at that time. Although, in defense of
7 Mr. Mann, he did flip-flop a bit on his opinion, but
8 he did say it could not be ruled out as a cause of
9 her harm.

10 At one point he said it was a common cause of
11 her harm. For that reason, the evidence is clear
12 that in September of 1988 we had the negligence. We
13 had the proximate cause, which resulted in a harm,
14 albeit, a very slight harm at that time. In that
15 under Doctor Hall's theory, there was a cyst present
16 which was causing harm to Mrs. Burke at that time.
17 That is their evidence. And it clearly shows that
18 this case is barred by the statute of limitations
19 and should have been brought within two years.

20 My second grounds for it, is that Doctor Hall
21 stands up here and does not claim to be a
22 pathology expert. Does not claim to be an
23 oncology expert. Yet in the course of his
24 testimony, offered opinions to that effect,
25 that contradicted the records upon which he

1 supposedly relied.

2 Essentially, Doctor Hall is speculating as to
3 what the source of this tumor is. What the cause
4 of it is. And, for that reason, there is no
5 credible evidence upon which a Jury could reasonably
6 return a verdict based upon the testimony of
7 Doctor Hall.

8 THE COURT: Mr. Mann?

9 MR. MANN: May it please, Your Honor, with regard
10 to the first point on the statute of limitations,
11 and, of course, this was extensively briefed and
12 argued prior to trial. And the evidence has not
13 changed. If anything, the evidence is much stronger.

14 There was limited amount of evidence that the
15 Court could probably consider at that point. But,
16 at this point, we have, despite Mr. Rawls' Cross
17 Examination, we have evidence that this was a benign
18 tumor in 1988 when it should have come out. We
19 have evidence that this tumor, which was benign
20 in 1988, that out of it grew the cancer that killed
21 this lady. And, we not only have that from
22 Doctor Hall, but we have that from the record of
23 Doctor Kennedy which was read, which he specifically
24 stated this is the treating oncologist and this is
25 an unusual presentation of cancer.

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1 The cancer grew out of a preexisting cyst,
2 which was said to be present in 1988. And, I would
3 doubt that it was malignant at that time. So, I
4 don't have just the testimony of Doctor Hall,
5 so that it's certainly not speculation. But, then
6 again, with respect to the statute of limitations
7 in question. The law in Virginia, as His Honor knows,
8 that it is not just malpractice. It's malpractice
9 that caused the injury. And Mr. Rawls refers to it
10 as a harm.

11 I think the Supreme Court decision says injury.
12 And there is no evidence in this record at the
13 present time that that benign lesion was causing
14 any injury whatsoever to Mrs. Burke in 1988. It
15 potentially could cause an injury when and if it
16 was allowed to become cancerous. There is no
17 evidence that it was pressing anything that you could
18 feel it. There is no evidence that it was doing
19 anything in 1988 except it was there.

20 And, to make the point that was made, I think,
21 early, and perhaps it could be made a little bit
22 clearer at this point. Suppose, for example, that
23 a year after this was there and not causing any
24 injury, but just there. Suppose this lady had died
25 of something else; from an automobile accident.

1 And, suppose then they found it. Would her
2 survivors have a cause of action? The answer is no.
3 Because the first question that any lawyer would
4 ask and the first question that His Honor would
5 ask and the first question that the Supreme Court
6 would ask, Mr. Mann, what injury did she have?
7 Couldn't he have taken it out? And if they
8 had taken it out, wouldn't she have been cured?
9 And the answer is yes.

10 It's not when the negligence occurred. It's
11 when the negligence caused the injury, and they
12 haven't shown anything that indicates that there
13 was any injury. And, the burden is on proof to
14 them to show it. It's not on me to show it.
15 It's not on me to exclude it, and no one knows
16 according to the evidence when it became cancerous.
17 No one knows when it metastasized. We only know
18 that in 1988 when it was available and it was
19 clearly visible, that it should have come out.
20 And, we know it was not cancerous then.

21 So, on the statute of limitations point, I
22 think the Court's original ruling was correct. I
23 think it still stands, and I think it's fortified
24 by the evidence.

25 Now, to move on to the second point about

1 whether or not we proved causation. I don't see
2 how that Motion can be seriously considered. It is
3 about the clearest case of causation that I have ever
4 seen in a cancer case. Because it's not a cancer
5 case until the benign lesion becomes cancerous.
6 And the evidence in this case is that the benign
7 lesion should have come out and it certainly
8 doesn't take a rocket scientist to determine if you
9 take out a benign lesion, then that ain't going to
10 cause cancer in this lady.

11 So far as Doctor Hall's testimony being
12 speculative is concerned, that's ridiculous.
13 Doctor Hall doesn't have to be a pathologist to address
14 causation issues. They can be addressed by any
15 medical witness. And certainly, even if he is
16 giving opinions that relate to the pathology or
17 oncologist, it would go to the weight of his
18 opinion and not the admissibility of his opinion.

19 But, certainly Doctor Hall as a medical doctor,
20 as a surgeon, as someone who goes throughout the
21 country reviewing medical records and determining
22 the cause of deaths, is emphatically qualified to
23 give a causation opinion. And, he has
24 unequivocally done so.

25 MR. RAWLS: Your Honor, if I might respond. 124

1 THE COURT: Mr. Rawls.

2 MR. RAWLS: The testimony of Doctor Hall is
3 that the cyst may very well be the cause of the
4 symptoms, the most common cause of the symptoms
5 that Mrs. Burke had in the fall of 1988. No one
6 is disputing that the cyst at that time was
7 benign. It was. That's not at issue in this
8 case. It never has been an issue in this case.

9 The question is, was it there. Was it a
10 present harm to Mrs. Burke in the fall of 1988.
11 And the answer on that is unequivocally, yes,
12 it was.

13 Now, Mr. Mann makes the point of saying
14 had a survival action been brought, what the
15 claim would have been. Now, Your Honor, I
16 think in that instance we were mistaking the
17 economic liability of a lawsuit from the technical
18 requirement of a lawsuit. That survival action
19 he mentioned would not be a very good suit. It
20 wouldn't be the experts coming to put it on.

21 But technically there would have been a harm
22 which coincided with the negligence, which would
23 have given rise to the cause of action. Albeit a
24 very small one.

25 This case as reported out by the Court before

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1 is very much like Hawks versus DeHart on it. And,
2 in that case, the foreign body which was left in
3 Mrs. Hawks did not cause her any harm for an
4 extended period of time. Yet the Supreme Court
5 found that that was a start of the statute of
6 limitations when it was left.

7 Moving to the second point, Judge, Doctor Hall
8 has based his testimony solely upon the medical
9 records in this case. Yet, he gets on the stand
10 and he says those records are wrong. I disagree
11 with the pathologist. I disagree with that.

12 And, importantly by his own admission, Judge,
13 he admits that he doesn't have the expertise or
14 standing to do so. He just says they are wrong
15 and for that reason it's barred by the statute of
16 limitations, and the Jury cannot rely upon his
17 testimony.

18 THE COURT: Thank you, Mr. Rawls.

19 MR. RAWLS: Thank you, Judge.

20 THE COURT: The Court was really impressed by
21 Doctor Hall's testimony, I'll be frank with you.
22 And it's a close question on the plea of the
23 statute of limitations. But I have read all the
24 applicable law and made my original decision. And,
25 I think it was a correct ruling, and I am going

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1 to stand by that. And the question is when did
2 the negligence cause the injury.

3 I will overrule both of your Motions and the
4 Record will show your exceptions.

5 MR. MANN: Your Honor, for the Record, I would
6 just like to add that we relied not only on what
7 I attempted to articulate this morning, but also on
8 the briefs and so forth that were filed in this
9 earlier. And I am sure Mr. Rawls does the same thing.

10 THE COURT: I understand. Any further Motions?

11 MR. RAWLS: No, Judge. If I could indulge the
12 Court for a few minutes break, I would appreciate it.

13 THE COURT: We will take a brief recess.

14 (Recess)

15 (Jury brought back into open Court.)

16 MR. RAWLS: Your Honor, we call Doctor Lo.
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1 HING-HAR LO, M.D.

2 was duly sworn and testified as follows:

3 DIRECT EXAMINATION

4 BY MR. RAWLS:

5 Q Doctor Lo, would you be kind enough to introduce
6 yourself to the Jury, please.

7 A My name is Hing-Har Lo, M.D., and I work with
8 Montgomery Radiologist Associates since 1982.

9 Q Doctor Lo, would you tell the Jury where you
10 went to undergraduate school?

11 A I went to Adelphi University, New York.

12 Q What was your degree in there?

13 A It was a Bachelor's in Physics.

14 Q What did you do following Adelphi University?

15 A I went to graduate school at Cornell Medical
16 School Institute, and got my Master's Degree in Radiation
17 Physics.

18 Q Is that not an M.D., Doctor Lo?

19 A No.

20 Q Why did you get a Master's Degree in Radiation
21 Physics?

22 A I thought I was interested in medical physics.

23 Q What did you do following your Master's Degree,
24 Doctor?

25 A I worked as a radiation physicist one year in

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1 Illinois, Chicago area. And, the following five years
2 I was a radiation physicist at Harvard's Massachusetts
3 General Hospital.

4 Q During your five years you were at Harvard, did
5 you hold any faculty positions?

6 A Yes, I was an instructor in Physics in the
7 Radiology Department.

8 Q With what university or college was that?

9 A Harvard Medical School.

10 Q And, Doctor, when did you go to medical school?

11 A After that time my family was fairly
12 well-situated and I thought I wanted to go on for a
13 doctorate degree. And I thought about going to a medical
14 school, a Ph.D. program. And, I was very happy I was able
15 to go to medical school at that time.

16 Q Where did you go to medical school?

17 A I went to the State University of New York at
18 Buffalo.

19 Q And did you take a residency following your
20 medical education?

21 A Right. I always wanted to go into nuclear
22 medicine and radiology. So, after my medical school,
23 I went to a radiology training program.

24 Q Where was that, Doctor Lo?

25 A At Massachusetts General Hospital in Boston. 129

1 Harvard Medical School.

2 Q And, Doctor, in your residency, was that a
3 radiology residency you went through?

4 A Diagnostic radiology.

5 Q When did you complete that residency?

6 A In December of 1977.

7 Q And, Doctor, are you Board-certified in
8 radiology?

9 A Yes.

10 Q What does it mean, if you can tell the Jury,
11 what Board-certification means.

12 A It's our College of Radiology has our specialty
13 examination of our competency in what the field we have
14 been trained in.

15 Q And, Doctor Lo, are you Board-certified in
16 any other field?

17 A Yes, I am also Board-certified in nuclear
18 medicine and radiation physics.

19 Q What does it mean to be Board-certified in
20 radiation medicine?

21 A That also means I have competency in nuclear
22 medicine training, in addition to my radiology training.
23 And, it's a completely separate specialty Board.

24 Q What about the radiation physics?

25 A I did that before I went to medical school,

1 just to complete my -- sort of my field in radiation
2 physics. I thought that would be accomplishing a goal
3 that I had.

4 Q Now, Doctor, since you completed your residency,
5 have you practiced radiology?

6 A Yes.

7 Q Where have you practiced, Doctor?

8 A I was professor at Emory Medical School for
9 two years. And, then, from there I went into private
10 practice two years in Columbus, Georgia with a major
11 medical center. And, then we moved here since 1982.

12 Q When you say Emory University, is that the one
13 in Atlanta, Doctor?

14 A Yes.

15 Q And, Doctor, why did you move to Blacksburg in
16 1982?

17 A Because my husband had been offered a
18 professorship at Virginia Tech.

19 Q And have you been in Montgomery County since
20 then?

21 A Yes.

22 Q Have you been with Montgomery Radiology Associates
23 since then?

24 A Right.

25 Q Doctor, if you would tell the Jury briefly,

1 what does the practice of radiology involve?

2 A We are typically asked to examine or do
3 examinations on patients to find out what is causing them
4 the problem. We can briefly look at their films if they
5 come in through the ER room. Or we may do a barium study
6 to see their gastrointestinal tracts. To see whether
7 they have upper GI problems or lower GI problems.

8 We could do nuclear medicine studies to look for
9 their pains. Bone pains. Or, if they have chest pains,
10 whether we do a lung scan to see if there are blood clots
11 and more recently we have ultrasound studies. Typically
12 we do most of our examinations in doing gallbladder,
13 because that's usually pain caused in the upper GI tract.

14 We also do modalities or CT scans. Tomography
15 examinations. And also the more recent thing is the
16 magnetic resonance imaging. That is, we look at the
17 brain. We look at the spine. We look at the
18 musculoskeletal joints and so forth.

19 Q As a radiologist, you typically take a history
20 of the patient being examined?

21 A Depends on what we are doing. If we are
22 doing GI studies, sometimes we ask why are you here,
23 and where are you hurting. And then we might come
24 in into the area of interest. Very often we may not
25 even see the patient, like, if you come through the ER.

1 We just see the requests saying why you are here in the
2 emergency room. And, we would look at the X-ray films
3 taken from there.

4 If we are doing a CT scan, a technologist would
5 talk to you and do the examination. And, we would look
6 at them afterward. If we have any requests about certain
7 areas, we may have to call you back and do a specialized
8 examination for that particular area.

9 For the resonance imaging, we don't talk to
10 the patient unless they are claustrophobic or have
11 pain. Then we may premedicate them.

12 Q Would you typically talk to the patient with
13 regards to a CT scan?

14 A Not typically.

15 Q Now, Doctor, if you could, would you try
16 to distinguish for the Jury between the role you play
17 as a radiologist consultant and a primary care physician?

18 A The primary care physician would often call us
19 up and ask us what the best exam to order for this
20 particular patient of mine with certain problems. We
21 would recommend certain examinations to them. That's
22 more or less the role of our studies.

23 And, often if they are very worried about
24 a certain patient, they would want us to call them with
25 the results right away before the patient leaves. So

1 they can have more immediate attention right after our
2 examination.

3 Q And, Doctor, are you involved in the care of the
4 patient after you read the study and perform the test?

5 A No.

6 Q Now, Doctor, even after you perform a test or
7 read a study, do primary care physicians frequently call
8 back and ask you to take another look at those tests?

9 A Sometimes they do.

10 Q Why would they do that?

11 A Sometimes they feel the answer is not what
12 they are expecting. Then they would ask us to look a
13 little bit more. Whether there is another examination we
14 can perform or can we review the case for them.
15 Whether we may have overlooked some problems.

16 Q Is that a fairly common occurrence, Doctor?

17 A Yes.

18 Q Now, Doctor, turning your attention to
19 Mrs. Burke, why was the CT scan done on September 1, 1988?

20 A It was done because in July Mrs. Burke came in
21 for right upper quadrant ultrasound study. Typically
22 they were expecting some problem in her gallbladder or her
23 liver.

24 Ultrasound study is the first line of study,
25 because that's easy to do on the patient and it's the 134

1 cheaper of all the examinations. I did the ultrasound
2 study.

3 Typically we would go into the room and examine
4 the patient ourselves with a probe. And, I found a
5 septated cyst in the liver. So I recommended to have
6 a follow-up study done of the CT scan to see a little
7 bit better, because the ultrasound can tell us something.
8 A CT can tell us a little bit more. That is sometimes
9 a complimentary examination.

10 Q Was it your understanding that the CT done in
11 September was in regard to a liver problem?

12 A Right.

13 Q Now, Doctor, after September 1, 1988, did
14 Doctor Dyer or any other physician, Doctor Asrani, did
15 they ask you to take a look at either of those studies
16 again?

17 A No.

18 Q And that included up through the time of
19 January 1991?

20 A Correct.

21 Q Now, Doctor, you performed an ultrasound on
22 Mrs. Burke in April of 1991, is that correct?

23 A Correct.

24 Q And, Doctor, what did you find at that time?

25 A Usually we don't have time to before and

1 often we like to know before whether this patient had
2 another examination or not. In her particular case,
3 we know it's a follow-up or possibly a follow-up of the
4 liver lesion.

5 I usually look at a case just before I go in,
6 just the ultrasound part. I don't remember if I did this
7 before or not, but I know I did it afterward. I saw the
8 cyst in the liver and I didn't think it changed very much.

9 But then, to my surprise, I found a five cm cyst,
10 particularly a lesion at the tail of the pancreas at that
11 time.

12 Q Was that on the ultrasound?

13 A Yes.

14 Q Did you go back and then look at the CT from
15 September of 1988?

16 A Yes. Usually we try to compare the same
17 examination with the examination or similar examination of
18 the abdomen. So I looked back on the ultrasound. I
19 couldn't see very much at that time in the pancreas. Like
20 Doctor Hall said, ultrasound doesn't see very well of the
21 pancreas because of overlying gas. But this particular
22 time I was able to see something. And, I went back not
23 only with the ultrasound, I went back just in case it was
24 there in 1988.

25 I looked at the CT scan, and there was a 3 cm

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1 thing. In retrospect, I saw that.

2 Q Would you describe what that cyst looked like
3 in 1988?

4 A It looked like a very simple single unilocular --
5 what that means is one simple looking fluid collection.
6 In the abdomen around the area you have loops of bowel and
7 it could be fluid-filled, also.

8 Q And what would you describe that 3 centimeter
9 cyst you saw?

10 A Looking back, I thought it looked like a small,
11 simple cyst. And, like we have gone through yesterday
12 and many things can happen. This pancreas, by majority,
13 a pseudocyst is the choice because it looks so simple and
14 very thin-walled. There is nothing else associated with
15 this thing.

16 Q When you say associated with it, Doctor, is
17 there a description often between a cystadenoma and a
18 pseudocyst looking on a CT?

19 A Yes. If there is any solid or nodular component
20 that we see on ultrasound, we would say this is a simple
21 cyst, or we see there is a mass associated with this cyst.
22 And, if there is a mass associated with it, then we would
23 think of a tumor involved, rather than just a fluid. A
24 simple fluid collection.

25 Q And what did you consider your diagnosis to

1 be in April of 1991 on both the CT and the ultrasound
2 you did?

3 A In April of 1991 on ultrasound I saw a single
4 cyst. But at the side of the wall I thought I saw what
5 we called multinodal right along the side of the wall.
6 There is a little nodule there. I thought that is
7 something that I would worry about now.

8 And, on CT, interestingly enough, I can't
9 really see that nodule. That was seen on ultrasound.

10 Q Now, Doctor, after you got the results of the
11 ultrasound on April 26, 1991, what did you do?

12 A When I knew there was a change if I looked
13 back to the CT of 1988, I immediately called
14 Doctor Dyer and told him about it. I said, she needs
15 definitely something more done to her and find out
16 what is the nature of this cystic mass.

17 Q Doctor, in your career as a radiologist,
18 approximately how many studies or films have you read,
19 if you know?

20 A I can't remember. It's -- I think we probably
21 read 10,000 cases each read at least.

22 Q And how long have you been a radiologist?

23 A Since 1977.

24 Q That's approximately 150,000 studies?

25 A Yes.

1 MR. RAWLS: If you would answer Mr. Mann's
2 questions, please.

3 MR. MANN: Your Honor, we have no questions
4 of Doctor Lo.

5 THE COURT: Thank you, Doctor Lo.

6
7 X X X X X X X X X X

8 WITNESS STOOD ASIDE

9 X X X X X X X X X X

10
11 MR. RAWLS: Your Honor, we rest at this time.

12 THE COURT: Any Rebuttal?

13 MR. MANN: No, sir.

14 THE COURT: Take the Jury to the jury room
15 again, and we will do Instructions.

16 (The Jury was excused.)

17 MR. MANN: Your Honor, please, at this time I
18 would move the Court for summary judgment on the issue
19 of liability or collected verdict on the issue of
20 liability on the grounds that the uncontradicted
21 evidence shows that this admitted negligence was the
22 proximate cause of the death of this lady. And,
23 rather than elaborate or enumerate at this time,
24 I think the argument that I previously made in
25 connection with Mr. Rawls' Motions are appropriate



* * *

1 nobody ever came back and followed up in all of
2 that.

3 There is ample evidence that that could very well
4 have been the cause of all of this.

5 MR. MANN: You have to have expert testimony to
6 prove the causation, and you already offered an
7 Instruction on that. There is no testimony along
8 those lines.

9 MR. RAWLS: Your Honor, I think it goes back to
10 what Doctor Hall said in his rather muddled testimony
11 on it as to what could have been or what was the
12 cause of it.

13 THE COURT: Doctor Hall, I will tell you, I think
14 Doctor Hall in 38 years is the only medical witness
15 I ever heard testify that the Jury could understand.
16 I hate to say that, but that's true. 10.2 is
17 refused.

18 MR. RAWLS: I think we have already addressed the
19 issues of what would be 10.3 and 10.4. Note my
20 objections noted on that, please.

21 THE COURT: 10.3 is the statute of limitations.
22 10.4 is already covered.

23 MR. RAWLS: 10.4 also contains a statute of
24 limitations element of it, Judge.

25 THE COURT: Yes, all right. Is that all the

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arrived at your verdict?

We the Jury on the issues joined find our verdict for the Plaintiff and set the damages at \$302,000 to be divided as follows: \$227,000 to James F. Burke. \$25,000 to Mary B. Dodson. \$25,000 to Nancy A. Burke. And, \$25,000 to Elizabeth B. Daly. Signed, Wanda W. Duffey, Foreman.

Does anyone wish the Jury polled?

MR. MANN: No, Your Honor.

MR. RAWLS: I do not, Judge.

THE COURT: Thank you very much for your work for these last two days.

(The Jury was excused.)

THE COURT: Are those Motions?

MR. RAWLS: I would make a Motion to set aside for the grounds previously set forth in my Motion at the conclusion of the Plaintiff's evidence.

MR. MANN: Your Honor, please, I believe the same remarks I made earlier would be applicable to the Motion.

THE COURT: All right, I will overrule your Motion, and I will say this to both of you gentlemen, I have never seen a better prepared and tried case in my time on the bench in practice of law. It is a pleasure to have good lawyers up here.

1 Come back, please.

2 (The proceedings were concluded at 2:15 p.m.)



VIRGINIA: IN THE CIRCUIT COURT OF THE COUNTY OF MONTGOMERY

JAMES F. BURKE, Executor of the)
Estate of MARY HUTCHESON BURKE,)
Deceased,)

Plaintiff,)

v.)

JUDGMENT ORDER

DR. HING-HAR LO)

Case No.: V-7791

and)

MONTGOMERY RADIOLOGY ASSOCIATES,)
INC.,)

Defendants.)

On the 6th day of December came the parties to this action, in person and by their attorneys, and both sides announced they were ready for trial upon the pleadings heretofore filed.

Whereupon, came the following jury of seven: Rhonda W. Duffle, Deborah L. Echols, Donald G. Englar, Donald G. Mackler, Michele K. Montgomery, Franklin R. Perdue, Tammy B. Phillips, who were sworn to well and truly try the issues in this matter and a true verdict render according to the law and evidence.

The Plaintiff then proceeded to introduce his evidence. After Plaintiff had rested, Defendants moved to strike the Plaintiff's evidence on the ground that as a matter of law Plaintiff had failed to prove the requisite causation. After hearing argument of counsel, the Court overruled the Defendants' motion, to which action Defendants objected and excepted.

The Defendants then renewed their motion for summary judgment based on their plea in bar on the ground that the

applicable two year statute of limitations barred the Plaintiff's claim. After hearing argument of counsel, the Court overruled the Defendants' motion, to which action Defendants objected and excepted.

The Defendants then presented their evidence and rested. The Plaintiff then moved the Court for summary judgment on liability on the ground that the evidence showed as a matter of law that the Defendants' negligence was the proximate cause of the decedent's death. After hearing argument of Counsel, the Court overruled the Plaintiff's motion, to which action the Plaintiff objected and excepted.

The jury, having heard all the evidence, received the instructions of the Court, and heard argument of counsel, retired to their room to consider their verdict and, after some time, returned and rendered the following verdict on December 7, 1993:

"We the jury on the issue joined find our verdict for the Plaintiff, and set his damages at \$302,000.00. We direct that said amount be divided as follows:

\$227,000 to James F. Burke;

\$25,000 to Mary B. Dodson;

\$25,000 to Nancy A. Burke; and

\$25,000 to Elizabeth B. Daley."

Rhonda W. Duffle
"Foreman"

The Defendants, by counsel, then moved the Court to set aside the verdict of the jury on the ground that it was

contrary to the law and the evidence, which said motion, upon consideration by the Court, was denied and overruled, and to which action the Defendants, by counsel, objected and excepted.

Upon consideration all of which, it is the judgment of the Court that the Plaintiff, James F. Burke, Executor of the Estate of Mary Hutcheson Burke, deceased, recover and have judgment against the Defendants, Dr. Hing Har Lo and Montgomery Radiology Associates, Inc., for the sum of Three Hundred Two Thousand (\$302,000.00) Dollars, the amount of the damages by jury in its verdict awarded, with interest thereon as provided by law until paid, together with his proper costs herein expended.

Enter this the 16th day of Dec., 1993.

Dwaine E. Smith
Judge

I ASK FOR THIS:

Robert W. Mann
Robert W. Mann, Counsel
for the Plaintiff

SEEN AND OBJECTED TO
FOR REASONS HERETOFORE
ASSIGNED:

Brewster S. Rawls
Brewster S. Rawls, Counsel
for the Defendants

JUDGMENT DOCKETED
NOV 27 PAGE 39

SPOTTS, SMITH, FAIN & RAWLS, P.C.

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WRITER'S DIRECT DIAL NO.: 788-1315

January 13, 1994

VIA FEDERAL EXPRESS

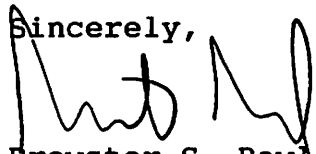
Allan C. Burke, Clerk
Montgomery Circuit Court
P. O. Box 209
Christianburg, VA 24073

RE: Estate of Mary Burke v. Montgomery Radiology
Associates, Inc., and Hing-Har Lo, M.D.
Case No. V-7791

Dear Mr. Burke:

Enclosed please find a Notice of Appeal to be filed with
regard to the above-referenced matter.

Thank you for your kind assistance.

Sincerely,

Brewster S. Rawls

BSR/cmm
Enclosure
cc: Robert W. Mann, Esq.

ASSIGNMENTS OF ERROR

- I. The trial court erred in ruling that plaintiff's action was not barred by the applicable statute of limitations.
- II. The trial court erred in overruling defendants' motion to strike the evidence, which motion was based on the fact that plaintiff did not properly prove that defendant's negligence proximately caused the death of plaintiff's decedent.
- III. The trial court erred in overruling defendants' motion to set aside the verdict as contrary to the law and the evidence.
- IV. The trial court erred in allowing plaintiff's expert to comment about what action would have been taken by the personal physician of plaintiff's decedent had the existence of the cyst been reported in September 1988.