IN THE COURT OF COMMON PLEAS
FIRST JUDICIAL DISTRICT OF PENNSYLVANIA
CIVIL TRIAL DIVISION

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KARIN JONASSEN, INDIVIDUALLY AND AS EXECUTRIX OF THE ESTATE OF SEAN JONASSEN,	:	MARCH TERM, 2009
vs.	:	
WILLIAM M. BATTLE, M.D. and FOX CHASE GASTROENTEROLOGY ASSOCIATES, P.C. and EDWARD LAWRENCE BEDRICK, M.D. and FOX CHASE MEDICAL ASSOCIATES, P.C. and THEODORE M. MAGIDA, M.D., and JEANES HOSPITAL	:	NO. 0222

WONG
GENDECIN

- - -

July 13, 2011
Courtroom 432 - City Hall
Philadelphia, Pennsylvania

- - -

B E F O R E: THE HONORABLE GEORGE W. OVERTON, J.

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JURY TRIAL
DAY 2, VOLUME 2

- - -

TRACY ALLEN, RPR

OFFICIAL COURT REPORTER

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DAY 3, VOLUME 2

State your full name and spell your last.

THE WITNESS: Paul Genecin, G-E-N-E-C-I-N.

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DR. PAUL GENECIN, after having been first duly sworn, was examined and testified as follows:

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THE CRIER: You may be seated. Your Honor, the witness is sworn.

THE COURT: Good afternoon. The attorneys have questions.

- - -

DIRECT EXAMINATION ON QUALIFICATIONS

- - -

BY MR. BEZAR:

Q. Doctor, tell the ladies and gentlemen of the jury in what area -- what do you do for a living?

A. I am an internist, so I see patients who are adults. I also teach and work in an administrative job at Yale.

Q. And that was my next question, where you practice.

A. New Haven, Connecticut.

Q. Doctor, what is the name of that practice?

A. Yale Health.

Q. And you described it as an internal medicine practice?

A. My practice is part of internal medicine, but it has all different specialties.

Q. Do you mean subspecialties like gastroenterology?

A. But also pediatrics, obstetrics, surgery, all types of clinical medicine.

Q. You talked about your practice being internal medicine as a similar area as Dr. Bedrick?

A. Yes.

Q. What is, just generally, internal medicine?

A. The medical care of adults, generally older than 18 and really no age limit. And it's the types of illnesses that are common. For example, diabetes and hypertension, cholesterol,

and also more rare problems, different types of cancer, for example.

Q. Would gastroesophageal reflux disease, GERD, be something you see as an internist?

A. Yes, almost daily.

Q. You have an opportunity to work with physicians in different subspecialties, like gastroenterology?

A. Yes.

Q. Have you had an opportunity to work with consultants like gastroenterologists and share patient, for lack of a better phrase?

A. Yes.

Q. Sir, the hour is late, so I am going to move through your qualifications pretty quickly.

Tell the ladies and gentlemen of the jury where you went to college.

A. Princeton University.

Q. And that's in New Jersey, sir?

A. It is.

Q. And after graduating from Princeton, what did you do?

A. I did courses at Columbia University to qualify for medical school and then went to

medical school at Columbia College of Physicians and Surgeons.

Q. And after graduating or when graduating Princeton, did you have any honors?

A. Yes.

Q. What honor was that?

A. Summa Cum Laude, the highest academic honor, and Phi Betta Kappa.

Q. Where did you go to medical school?

A. Columbia.

Q. When did you graduate?

A. 1983.

MR. BEZAR: And, Ms. Pieta, do you have a copy of the CV?

(Pause.)

MR. BEZAR: Your Honor, we have a copy marked Plaintiff's Exhibit 14. May I hand that to the witness?

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(Plaintiff's Exhibit 14 for identification.)

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MR. BEZAR: Your Honor, I have

a copy of the report. To save time, can I mark that as the next exhibit, that's 15?

THE CRIER: Your Honor, both have been marked as 14 and 15 and shown to the witness.

BY MR. BEZAR:

Q. At any time, Doctor, if you need to refer to your CV or resume, do so.

After graduating medical school, what did you do?

A. I did an internship and residency in internal medicine also at Columbia.

Q. After that, what did you do, sir?

A. Then I did three years of additional training at Yale University, mostly in liver disease.

Q. And looking at your CV, Page 2 says, postdoctoral clinical fellow, digestive diseases.

Is that the training you are talking about?

A. Yes.

Q. And after that training at Yale, what did you do?

A. I went to work in 1989 as an internist.

Q. And where was that, sir?

A. Also at Yale University at what is now called Yale Health.

Q. Take us, if you could, from when you started at Yale University Health Services up to the present date and describe your employment.

A. Well, I should probably say that as of now I am the director of Yale Health and an internist. I am attending physician at Yale New Haven Hospital, and I am a clinical associate professor of medicine at the School of Medicine in the Department of Medicine.

And in that capacity, I see patients both in a clinic-type of appointment setting and also in the hospital.

And I also do a bit of teaching.

Q. Teaching? Who do you teach, sir?

A. Yale School of Medicine medical students and the interns and residents at Yale New Haven Hospital.

Q. Do you have an opportunity to train young -- I guess recently graduated medical students becoming young doctors?

A. Yes.

Q. Sir, can you describe some of the honors and recognitions that you've received?

A. In medical school, I graduated, again, with some honors, Alpha Omega Alpha, an honor society for medical graduates, a graduation prize, and a number of other prizes and recognitions, including the Top Docs and Top Physician type of recognition.

Q. Are you licensed to practice medicine?

A. Yes, in Connecticut.

Q. And are you board certified?

A. Yes.

Q. In what areas?

A. Internal medicine.

Q. Sir, are you -- do you have an advanced training in radiology?

A. No.

Q. Do you plan on offering any standard of care testimony with respect to radiology?

A. No.

Q. Do you have any advanced training in oncology?

A. No.

Q. Do you have any plan on offering

testimony with respect to oncology?

A. No.

Q. Page 4 of your resume, it says 1989 to the present, lectures in clinical internal medicine, and you list 30 of them. Without going through them, cite a coup of them that might be applicable in this particular case.

A. Well, acid peptic disease and other causes of management of GI bleeding, inflammatory bowel disease, acute and chronic pancreatitis, some tangentally manifestations and complications of liver disease. That's probably it.

Q. Sir, have you published or been involved in a publication of any papers?

A. Yes.

Q. Have you been involved in publication of any chapters in textbooks?

A. Yes.

Q. Have you had the opportunity to offer testimony during medical/legal matters on prior occasions?

A. Yes.

Q. And have you had the opportunity to testify for both plaintiffs and defendants?

A. Yes.

Q. Sir, over the course of how many years have you offered your testimony in medical/legal matters?

A. More than ten, probably 13 or 14 years.

Q. And I'm sorry if I asked this: Did you offer testimony on behalf of both physicians and patients?

A. Yes.

Q. Sir, are you familiar with the standards of care involved in internal medicine?

A. Yes.

Q. Are you familiar with the standard of care involved with the comanagement of patients?

A. Yes.

Q. When I say "comanagement", sir, I am talking about managing patients with other subspecialties besides internal medicine.

A. Yes.

Q. Sir, are you familiar with the standards of care in terms of followup after receiving ultrasound reports?

A. Yes.

Q. Sir, in your practice, have you had the

opportunity to order follow-up studies after reviewing an ultrasound report?

A. Yes.

MR. BEZAR: Those are all the questions on qualifications.

MR. CAMHI: May I proceed?

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CROSS-EXAMINATION ON QUALIFICATIONS

- - -

BY MR. CAMHI:

Q. I will try to be brief.

The articles that you've published are listed in your Curriculum Vitae; they total seven, and none of them have anything to do with gallbladder cancer, true?

A. Yes.

Q. The last article that you published was over 17 years ago, in 1994, true?

A. Yes.

Q. And no publications in the last 17 years, true?

A. Yes.

Q. The lectures that you lectured on, you list some cancer in your collection; meaning, you

list some topics of various types of -- you list the topics of lectures in your CV that Mr. Bezar asked you about, some having to do with cancer and none having anything to do with gallbladder cancer, correct?

A. Yes.

Q. Director of Yale Health, now, Yale Health is essentially a network of physicians who treat patients that have something to do with Yale University, correct, sir?

A. It's not exactly a network. It's actually a factorial-specialty practice and provides care to the faculty and staff, dependents and students and also retirees.

Q. So there's 11,000 students at Yale?

A. Yes.

Q. There's a large number of faculty at Yale, family members of faculty, and retirees of Yale; and those are the people that compromise the patient population for you and other members of different specialties at Yale Health?

A. Yes, as well as a staff members, clerical and technical workers, service, maintenance, management, professional staff; not

just faculty.

Q. Can we agree, sir, that approximately 60 percent of your professional time is spent with administrative duties?

A. At the moment it's about half and half; at times, 60 percent.

Q. Fifty to 60 percent of your time is dealing with budgeting, staffing buildings, electronic medical records, things like that, sir?

A. That's correct.

Q. You said you had a practice similar to Dr. Bedrick? Do you remember saying that?

A. Yes.

Q. Sir, the fact is that when you see patients in an office setting, you essentially do that for three half-days a week?

A. That's right.

Q. Do you know how often Dr. Bedrick sees patients in his office setting?

A. My understanding is he's a full-time clinician.

Q. Am I correct, sir, that you are still seeing patients three days a week, on Tuesday, Wednesday, and Fridays?

A. Tuesdays, Thursdays, and Fridays.

Q. That's why you are here today, Wednesday?

A. Could be.

Q. Now, you were asked briefly about your experience in testifying in -- I'm sorry -- in reviewing medical malpractice cases.

A. Yes.

Q. I believe you said that's about 13 to 14 years, sir, and you reviewed, sir, between ten to 15 cases per year over that period of time?

A. Yes, that's about average.

Q. If we did the math, we would get between 150 and 170 and 180 total cases received where doctors are accused of negligence and patients are seeking money damages?

A. Yes.

Q. Some of those times have been on behalf of the doctors, where doctors' lawyers may contact you and say, Doctor, take a look at this case and provide an opinion on behalf of the doctor, and more than half those cases have been on behalf of the patients bringing claims on behalf of -- I'm sorry -- have been on behalf of lawyers bringing

claims on behalf of patients suing doctors?

A. Yes.

Q. That's approximately 80 to 90 percent of the time would be testifying -- I'm sorry -- reviewing records on behalf of the patients suing the doctors?

A. Yes, it's three or four to sometimes five to one of patients to physicians.

Q. As far as your testimony is concerned, you've given testimony under oath in courtrooms as an expert, true?

A. I have.

Q. Somewhere between 30 to 40 times?

A. That could be, yes.

Q. You've given deposition testimony where you are, under oath, asked a series of questions at a deposition, and you've done that 30 to 40 times?

A. Approximately.

Q. Do you charge for your services?

A. Yes.

Q. I should say you charge for the time you put into the doing the work you are asked to do?

A. Yes.

Q. Still $400 per hour to review records?

A. Yes.

Q. $5,000 to come testify in court plus travel expenses, sir?

A. Yes.

Q. You reviewed cases that come from a variety of states around the United States, and I am not going to take the time to go through them. Can we assume -- would you agree it's in the neighborhood of 25 states?

A. I never counted, but it's quite a few.

Q. You wouldn't disagree with 25 or so?

A. I would have to count in order to be certain, but a lot.

Q. And for some reason, sir, half or more those cases come from Pennsylvania?

A. I would say more than half.

Q. More than half?

A. Yes.

Q. You are in Connecticut?

A. I am.

Q. And the reason why those cases -- you have a majority of the cases from Pennsylvania, even though you are in Connecticut, is what, if

you know? Maybe you don't know.

A. I don't really know.

Q. Sir, you are associated with and have been associated with various services that match experts to malpractice cases, true?

A. Yes.

Q. There's a company called MedQuest, and you deal with Elliot Stone at MedQuest?

A. Yes.

Q. And over a period of several years Mr. Stone or his office have sent you cases and said, take a look at the case and let me know what you think?

A. Yes.

Q. The same is true for New England Medical Legal Consultation Services?

A. I don't think I've seen a case from there in five years, but, yes, in the past.

Q. Over the years, that service sent you cases, correct?

A. Yes.

Q. There's a service located in Blue Bell, Pennsylvania, Technical Advisory Services for Attorneys, TASA. You receive cases from that

company as well, sir?

A. Yes, on occasion.

Q. And another company called Consolidated Consultants sent you cases over the years to review, sir?

A. Yes, one or two, one or two a few years ago.

THE COURT: Any other questions?

MR. CAMHI: No, sir.

MS. RAYNOR: No, thank you.

MR. PITT: No, Your Honor.

MR. BUSHMAN: No, sir.

THE COURT: You are offering the doctor as an expert?

MR. BEZAR: In internal medicine, Your Honor.

THE COURT: Dr. Genecin will be accepted as an expert in the area proffered.

You may proceed.

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DIRECT EXAMINATION

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BY MR. BEZAR:

Q. Doctor, just a couple questions to follow up on a couple questions Mr. Camhi asked you.

You have been qualified as an expert in approximately 25 states around the country?

A. As I said, I haven't done a count, but in quite a number of states.

Q. When you are qualitied, it's as an expert witness in the area of internal medicine?

A. That's correct.

Q. And in reviewing cases or getting medical records to review, when you receive them on behalf of a plaintiff or patient, do you always find merit with the case?

A. No, certainly not.

Q. When you receive it on behalf of a defendant or doctor, do you always defend that case?

A. No.

Q. Sir, is there anything about your prior history in reviewing cases or testifying as an expert that influences your opinion that you are

about to present to the Court today?

A. No, my opinions are based on my education, my training, my experience in internal medicine.

Q. Moving on, Doctor, at my office's request, did you review records involving Sean Jonassen?

A. Yes.

Q. Dr. Heller this morning, and I believe Dr. Wong, talked about a bunch of records that they had seen and reviewed.

If you could just take a look at your report, which I believe we marked as Plaintiff's Exhibit 15, and if you could identify the records and the information that you reviewed regarding Sean Jonassen.

A. Yes, Fox Chase Gastroenterology Associates; Fox Chase Medical Associates; Jeanes Hospital admission January 17th, 2006; Jeanes Hospital outpatient radiology studies; records of Gastrointestinal Associates; Memorial Sloan-Kettering outpatient records as well as records of admissions in July 2007; and then, finally, deposition transcripts of Drs. Bedrick,

Magida, and Buhl.

Q. Doctor, did you have an opportunity to review Dr. Bedrick's office notes?

A. Yes.

Q. And you had the opportunity, sir, to review Dr. Buhl's office notes?

A. Yes.

Q. Now, we talked about Plaintiff's Exhibit, I believe, Number 2?

A. Yes.

Q. And Plaintiff's Exhibit 2, which is this ultrasound report from an ultrasound done in January of 2006?

A. (Nonverbal response.)

Q. I believe, Doctor, you were in the courtroom when it was discussed a little bit?

A. Yes.

Q. And you had an opportunity to look at this ultrasound report?

A. Yes.

Q. Very familiar with it?

A. Yes.

Q. Familiar with the issues surrounding this report?

A. I am.

Q. Sir, based on information that you reviewed, did you formulate an opinion as to whether the care provided by Dr. Bedrick met with the appropriate standards of care?

A. I did.

Q. What is the opinion, sir?

A. My opinion is that when Dr. Bedrick received this result stating that the gallbladder was markedly abnormal, the standards of care required that he do follow-up testing.

Q. And is your opinion, sir, within a reasonable degree of medical certainty?

A. Yes.

Q. Sir, do you have an opinion whether a follow-up CAT scan in January 2006 would have revealed a gallbladder cancer?

MR. CAMHI: Objection.

THE COURT: Sustained.

BY MR. BEZAR:

Q. Do you have an opinion as to whether follow-up testing would have revealed the gallbladder cancer in January or February --

MR. CAMHI: Objection.

THE COURT: Sustained. Calls for speculation.

BY MR. BEZAR:

Q. Sir, why was Dr. Bedrick required to do followup after receiving this ultrasound?

A. Because the doctor is required to use what's called a differential diagnosis in that -- what that means is that the doctor needs to consider all the different possible explanations for why this gallbladder was diseased and markedly abnormal because that's a most unusual finding in a young man.

The differential diagnosis would include conditions that have been called benign, in other words, not cancer, but it could also be cancer.

The importance of follow-up testing is in order to distinguish disease that's benign, or not cancer, versus malignant, which was cancer.

Q. Dr. Wong testified probably about an hour ago that the phrase "markedly abnormal" when read with the rest of the report didn't jibe. I believe she used the expression, didn't jive.

Does it matter what it says in the

rest of the report?

MR. CAMHI: Objection.

THE COURT: Overruled.

BY MR. BEZAR:

Q. Based on the phrase "markedly abnormal" in reference to the gallbladder, are you going to do follow-up testing?

A. The second part is correct, yes, a markedly abnormal gallbladder needs additional testing.

Q. Would it have been helpful if cancer or the potential for cancer had been identified in this ultrasound report?

A. Yes.

Q. Would that have changed your course of conduct?

A. No. I think that when I read that a gallbladder is markedly abnormal in a 35-, 36-year-old man, that's sufficiently unusual and alarming that it demands a workup because cancer is a differential diagnosis, and I would say that regardless of whether the word "cancer" or "malignency" is mentioned in the report.

Q. Now, you said cancer. When you read

"markedly abnormal", that's within the differential diagnosis?

A. Correct.

Q. Why is that?

A. Because a markedly abnormal gallbladder with thickening of the wall raises a concern about what's called neoplastic, or a tumor, type of lesion. There's other findings that are also abnormal, and there's a reading that it could possibly be due to a condition called adenomyosis, which is really adenomyomatosis.

If so, it doesn't sound like it from the description, and further testing would be needed to characterize what was going on with this gallbladder.

Q. So read together, Doctor, the thickening of the wall -- the gallbladder is markedly abnormal with thickening of the wall, and the reference to adenomyosis or adenomyomatosis, does that dissuade you that cancer is a possibility?

A. Does it?

Q. Does it -- I'm sorry. Does that dissuade you that cancer is a possibility?

A. No, it doesn't dissuade me because you

can't exclude the possibility of cancer in an abnormal gallbladder, and the diagnosis of an adenomyomatosis is best made under a microscope, not, for the most part, an ultrasound result.

Q. Now, there's testimony also that this ultrasound or any CAT scan to follow it could not definitively diagnose cancer.

Do you agree with that, sir?

A. Yes.

Q. What would diagnose cancer?

A. In order to make a definite diagnosis of cancer or to rule out, a biopsy or tissue diagnosis is required.

Q. As an internist, what is the next steps you would take after reading the report to secure a biopsy?

A. First, the patient would need a CT scan, then likely a guided biopsy using CT, but there's a variety of ways to obtain a biopsy; a surgeon can do that.

Q. As a clinician, can you ignore or not act on this report?

A. No.

Q. Why not?

A. Because an incidental finding of this sort is similar to an unexpected finding of a mass in the lung or an abnormality in the kidney, could be cancer. And in that situation, diagnosis has to be done aggressively because if it's delayed, then that decreases the patient's chance of recovery. Often, a cancer is most curable when they remove it surgically, and the delay in the diagnosis of cancer means that it cannot be curable.

Q. Sir, in treating patients, when educating residents about treating patients or medical students about treating patients, do you inform them, or do you believe that a patient has a right to know about an abnormal finding?

A. Yes, that's essential.

Q. Should Sean Jonassen have been told that he had a markedly abnormal gallbladder found on ultrasound?

A. Yes.

Q. Why?

A. Because a patient has a right to understand the risks and the benefits of any step that a doctor recommends, so if the patient has a

markedly abnormal gallbladder and it's really found as unexpected or incidental finding and the doctor does not feel another workup is warranted, he has to tell that patient that this could be benign but it could be malignant and that the risk of not doing further testing is we may miss a cancer.

Q. Is there an advantage to keeping this information from Sean Jonassen?

A. No, a patient has to be notified about the result of a study.

Q. Sir, does the fact that Dr. Bedrick was treating the patient along with Dr. Buhl relieve his obligation to act on this result?

A. No.

Q. Is the fact that Mr. Jonassen's symptoms or some symptoms may have responded to medical therapy relieve Dr. Bedrick from following up on this result?

A. No.

Q. Why not?

A. This was an incidental finding, or unexpected finding. It was not likely that Mr. Jonassen's symptoms were due to this problem

in the gallbladder, and it's not unexpected that he got better as an otherwise well young man with treatments that were provided. That did nothing to either diagnose or rule out or exclude a diagnosis of cancer in this abnormal gallbladder.

Q. Is it your testimony, sir, that the fact Mr. Jonassen responded or improved with the use of the purple pill and Asacol did not relieve Dr. Bedrick of his responsibility to act on the abnormal gallbladder?

A. That's right. The abnormal gallbladder stood alone, really was not related to symptoms whether they improved or did not improve. And that finding by itself required followup independent of what happened -- what Mr. Jonassen's symptoms were.

Q. Sir, we may hear testimony in the case -- it's been alluded to that Dr. Bedrick ordered this ultrasound because of the concern of pancreatitis and/or watery stools. We also may hear that he responded, Mr. Jonassen, to the use of medications after a colonoscopy and an endoscopy.

With all that considered, is there

still an obligation to follow up on this markedly abnormal gallbladder and the finding on the ultrasound?

A. Yes, I that believe Dr. Bedrick also testified that there are other type of problems, including gallbladder problems, that you look for with an ultrasound, so it's not just pancreatic problems. In addition to the pancreas, it's often not completely visualized with ultrasound, so that question was in some ways left-handed.

Q. If a CAT scan of the pancreas -- sir, you see under impression, is there a recommendation for further follow-up diagnostics?

A. Yes.

Q. What is that for?

A. It was for a CT scan to do further evaluation of the pancreas.

Q. If a CT scan had been done on the pancreas, would that have imaged the gallbladder as well?

A. Usually, yes.

Q. Have you looked at CT scans where they were for one organ and found information about another organ?

A. Yes.

Q. If you found information -- if you found -- if you ordered a diagnostic study for one purpose and it revealed information about something else, is that what's called an incidental finding?

A. Yes.

Q. Sir, in your practice, do you use incidental findings to treat patients with other diseases?

A. Yes, that comes up all the time.

Q. Sir, in your practice, have you found incidental findings that have saved patient's lives?

A. Yes.

Q. It's part of medical practice, isn't it, sir?

A. Yes.

Q. That's what you teach your students and residents?

A. Yes.

Q. Was Dr. Bedrick required -- strike that.

Would it be within reasonable standards of care medically for Dr. Bedrick to

follow up on an incidental finding?

A. Yes, sir.

Q. Would it have been within reasonable standards of care, standards of medical care, for Dr. Bedrick to act on the markedly abnormal gallbladder?

A. Yes.

Q. Is the, I guess, reverse true? Is it a breach of the standard of care not to act on this information?

A. Yes, that's right. You have to act on it; you can't ignore it.

Q. Sir, in your practice, have you ever received a ultrasound report or any kind of report from a radiologist and contacted the radiologist for clarification?

MR. CAMHI: Objection.

THE COURT: Sustained.

BY MR. BEZAR:

Q. Sir, is it within appropriate standards of care to follow up with a radiologist if a report is unclear?

A. Yes.

Q. Would you -- why would you do that?

A. Sometimes it's not clear what the language means or what the radiologist is really thinking. Sometimes there's additional clinical information which, if the radiologist knew, that would assist in further clarifying the finding. So a dialogue between an ordering clinician and the radiologist happens all time, and it's sometimes very useful.

Q. Doctor, do you have an opinion as to whether or not Dr. Bedrick's failure to follow up on the ultrasound report increased the risk of Sean Jonassen's death?

MR. CAMHI: Objection.

THE COURT: Overruled.

THE WITNESS: Yes.

BY MR. BEZAR:

Q. Why is that, sir?

A. At the time that his gallbladder was noted to be markedly abnormal in January of 2006, further workup at the time likely would have provided a diagnosis of cancer at an earlier stage than one-and-a-half years later when the diagnosis was finally made.

Q. Doctor, have the opinions you offered

today been to a reasonable degree of medical certainty?

A. Yes.

MR. BEZAR: Thank you, sir.

THE COURT: Cross.

MR. CAMHI: Thank you, sir.

- - -

CROSS-EXAMINATION

- - -

BY MR. CAMHI:

Q. One last time today, the ultrasound report, Doctor, you said that adenomyomatosis is a benign condition and it is not an ultrasound diagnosis, right?

A. Not exactly.

Q. Explain.

A. Adenomyomatosis may sometimes be diagnosed when it has a typical appearance on ultrasound. An unusual description like that does not sound like adenomyomatosis.

Q. What is unusual about this gallbladder disease with thickening of the wall and underlying adenomyosis?

We are all saying adenomyomatosis,

but that's not the word here.

What is confusing about the term gallbladder disease with thickening of the wall and underlying adenomyosis? Which part of that is confusing?

A. I think the diagnosis of underlying adenomyomatosis needs to be diagnosed with a biopsy or tissue. It's difficult to state it was not a cancer or some other process based on this description.

Q. I understand that this report says adenomyomatosis, a benign condition; it says that?

A. Yes.

Q. That's the language on the report?

A. Yes.

Q. Do you have the report in front of you marked P-15?

A. Yes.

MR. CAMHI: You can take that down and put...

BY MR. CAMHI:

Q. Can you agree, the bottom of Page 1, you reference a paragraph about Dr. Bronstein's, Dr. Bedrick's partner, initial visit with Sean

Jonassen on November 28th?

A. Yes.

Q. And on Page 2, you reference -- the very first paragraph references lab data, correct?

A. Yes.

Q. And then there's one, two, three -- three more paragraphs that take up most of the page that all reference Dr. Bedrick's January 6th, 2006 office visit with Mr. Jonassen, correct?

A. Yes.

Q. And in there you report what Dr. Bedrick got by way of a history, what his physical examination revealed, and what his assessment was?

A. Yes.

Q. Can we agree, sir, you have no issues with the history that Dr. Bedrick obtained the physical examination performed by Dr. Bedrick and his assessment?

A. That's correct.

Q. In fact, it takes up most of that page, sir? It was a rather thorough, detailed history, physical, and assessment, correct?

A. Yes.

Q. His recommendation to get an ultrasound, you obviously agree with that, correct?

A. Yes.

Q. And then, sir, there's a paragraph that begins with laboratory data was obtained on January 6 and reported as negative.

Do you see that?

A. What page?

Q. The same page, single sentence here, Page 2, laboratory data.

THE COURT: The last paragraph?

MR. CAMHI: Above the last paragraph?

THE WITNESS: On Page 2?

MR. CAMHI: Yes, sir. A single line right here. "Laboratory data" are the first two words.

THE WITNESS: No, it's a little different than this one here.

MR. CAMHI: May I look at what the doctor has, Your Honor?

THE COURT: Sure.

MR. CAMHI: May I?

DAY 3, VOLUME 2

THE COURT: It's a different report.

Doctor, show him the report you have. Go to the next page.

MR. CAMHI: I'm sorry. That was my fault.

MR. BEZAR: Can we have a clarification of what just happened with the report?

MR. CAMHI: I was looking at the wrong report. My fault. I'm sorry for that.

BY MR. CAMHI:

Q. Sir, you are now on Page 2 of your report?

A. I am.

Q. Go the to Page 1. Page 1 deals with Dr. Bronstein's evaluation on November 28th and Dr. Bedrick's on January 6th, correct?

A. Yes.

Q. Page 2, the second full paragraph deals with the results of the January 12th ultrasound, correct?

A. Yes.

Q. Then the next thing that you mention about medical care after the January 12th, 2006 ultrasound is June 3rd, 2007. The next medical care you reference is June 3, 2007 correct?

A. June 3, 2007.

Q. About year and four months later?

A. Yes.

Q. And what's not contained in your report is any details about the colonoscopy performed by Dr. Buhl on January 17th, the endoscopy on January 24th, and the phone call with Dr. Bedrick and the patient on January 24th, the follow-up visit with Dr. Bedrick and the patient on February 6? You don't have the details of those things in your report, correct, sir?

A. Well, I have in the middle paragraph, saw him for an upper GI endoscopy or colonoscopy as well as three follow-up visits.

Q. And the result of the endoscopy and colonoscopy --

A. Yes.

Q. -- are they in the report?

A. No -- yes, did start Mr. Jonassen on Asacol for nonspecific colitis, but this diagnosis

was not borne out on biopsies.

Q. And the upper endoscopy, what results do you have in your report?

A. I didn't mention it.

Q. What treatment do you mention in your report was given as a result of the upper endoscopy?

A. I know that he received Asacol and a proton pump inhibitor.

Q. If we go back to the question, you indicate in your report what treatment was provided as a result of the upper endoscopy?

A. That would have been the Nexium.

Q. Is it in your report?

A. No.

Q. Is that just from your memory or recent review of the records?

A. From my memory.

Q. Sir, we had an oncologist testify yesterday, and he testified about the relative rareness of the diagnosis of gallbladder cancer.

Were you made aware of his testimony?

A. No.

Q. Can you agree, sir, that gallbladder cancer is generally considered to be a rare diagnosis?

A. Yes.

Q. Sir, when you prepare expert reports in your cases that you have been reviewing for several years, occasionally you will look at some literature textbooks, true?

A. Yes.

Q. Did you review Harrison's Principles of Internal Medicine on the subject of how frequently gallbladder cancer is seen in the United States?

A. No.

Q. You have not?

A. No.

Q. Are you familiar with statistics that demonstrate gallbladder cancer, there's about 6,000 of them diagnosed in the United States each year?

A. It is a rare cancer.

Q. Are you familiar with that statistic?

A. No.

Q. Can you agree the ratio of men to women, that women have -- generally are diagnosed with

gallbladder cancer three or four times more than men?

A. Yes, in general, it's a diagnosis that is found more in older people and women more than men.

Q. Now, when you review these cases, including this malpractice case -- then I will sit -- sir, you receive a pile of records, and I assume in this case it was literally a pile of records, perhaps several-inches thick, true?

A. Yes.

Q. And, sir, when you receive the case, it comes to you from a lawyer, obviously. Do you understand that someone is looking into whether or not there is a viable legal action, correct, sir?

A. Yes.

Q. And you know in this particular case that by the time you got the case, Mr. Jonassen passed away?

A. Yes.

Q. Of gallbladder cancer?

A. Yes.

Q. Your job, sir, is to review those records and try to come to some sort of assessment

whether that gallbladder cancer that was ultimately diagnosed could have been diagnosed sooner?

A. That's right.

Q. And in this particular case, knowing what happened, you needed to take a retrospective view of the case and look back and see could it have been diagnosed sooner, correct, sir?

A. I don't fully agree with that. I think the expert looks at the information that's available to the doctor at that time and not just in terms of what he knows later because the doctor, for example, in January 2006, would not have had the opportunity to know that a year-and-a-half later he was going to have a cancer diagnosis. So you have to use the information that he had. In this case, it was really that ultrasound report.

Q. Thank you.

That was why I asked the question. What you said was that you looked at that ultrasound report, and you, sir, considered in the differential diagnosis gallbladder cancer?

A. Yes.

Q. And you did that knowing that Mr. Jonassen died of complications related to gallbladder cancer?

A. Possibly, but primarily I based that on the description of a markedly abnormal gallbladder. This was something unusual, an incidental but significant finding and one in which I wouldn't be able to look at that report and say clearly this was a benign disease.

Q. Despite the statistics that this jury heard?

A. Yeah, because things can happen. It could be the patient bumped his head, had a CT scan, and there's a finding of a tumor that you wouldn't ignore because it doesn't yet have symptoms.

MR. CAMHI: Thank you. That's all, sir.

MS. RAYNOR: No questions, Your Honor.

MR. BUSHMAN: A few. Thank you.

BY MR. BUSHMAN:

Q. Doctor, as I understand your

testimony -- by the way, I am Ira Bushman.

As I understand your testimony, it was the term "markedly abnormal" in the ultrasound report that causes you the greatest concern?

A. Yes.

Q. And we've heard testimony previously -- I just want to know if you agree that the term "markedly abnormal" is really a red flag, something that is of concern?

A. I agree it's a red flag.

Q. Portends a potential ominous situation?

A. Yes.

Q. That's the reason you want to follow up on that terminology?

A. Yes.

Q. You heard Dr. Wong testify earlier, and she was critical of Dr. Magida for not fully describing certain things on the study? You heard that?

A. Yes.

Q. Nevertheless, it's your testimony before this jury, as a board-certified internist having seen this report, there was enough in that report to cause you to act?

A. That's right.

Q. That's what would be required standard of care for an internist?

A. Yes.

Q. We heard testimony earlier that had a CT scan been performed as recommended by Dr. Magida, it would have given us a better image of the gallbladder; is that correct?

MR. CAMHI: Objection.

THE COURT: Overruled.

THE WITNESS: Yes.

BY MR. BUSHMAN:

Q. And that had we gotten a better image of the gallbladder, the next logical step would include trying to determine through pathology a tissue sample and get a firm diagnosis?

A. Yes.

Q. So, in other words, Doctor, had the recommendation of Dr. Magida been followed, the overwhelming likelihood is that Sean Jonassen's diagnosis would have been confirmed and we would not be in the courtroom?

MR. CAMHI: Objection.

THE COURT: Sustained.

BY MR. BUSHMAN:

Q. Do you believe, Doctor, that had the recommendation of Dr. Magida been followed, a CT been done, a tissue biopsy obtained, that Sean Jonassen's diagnosis would have been confirmed?

A. Yes.

MR. BUSHMAN: Thank you.

THE COURT: Redirect examination?

MR. BEZAR: No redirect examination, Your Honor.

THE COURT: Thank you, Doctor. You may step down.

(Witness excused.)

THE COURT: Members of the jury, we did better than 5:30, so with that said, we are going to adjourn for the day. Have a good evening, and we will see you back -- can you arrive by 9:00? The Court has no other business, and we will get started by 9:30.

So have a great night. Do not discuss anything you heard thus far.

THE CRIER: All rise while the

jury exits the courtroom.

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(The following occurs in open court outside the presence and hearing of the jury.)

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THE COURT: Anything before we adjourn?

MR. PITT: No, sir.

MR. FOERSTNER: No.

THE COURT: Court is adjourned.

(Matter adjourned.)