VIRGINIA: IN THE CIRCUIT COURT OF THE CITY OF NORFOLK

DENISE DAVIS, Plaintiff, v. CANDICE A. GEARY, M.D., VIRGINIA CENTER FOR WOMEN and MID-ATLANTIC WOMEN'S CARE, PLC, Defendants.	I I I I I I I I I I I	Case No. CL07-4320

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DEPOSITION OF JAMES H. CANE, M.D.

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July 14, 2009
Richmond, Virginia
Registered Professional Reporters
P. O. Box 9349
Richmond, Virginia 23227
Reported by: Dorothy J. Lewis, CCR
Certification No. 0315017

Deposition of JAMES H. CANE, M.D., taken by and before Dorothy J. Lewis, CCR, Notary Public in and for the Commonwealth of Virginia at large, pursuant to Rule 4:5 of the Rules of the Supreme Court of Virginia, and Notice to Take Deposition; commencing at 3:05 p.m., July 14, 2009, at the medical offices of James H. Cane, M.D., 8266 Atlee Road, Medical Office Building II, Suite 215, Mechanicsville, Virginia.

Appearances:

SHAPIRO, COOPER, LEWIS & APPLETON, PC
By: JAMES C. LEWIS, ESQ.
attorney, of counsel for Plaintiff

THE OAST LAW FIRM
By: TAYLOR D. BOONE, ESQ.
attorney, of counsel for Defendant

o0o

I N D E X

DEPONENT

JAMES H. CANE, M.D.

E X H I B I T S

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(Marked Dr. Cane Exhibit Nos. 1, 2.)

JAMES H. CANE, M.D.

was sworn and testified as follows:

DIRECT EXAMINATION

BY MR. LEWIS:

Q Doctor, for the record, would you state your full name and your professional address, please.

A I am James Howard Cane, C-A-N-E, and my address is 8266 Atlee Road, Mechanicsville, Virginia, and, of course, it's Medical Office Building Number II, Suite 215.

Q And you are an obstetrician/gynecologist?

A That is correct.

Q And you have been designated by Dr. Geary's attorneys in the Denise Davis case as an expert obstetrician/gynecologist, who is prepared to render opinion testimony at the trial of this matter?

A That is correct.

Q And you have been deposed before?

A That is correct.

Q All right. So I'm not going to bore you with all the rules. If I ask you a question that doesn't make sense because I don't know what I'm

talking about, just tell me. I take no pride in authorship of my questions. Fair enough?

A Fair enough.

Q Take a look for me, sir, at your deposition exhibit No. 1. This was provided to me by Mr. Boone. Just confirm for me that it is reasonably accurate and relatively current.

A It is relatively current.

Q Any corrections?

A None.

Q You can hold onto it, Doctor. I'm going to ask you some questions about it.

A Okay.

Q You may find it beneficial to have it in your hand.

On page number 1 there's a heading over on the left-hand side entitled "education," and for the next number of pages, two actually, there are listed by date and provider, it looks like some, something that I would consider continuing medical education sort of stuff?

A That's correct.

Q And that's what this is intended to --

A That's right.

Q -- tell the reader?

On page 3, you have admitting privileges at Henrico Doctor's Hospital?

A Actually, I didn't renew those, because now I'm employed by the hospital here. I just figured I didn't want to run around.

Q The "hospital here" being --

A Memorial Regional. I didn't want to run all over town anymore, so I don't need to do that.

Q So you're not admitting patients to any hospitals other than to this one now?

A That is correct.

Q All right. What is the distinction, Doctor, between being certified by the American Board of Obstetrics and Gynecology and being a fellow of that organization?

A Okay. The way it is set up is that when you finish your residency, first you must take a written exam after finishing your residency, and you have to be certified to take that exam by your chairman, because he can stop you if you don't -- that's part one.

After he certifies you to take that exam and you take it and pass it, you are now considered board eligible. That's part one.

Once you're a board eligible, most doctors

will either become an academician or they go into private practice, but either way you have to wait two years, and during that two-year time period, you accumulate a fair number of cases to submit to the American College, or the American Boards, I should say, and you must put that in some nice reasonable format -- a standard format, in fact, that they prescribe for you -- and you submit all those cases summarized to the American Board, and they -- the exams are usually in November for the east coast in Chicago, and you do that six months before the exam, and then you go to Chicago and you have an oral exam by numerous guys in a hotel room, and they interrogate you and intimidate you, and then --

Q Yes, sir, I understand that to be true.

A -- and then after that is done, if you pass that, you are now board certified. You are no longer board eligible, and you are allowed to take that exam no more than three times. And if you take it three times and don't pass it, you've got to start over again.

Q How many times did you take it before you passed it?

A I passed it the first time.

Q Okay.

A Okay. So -- I was very fortunate. Thank God I passed it the first time. So I'm board certified.

Now, once you become board certified, it's an honor to become a Fellow of the American College, FACOG, but you don't -- it's not guaranteed.

In order to become a Fellow of the American College, you submit your paperwork saying, "I am now board certified, and I'd like to become a fellow of the American College," and they have a ceremony like at graduation, you know, with cap and gown and all that stuff.

If one person -- and they put it in the Green journal that you are applying to become a fellow -- if one person who is already a fellow sees that you are applying and knows you and wants to indict you for moral turpitude or anything that is a black mark, they can blackball you. And they write a letter saying that "Jim Cane cannot be a fellow, in my opinion, for these reasons," you won't ever become a Fellow. So it's an honor to become a fellow.

Q Is there a minimum amount of time that you have to be board certified before you're eligible to become a fellow?

A If I remember correctly, it's -- they do

it within a year. It's usually in the summer, so I think it's the summer following that November. It's pretty quick.

Like you become board certified on the east coast in November if you pass, and usually around June or so, like the usual graduations for the colleges, so it's June, about six months later, I guess. You're entitled to go to the ceremony and all that. I didn't do that, because I was in private practice at that time.

Q Trying to make a living.

A Right. They send you the paperwork saying you're a fellow -- right? -- and they send you a nice certificate, which is considered a honor.

Q On page 9 of your Exhibit 1, Doctor, "milestones," it says you performed the first laparoscopically-assisted vaginal hysterectomy in the State of Virginia in May of 1990?

A That's correct.

Q How do you know you were the first one?

A Well, first of all, it was publicized on TV when I did the first one. Publicized on TV, in the newspaper, and, you know, it pretty -- you know, if anybody had done it before, they would have put theirs on TV. It was on the news.

So, you have -- in medicine when you are the first, it's usually a media hit, and so you know it's going to be first, because it's released within a week or so.

Q And so --

A If anyone said they've done it first, they're going to refute that.

Q Then the same with the first laparoscopic supracervical hysterectomy?

A Right. That was in central Virginia. The laparoscopic was in northern Virginia. And the first one done in the world was by Dr. Harry Reich, in 1989. Harry Reich, R-E-I-C-H. He did the first one, the first laparoscopic hysterectomy in the world.

Q I take it from page 10 of exhibit 1, that you have donated a considerable amount of assets to St. Catherine's?

A Don't remind me.

Q Okay. I'm sorry. I couldn't help it.

A Did your kids go there?

Q No, my niece and my nephew went there.

A My two daughters went there, so you know the deal there.

Q I do. All too well.

Doctor, what professional organizations do

you belong to?

A Richmond Academy of Medicine. I used to belong to the American Medical Association, but a lot of us doctors are not enamored with the American Medical Association anymore, so we're kind of backing away from them. They're not doing much for us. I'm a member of AAGL.

Q What's that?

A It's the American Association for Gynecologic Laparoscopy.

Q Okay. How about the Society of Laparoscopic Surgeons?

A No, I'm not. It's not that I didn't want to be a member. It's just that it becomes very expensive to be a member of all of those. Membership is between 3- to $600 a year.

Q Are you familiar with the Society of Laparoscopic Surgeons?

A Yes, I am.

Q Have you ever been a member?

A No.

Q Do you subscribe to or read any of its publications or periodicals?

A Sometimes, yes.

Q Do you know a Dr. Paul Wetter?

A I've heard the name.

Q Tell me what you've heard about him.

A I don't know much about him. Like I said, I've heard the name.

Q Do you understand him to be an endoscopist?

A Yes.

Q Are you familiar with a textbook he edited entitled, Prevention and Management of Laparoendoscopic and Surgical Complications?

A Yes.

Q Have you read it?

A No.

Q Do you consider it to be a reliable authority in the field of laparoscopic surgical procedures?

A Well, I can't comment on it really, because I've not read it.

Q What publications, texts, periodicals or other writings, Doctor, do you consider to be authoritative in the field of gynecologic laparoscopy procedures?

A I like to read the current journals, and --

Q Give me some names.

A The Green Journal --

MR. BOONE: Journals that he likes to read or --

MR. LEWIS: No, journals that you consider --

MR. BOONE: Journals that you consider a reliable authority --

MR. LEWIS: No, I didn't say "reliable."

BY MR. LEWIS:

Q No, journals that you consider authoritative.

A Oh, okay. I got you. Well, the journals that are provided by AAGL. I like -- my, my -- the one that I like the most, though, I like personally the most, OB GYN Management.

Q That's the name of the periodical?

A Yes.

Q Who is it published by, if you can remember?

A I can't remember. I used to get the hard copy, which you get online. I hate storing paperwork --

Q These days everyone does.

A -- and so I can get online and the articles that I want to search, I can find them, and

they're excellent, because they're by the same guys that you were talking about. Any of the journals that you're talking about, those same guys will submit articles for that journal --

Q Yes, sir.

A -- paper journals.

Q Same question, only I'm going to change the word "authoritative" to the word "reliable." Any distinction between those two in your view when it comes to literature in your field of specialty?

A We're getting pretty picky, I would think.

Q I don't disagree with you, but judges and lawyers tend to get picky.

A I've never made the distinction.

Q Okay. Doctor, as I understand it, you are prepared to comment on what you believe to be the applicable standard of care in this case and whether or not it was complied with. Do I understand that correctly?

A That is correct.

Q What I would like for you to do, sir, is to define the phrase, "applicable standard of care" as you understand it.

A As I understand it, it is the care that would be rendered by a specialist in the same field as

the defendant, and would be considered by his peers in that region to be administering reasonable and prudent care in a particular situation or in every situation that was applicable.

Q Doctor, can you tell me when you first began reviewing medical charts for individuals who are not your patient? That includes insurance companies, defense lawyers, plaintiff lawyers, risk managers, I don't care. Just any chart review for someone not your patient. When did you start doing that?

A Maybe about 10 to 12 years ago.

Q And how did that come about?

A I was recommended by one of my peers, and I was contacted.

Q By whom?

A At that time that was an individual at St. Paul. He is no longer with them. I forget his name.

Q Most people aren't any longer with St. Paul.

But it was an employee of an insurance company that wrote liability coverage for healthcare providers?

A Absolutely correct.

Q What did he ask you to do?

A To -- he asked me would I be willing to

review the medical records of a case, litigation was involved, and I said yes, I would, and the lawyer contacted me. I guess it was a lawyer on retainer for St. Paul, and that is how I got started.

Q Any way for you to estimate for me, Doctor, the number of charts you have reviewed in that 10 to 12 years? First of all, do you keep track of them?

A I don't keep track of them.

Q Okay. Can you estimate for me?

A I would estimate, let's be conservative, maybe 30 --

Q In 10 to 12 years?

A -- or 40.

Q Okay. Roughly three a year?

A Yes. Uh-huh.

Q Give or take.

A Give or take?

Q And of the 30 or 40 you reviewed, how many have been on behalf of a healthcare provider versus on behalf of a patient who was unhappy with his or her healthcare provider?

A All of them on behalf of the healthcare provider.

Q Never -- if a plaintiff lawyer called you

up today and said, "Dr. Cane, I would like for you to take a look at a chart involving a client of mine where an obstetrician gynecologist did X, Y, Z, and we don't think that was appropriate, would you do it?

A I would look at it.

Q And is there any reason why you've never been asked to look at a plaintiff's case in 10 to 12 years?

A I guess because they knew I did all defendant work. I don't know.

Q I like experts who do nothing more than defenses work.

A You would like that?

Q I would. I would think you would have tremendous credibility for a plaintiff because you've never testified for one, but that -- we digress. Let me ask you this: I take it, then, from that answer, Dr. Cane, that you have never testified at deposition or trial on behalf of a plaintiff?

A That is correct.

Q Can you remember or estimate for me the number of depositions you've given in the 10- to 12-year period?

A Hmm. I would say less than 10.

Q Of the 30 to 40 files that you have

reviewed over the 10 to 12 years that you've been doing this, Dr. Cane, have you ever concluded that the doctor whose chart you were reviewing had violated the applicable standard of care?

A Maybe one.

Q One out of 30 to 40?

A Right.

THE COURT REPORTER: Excuse me, sir. Did you make an objection?

MR. LEWIS: He did.

BY MR. LEWIS:

Q How many times have you actually gone to a courthouse, Dr. Cane, and sat down in front of a jury and shared your views with them?

A I think somewhere around four times, four or five times.

Q All of them Virginia cases?

A Well, one case was in Delaware, but that was a deposition.

Q All the other ones have been in Virginia?

A That's correct, uh-huh.

Q Have you ever failed to qualify as an expert?

A No.

Q How much do you charge to review medical

charts of someone who is not your patient, Dr. Cane?

A I have to pull it off my computer, but I think, without looking at it -- I have it stored -- I think it's 300 an hour.

Q To review charts?

A Yes.

Q How about to give deposition testimony?

A If you want me to go get it, I can go get it.

Q If you would be more comfortable doing that, I'm happy to have you.

A Because I don't want to give you misinformation.

Q I don't either. Let's take a break.

(Recess from 3:21 p.m. to 3:23 p.m.)

BY MR. LEWIS:

Q Dr. Cane, you have kindly retrieved a fee schedule for me, and it says you charge $300 an hour for review of medical records, deposition transcripts, and completion of a report, and you charge $750 an hour for deposition testimony, correct?

A Correct.

Q And fee for live trial appearance is $4,000. Is that per day?

A Correct.

Q And is that inclusive of travel?

A Correct. I've never had to be -- appear any more than one day, though.

Q But that, that $4,000 charge assumes that you're only going to be taken away from your medical practice for one business day?

A That is correct.

Q Okay. Doctor, is there any way for you to tell me how many hours you have spent on the Denise Davis file prior to today -- strike that.

Prior to preparing for today, i.e., how many hours did you spend formulating the opinions that you have in this case?

A Do you want me to guess or give you a actual?

Q I want an actual figure, if you can do it.

MR. BOONE: I mean, if he can do it within a timely manner.

THE DEPONENT: I've got to go back to the computer. I don't want to waste your time.

BY MR. LEWIS:

Q Well, if it's as quick as this one, go ahead.

A It won't be as quick as this one.

Q All right. How long will it take?

A 10 or 15 minutes.

Q Can you get a staff member to do it?

A No, because I don't give them access to that kind of information.

Q Okay. Then guestimate for me.

A Okay.

Q If we have time at the end without infringing on Mr. Boone's schedule, we'll get you to run it for me.

MR. BOONE: Thank you.

MR. LEWIS: You're welcome.

A Let me say somewhere between 10, 15 hours. I'm guessing.

BY MR. LEWIS:

Q And could you tell me what it is you did for that 10 or 15 hours?

A I read through depositions.

Q Whose?

A Dr. Rahman, Mr. Davis, Mrs. Davis, the record, the case records. I'm trying to remember, was it Dr. Geary? I don't think Dr. Geary was deposed, was she?

Q Dr. Geary was deposed. Did you read her deposition?

A I read Dr. Geary's deposition. I read all

the depositions. And then -- okay. The next thing was all the case work, chronology, case work chronologies.

Q Chronologies? Did you prepare those chronologies or did someone else prepare them for you?

A They were prepared for me.

Q Who prepared them?

A It was a summarization.

Q The lawyers?

MR. BOONE: If you don't know, you can just say, "I don't know."

THE DEPONENT: I don't know the name of the person.

BY MR. LEWIS:

Q Well, was it affiliated with the law firm that has hired you in this case?

A Yes.

Q Did you rely on the chronology?

A No. I had already read my information. I didn't rely on chronology.

Q And I know that this is going to sound like a memory quiz, but I'm going to ask the questions, and if you can't answer them, just say, "I'm sorry, Mr. Lewis, I can't answer them."

A Sure.

Q Do you remember looking at the records from this lady's October, 2001, hospitalization at Chesapeake General?

A Is that the one where she had the laparoscopy?

Q She had a laparoscopy with lysis of adhesions.

A Yes, I did.

Q Did you look at the records from September, 2002, hospitalization at Chesapeake General?

A Is that the one with the hysterectomy?

Q Your memory is very good. Yes?

A Yes.

Q How about April of '03, Chesapeake General?

A Yes. That's that one that was converted to a laparotomy?

Q Yes, sir. And August of '04 -- strike that. Yeah, August 29th -- August of '04.

MR. BOONE: Do you mean '04 or '05?

BY MR. LEWIS:

Q '05.

A Would you just tell me what was done.

Q I will tell you it was a diagnostic

laparoscopy.

A Yes, sir. Okay. I saw that.

Q And, obviously, August of '05 you've read?

A Right.

Q And the subsequent hospitalization that commenced 36 hours after the August 29th procedure?

A That is correct.

Q Have you reviewed the records of her incarcerated ventral incisional hernia repair?

A Correct.

Q And have you read the records with respect to her colon resection reversal?

A Correct.

Q Any other records that come to mind that you've read?

A I think you've covered everything.

Q How about Dr. Geary's office chart? Did you read that?

A Correct.

Q Have you ever testified in a case prior to this one for Mrs. Oast or any members of her firm, and that is Mr. Boone's partner?

A Testified in a case?

Q Strike that. Let me ask it a little more broadly. Have you ever reviewed charts for her or any

member of her firm?

A Yes.

Q How many?

A Maybe four.

Q And how did you come to meet her?

A I don't think I've met her.

Q Never met her?

A Never met her.

Q Do you have any idea how she or her firm came to find you?

A It may have been through -- I'm going to be honest with you. I don't know. I think with Dr. Partridge.

Q One of your colleagues?

A One of my colleagues, that's correct.

Q And you've looked at approximately four files for her or members of her firm over the 10 to 12 years you've been doing this?

A I think four to five, yes.

Q In any of those four to five, have you concluded that the physician whose chart you were reviewing violated the appropriate standard of care?

A No.

Q In any of those four or five files, have you testified at deposition?

A Not so far.

Q Until today?

A That's correct.

Q And so I take it that you've never been to court with Mrs. Oast or any members of her firm, including Mr. Boone?

A Not to my recollection. This is my first time meeting Mr. Boone, actually.

Q It could be a pleasant experience.

A At least for me. I can't say the --

Q He's doing fine. I see that big smile on his face. I'm not bothering him.

Doctor, do you keep track of how much money you make reviewing files for individuals who are not your patients?

A No.

Q Is this the only case you've done for a lawyer or an insurance company in 2009?

A Yes.

Q Doctor, how many claims have been filed against you in which it was alleged that you failed to comply with the appropriate standard of care?

A Maybe about four in 30 years. Actually in 34 years, including residency.

Q How many of those cases went to lawsuit?

By that I mean you actually got sued?

A One, and we won. I won that one.

Q You won that case?

A I won that case.

Q All right. Who was your lawyer?

A Lynn Facella.

Q What city?

A Richmond.

Q What firm is Lynn with?

A I don't know. Do you know Lynn --

Q He doesn't have to answer questions. That's okay.

MR. BOONE: If you don't know --

A She left the area.

BY MR. LEWIS:

Q What city was it pending in? The city of Richmond or the county of Henrico? If you won it, you had to go to a courthouse.

A Yeah, in Richmond.

Q Downtown?

A Yes.

Q What year?

A 2001.

Q Who was the plaintiff?

A You mean the attorney?

Q No. Who was your, who was the patient who sued you?

A I can't remember. I think -- the last name was Webb, I think.

Q I would think you would remember that. And it actually went to a jury verdict and you prevailed?

A I prevailed, yes, sir.

Q Okay.

A I think it was Kilduff and Emroch.

Q Uh-huh. I know the firm.

You also, as I understand it, Doctor, settled a claim in 2001?

A No, that's the one we're talking about.

Q Oh, I thought you just told me you won that case?

A Exactly. That's an error.

Q It says here -- I'm looking at your web page on the Virginia Department of Medicine Practitioner's sheet --

A I answered it.

Q You did?

A I'm the one that answered that.

Q As I understand it, that's your entry.

A I can bring -- I can print off the data.

I won that one.

Q Okay.

A Okay. The date must be wrong, 2001, for this one. This is not the year. This is the correct case, but not the year.

MR. BOONE: Maybe that's the last updated one.

A As I read the information, this is correct, but the date is wrong.

BY MR. LEWIS:

Q Okay. But according to what you're holding in your hand, that case didn't go to trial. You and your attorney decided to settle.

A What happened -- do you want a summary of it?

Q No, I'm just wondering why you told me a few minutes ago you won that case --

A Because --

Q -- when, in fact, you voluntarily --

A -- this is not the same --

Q -- hold on -- when you voluntarily paid your patient.

A Because it's not the same case.

Q Different case?

A Different case.

Q Okay. All right.

A See, the case I'm talking about -- I gave you the name of the patient.

Q Yes, sir.

A This one I remember pretty well. It was Prince, Sonya Prince.

Q And that's the case -- did you get sued in that case, or was that settled, or was that filing of a lawsuit?

A What happened is it settled. The plastic surgeon -- I did a hysterectomy. The plastic surgeon did a abdominoplasty, liposuction, et cetera --

Q Yes, sir.

A -- after I finished my part. Then he put a binder on her. She couldn't breathe. I was out of the picture at that point.

Q Yes, sir.

A I did my part and left. Apparently she had respiratory arrest. My understanding of it is because the binder was too tight, and she was very obese, and she couldn't breathe, and she stopped breathing. So we, we -- everybody settled.

Q And was that after a lawsuit was filed or before?

A I think it was actually -- yeah. It was

after.

Q And what was that patient's name?

A Sonya Prince.

Q And was that also pending in the Richmond Circuit Court?

MR. BOONE: Asked and answered.

BY MR. LEWIS:

Q Do you remember who your lawyer was in that case?

A Let me see. She is now in Norfolk. She was with Bryan, Russell and Barnes is what I can tell you.

Q But he's in Norfolk now?

A He left.

Q Oh, well, do you remember who the plaintiff's lawyer was?

A No.

Q You can give me that back, Doctor.

A Uh-huh.

Q If you want a copy, I'll be glad to make a copy for you.

Doctor, in your career, can you tell me how many patients you have taken care of where you performed five laparoscopic procedures in four years?

A Well, I can't think of any, but I have

performed the fifth laparoscopic procedure where the patients have had multiple operations.

Q Before they came to see you?

A Exactly.

Q But you've never --

A I've done that numerous times.

Q -- with any of yours?

A Numerous times, but not where I have performed. Usually my patients that -- I'm treating endometriosis patients with chronic pain, usually it's about every two years, because they don't want hysterectomies. And I tell them the pain relief will last them about two-and-a-half to -- a year-and-a-half to two years, so usually they're coming back every two years, year-and-a-half until they decide to have a hysterectomy.

Q And usually when they have the hysterectomy, that puts an end to --

A Yes, sir.

Q -- the need for laparoscopic endometriosis care?

A Yes, sir.

Q Okay.

A Close follow-up thereafter, but usually that's the end of the surgical part of it.

Q Do you have an explanation for why that wasn't the end of Mrs. Davis's need for additional laparoscopic surgery?

A I'm not clear on that, sir. Explain what you mean by your question.

Q Well, she had a hysterectomy in 2002 --

A Okay. Now I can explain.

Q -- but now we've got a laparoscopy in '03, a laparoscopy in '04 and a laparoscopy in '05.

A Her ovaries weren't removed. She wasn't totally castrated.

Q Okay. Would you -- go ahead.

A And the other thing is that she developed adhesions, and that, in and of itself, sometimes will perpetuate that cycle, because --

Q Right. Additional surgeries create additional adhesions?

A Yes, sir.

Q Would you agree with me, Doctor, that the more abdominal surgeries a patient has had, the more that patient is at risk for the formation of abdominal adhesions? I think you just answered it.

A Well, I would like to clarify, if I may.

Q Certainly.

A We -- usually that's more pertinent to

laparotomies --

Q Yes, sir.

A -- and less pertinent to laparoscopies.

Q But it is still, nonetheless, an accurate comment, is it not?

A Yes. Uh-huh.

Q Would you also agree with me, Doctor, that the formation and existence of abdominal adhesions makes surgical visualization of the abdomen laparoscopically more difficult than with a patient who has had few or no prior abdominal surgeries and subsequent adhesions?

A Depending upon the extent of the adhesions. Sometimes the adhesions don't make it much more difficult unless they're extensive adhesions.

Q How about Ms. Davis? Were her adhesions extensive in 2004 and 2005?

A Moderate.

Q Well, they were so -- didn't Dr. Geary have to convert to a laparotomy in '03, because she couldn't get good visualization?

A I guess I was using it based on my judgment from my skills.

Q Yes, sir.

A But I would say moderate, from the reading

of the records.

Q Doctor, other than Dr. Geary's deposition, which you've told me you've read, and the operative report that she dictated, do you have any other information available to you to describe the surgical technique that she used when she surgerized this patient on August 29th of 2005?

A No.

Q And based upon her deposition and the operative report, describe for me the surgical procedure that she performed on that date.

A Now, we're talking about that surgical procedure, the last one, right?

Q The October 29th, 2005.

A Correct. She brought the patient in to do a laparoscopic procedure. When she did the laparoscopy, she noted adhesions, and she lysed adhesions, which were in the right side of the pelvis, and there was an area where there was a pseudocyst -- based upon ultrasound, they said it was a cyst, but it turned out to be a pseudocyst involving the bowel and the bladder, where the bowel was loculated over the bladder, and it was consistent with a cyst -- and she freed up those adhesions and irrigated copiously to confirm that there was no evidence of any perforation,

and the fluid was clear, and she got out.

Q Did she treat the pseudocyst?

A Yes, she did.

Q How did she do that?

A By releasing the adhesions that were involving the bladder.

Q Did she drain it?

A Well, you see, when she released the adhesions, the fluid came out. She irrigated and aspirated the fluid, so that took care of that.

Q Okay. That's why you were calling it a pseudocyst?

A Right.

Q Doctor, would you agree with me that when performing a patient -- performing a procedure like this one, once a scope has been successfully placed in the patient's abdomen, that any further trocar insertions should be done under direct visualization?

A Correct.

Q And do you have an opinion as to whether Dr. Geary inserted the trocars into this patient on the surgery in question under direct visualization?

A Yes.

Q What is your opinion?

A She did it under direct visualization.

Q What do you base that upon, sir?

A Well, because she exceeded the standard of care from point one. She -- typically most doctors who are adherent to the standard of care will insert the trocar -- do the Veress needle insertion first. Then you insert the trocar. When you insert the Veress needle to insufflate the abdomen, there is a risk that you can perforate the bowel.

Q Sure.

A She didn't do that.

Q Right.

A She exceeded the standard of care because she did the Hassan technique --

Q I understand.

A -- which is better than inserting a trocar.

Q Okay.

A So then she visualized that, and then she visualized the insertion of the other trocars.

Q And where in her deposition or her operative report does she say she inserted the subsequent two trocars under direct visualization?

A Well, it's -- it's not said, but it's just not done that way, because once you do Hassan technique and you put the trocar in, you're seeing --

no one that I've ever taught or seen inserts the ancillary trocars blindly. It's just not done.

Q It's not done intentionally?

A No. It's not done. No one has ever done that. It's just not done, because you've got a scope in and you're looking in the belly. Why would you close your eyes and put in other trocars? Well, you're already looking -- once you put the scope in, you can see --

Q So you are basing --

A -- trying to determine where to place the scope, other trocars. That's how you determine how to place them.

Q You are basing your assumption that she inserted the second and the third trocar or the first and second trocar technically, although I guess the Hassan is a trocar, it's just not a sharp one?

A That's right.

Q But you're basing that opinion upon your experience that it's not done?

A And --

MR. BOONE: Just let me make an objection to the use of the word "assumption."

BY MR. LEWIS:

Q Okay.

A Based on what she described when she saw adhesions, the only way she could have avoided adhesions it to know where to place the trocars, and she described where she placed them. She had to be looking to describe -- to, to know where to place them. She actually gave centimeters where she placed them on the abdomen. She was looking to decide where to place them. We all do it that way. That's the standard of care.

Q Do you know, Doctor, where Dr. Geary placed the second trocar?

A It's clearly stated. I don't want to misquote it. In the operative report she actually tells you centimeters where she placed them.

Q How about the third one?

A She tells you where she placed that one, too.

Q What did she say?

A If you -- I don't want to misquote, but I can read the operative report.

Q Okay. Confirm for me that the two-page document that I'm now handing to you is her dictation from the August 29th, 2005, operation.

A Yes, is it.

Q And would you read for me in that

dictation where she describes where she places the third trocar.

A Okay. What I like about what she says is, she says, "A second port was put 5 centimeters up and 8 centimeters over on the left side." And then she said, "Through these two ports" -- meaning this one and the other one -- she was able to use shears to take down the adhesions, and once enough were taken down in the lower, then she was able to see enough to put in the third portal. So she did on direct visualization.

Q Did she describe for you in that document where --

A She doesn't --

Q -- she placed the third port?

A It says that she put this third port on direct visualization. What I'm saying is she saw herself putting that third port in.

Q That's not my question. I want to know where in this patient's abdomen that portal was placed, if you can tell me from that document that you have in your hand.

A Well, it would have to be on the right side, because she put the first one on the left side.

Q Can you tell from reading that document?

A Well, you don't put two on the same side.

Q That's not my question, Doctor. What I want to know is if I walked Denise Davis in here today fully clothed, would you be able to put your finger on the scar where that third port was placed?

A If I saw the scar.

Q No, without seeing it, with just reading that document?

A No.

Q And that document and her deposition are the only two documents that we have to describe where the third port was placed, correct?

A Correct.

Q And in her deposition, she wasn't asked that question, was she?

A Okay.

Q Correct?

A No.

Q Okay. Thank you, sir.

A Uh-huh.

Q Allergies are killing me this week. I don't know what's going on.

Doctor, from your training and experience -- I think you told me you've been at this business for 34 years?

A That's correct.

Q Is it possible for a gynecologist performing laparoscopic surgery like Dr. Geary was performing on this patient on the day in question, to inflict an injury to that patient's bowel and not realize that he or she has done so?

A If they don't go through certain steps to ascertain whether they did or did not.

Q It is possible?

A If they don't go through certain steps to ascertain if they did or did not.

Q Has it ever happened to you?

A No.

Q Have you ever inflicted a bowel injury on a patient, period?

A Yes.

Q In what setting?

A Endometriosis.

Q Laparoscopic procedure?

A Yes.

Q You realized you did it when you did it or before the surgery was over?

A And repaired it myself.

Q And repaired it yourself?

A Right.

Q How many times has it happened to you?

A Twice. It was extensive endometriosis.

Q Did this patient have endometriosis?

A I've never read that she had endometriosis. That's the worst form of adhesions, endometriosis is.

Q Yes, sir. And would you agree with me, Doctor, that it's possible for an obstetrician gynecologist performing laparoscopic surgery like the one -- strike that. I've asked you that already.

Tell me all the steps that you think the standard of care requires the surgeon to go through to confirm that he or she has not inflicted, inadvertently inflicted a bowel injury on a patient during a procedure -- and we can speed this up some, Doctor, if you and I can agree that all I'm here to talk about is OB-GYNs doing laparoscopies, so I don't have to keep saying all that.

A Sure.

Q Okay. What are all the steps that, that a surgeon needs to go through to ensure that he or she hadn't inflicted a bowel injury?

A Direct visualization. Looking --

Q Yes, sir.

A -- in the bowel carefully. Irrigation,

and irrigation, to make sure that there is no discoloration or seepage of usually greenish fluid or feces into that clear fluid. And oftentimes depending on the size of the perforation, bubbles, air bubbles.

Q Spontaneously?

A When you're moving the bowel around, you can express it. Because -- not spontaneously, but just irrigating and moving the bowel around, I guess like, kind of a balloon. If I press the balloon, it's going to make the air come out faster.

Q Do you know Frank Botaglieri(phonetic)?

A No.

Q He testified in response to Mr. Boone's questions last week -- was it last week?

MR. BOONE: I think it was last week, yeah. Or two weeks ago.

BY MR. LEWIS:

Q That in his view, the only way to definitively rule out a bowel injury -- and I'm taking some poetic license with his opinion -- was to insert a sigmoidoscope and put air into the bowel lumen.

A I don't agree with that.

Q You do not? Have you ever done that?

A No, I have not.

Q Have you ever been taught that it is one

way to definitively rule out a bowel injury?

A One way.

Q Uh-huh.

A It is one way, but not the only way.

Q I understand. Is it your testimony, Doctor, that in every bowel perforation done laparoscopically, the operating surgeon is going to see discolored fluid and/or bubbles and/or both?

A Depending on how the perforation is, because I have seen colleagues of mine perforate with a trocar entry, and then they look around, and they're looking into the lumen of the bowel.

Q Right.

A So there is nothing coming out that they recognize sometimes, until they see some brown stuff that they're actually in the lumen. There's nothing coming out, because you're not supposed to take the trocar out at that point, make an incision, leave the trocar in --

Q How would those individuals have inflicted that injury?

A By inserting the trocar blindly. In other words, the first trocar --

Q The, the --

A -- instead of using the --

Q The umbilicus trocar?

A Instead of exceeding the standard of care like Dr. Geary did, they will go in blindly -- and this is what I teach not to do, going in blindly through the umbilical first port and reinjure the bowel, because the other ports you're going to see yourself going in.

Q Is it your testimony that other than an instance where the trocar is essentially plugging the perforation, other than in that instance, every bowel perforation during one of these procedures is either going to yield discolored fluid or bubbles or both?

A Exactly. You have to look for it.

Q Is that a "yes"?

A Yes.

Q Every one?

A Every one. Some doctors don't find it, because they don't do those things. They just get on out. Dr. Geary was diligent. She irrigated, and she irrigated until the fluid was, you know, as clear as it could be, and she looked and waited, and she moved the bowel around and nothing happened. She did everything according to due diligence and the exact same way that I would have done it.

Q Would you agree with me, Doctor, that it

is important for a surgeon performing this type of patient -- performing this type of procedure on a patient with a prior history of four abdominal surgeries, to be sure that he or she has not inflicted a bowel injury intraoperatively?

MR. BOONE: Objection.

A And that is what she did.

BY MR. LEWIS:

Q But it is your opinion that that is important?

A It is very important.

MR. BOONE: Objection.

BY MR. LEWIS:

Q Doctor, take a look at what our court reporter has marked as -- I don't know what I did with it. Let me find it. There it is -- as Dr. Cane Deposition Exhibit No. 2.

A Yes.

Q And if you would like to read through it, feel free.

A Okay.

Q Have you seen that document before today?

A Yes.

Q Did you author it?

A This entire document?

Q The part that attributes to you --

A Oh, yes.

Q -- your opinions? Did you write it?

A No, I didn't write this.

Q Who did?

MR. BOONE: Jim, where's the -- oh, you have it through page 4.

MR. LEWIS: I just have Dr. Cane's designation.

A This is not something that I typed up.

BY MR. LEWIS:

Q I understand that.

A So if that's what you're asking.

Q You didn't author it. Do you know who did?

A I would have to ask.

Q You don't know who did it?

A I don't.

Q Were you asked to review it for accuracy and completeness?

A Yes.

Q And in your opinion, Dr. Cane, does Exhibit 2 accurately and completely state the opinions that you hold in this case?

A Yes.

Q And I'd invite you to read it again right now if you would like to, just to make sure.

A Okay.

Q Have you had an opportunity to review it in its entirety?

A Yes.

Q And does it contain all of the opinions that you hold in this case?

A Yes.

Q Are any of the opinions that it -- meaning "it" being Exhibit 2 -- are any of the opinions that Exhibit 2 attributes to you not your opinions?

A No.

Q So everything in Exhibit 2 is accurate as far as you're concerned?

A Correct.

Q All right. We'll start on page 2, obviously, where your name appears. The first opinion says, "Dr. Cane will testify that it was appropriate, that it was appropriate for Dr. Geary to proceed with a laparoscopy." Why do you hold that opinion?

A Well, she was having pain. It is a superior procedure. It's minimally invasive. I mean, it enhances and expedites the recovery of the patient. I feel it's a safer procedure.

Q So when you say it was appropriate for Dr. Geary to proceed with laparoscopy, you mean as opposed to laparotomy --

A Correct.

Q -- or nothing?

A Well, both.

Q Right. Maybe I should have said "and."

Next paragraph begins, Dr. Cane, with, "Plaintiff suffered from a bowel injury, which is a known complication of surgery." What does that mean, that, from time to time people's bowels get injured during surgery? Is there any more to it than that?

A No.

Q But this patient, in your opinion, didn't suffer a bowel injury as a result of the surgery itself, correct?

A No, I'm sorry. I want to be more specific.

Q Yes, sir, please do.

A The patient did not have a direct bowel injury from Dr. Geary.

Q Right.

A I'm saying that an injury resulted from situations that were existing in her pelvis.

Q And you go on to note that the patient

accepted this risk of surgery and its known complications including the risk of bowel perforation. What are you relying upon in asserting that comment, Doctor?

A From the informed consent process that is referred to in documents that I read.

Q You mean in Dr. Geary's deposition testimony?

A Yes, sir.

Q She didn't have any informed consents about perforation in her chart, did she?

A She said that she mentioned perforation as a potential risk.

Q That wasn't my question. She didn't have any informed consent documents in her chart that talked about perforation as being a risk of this procedure, did she?

A The consent form. It is implied in the consent form.

Q Okay. We are parsing words.

A All right.

Q And is the answer to my question "yes" or "no"?

A Yes.

Q She did have informed consent documents in

her chart that identified bowel perforation as a known complication of this procedure?

A No.

Q No? Okay. All right.

Page 2, Doctor, I'm just moving on down the page. "The perforation did not occur intraoperatively, as the plaintiff would have been sick sooner than she was." Explain that statement for me, please, sir.

A Okay. With a perforation and leakage of bowel contents, especially the colon, there is going to be peritonitis within a few hours.

Q Are you aware, Dr. Cane, of any literature that stands for the proposition that it can be as long as 36 hours or more before the patient presents with an acute abdomen?

A I'm going on 34 years of experience.

Q I understand, but I've done a records -- a literature search in the case --

A But I'm going on what I know for a fact.

Q How many bowels have you perforated?

A I have been involved and seen doctors, and I've been consulted, and I know what I've seen.

Q Okay. So your opinion is --

A I've been called in many times.

Q -- if a bowel perf occurs in the sigmoid colon, the patient is going to show symptoms in how long? A couple hours?

A No. Within four to six hours.

Q Four to six hours?

A And I would maintain, sir, even more so in the sigmoid colon. Even more so as opposed to the cecum, right colon. Even quicker.

Q Well, let me ask you this: How long after that surgery did Mrs. Davis begin feeling ill?

A She didn't show signs of sepsis until 24 hours later.

Q 24 hours?

A Yes.

Q What were the signs?

A Temperature elevation, increased platelet count, increased pulse.

Q How about just feeling bad? Abdominal discomfort. How long after the surgery did those symptoms start?

A Well, a little abdominal discomfort is not unusual after the surgery because of the incisions.

Q It's also not unusual with a bowel perforation, is it?

A I mean, when you do laparoscopic surgery,

patients are going to have discomfort.

Q Yes, sir, I know. But do you know how long after this surgery Mrs. Davis first started feeling ill?

A She was feeling discomfort immediately after the surgery.

Q Well, how do we know when what she was feeling immediately after the surgery becomes secondary to a delayed bowel perforation? Do you understand my question?

A When she gets to the point where she is getting distended, temperature elevation, increased pulse, those things.

Q Okay. And when did that start?

A About 24 to 30 hours.

Q How do you know that?

A Based on the records.

Q What records?

A When she was sent to the emergency room and history that was obtained.

Q Well, Dr. Rahman, in his consult, says that she started with her symptoms the night of the surgery. Did you read that?

A The night of the surgery?

Q Yes, sir.

A Well, she didn't have the symptoms that I mentioned the night of the surgery.

Q Well, did you read Dr. Rahman's consult? Is he wrong?

A I -- well, I can't say that he is wrong.

Q Okay. Did Mrs. Geary -- strike that.

Did Mrs. Davis or her husband testify at their deposition as to when she started feeling sick?

A I can't recall the exact time that they said.

Q Did they, one way or the other?

A I don't recall.

Q This designation goes on to say the first evidence of plaintiff being sick is at 10:30 on August 30th, 2005.

A Right.

Q Now, you're getting that from the history and physical that was taken when she presented at 3:00 a.m. the 31st, correct?

A Correct.

Q You didn't get that from Dr. Rahman's consult when she was seen at the request of Dr. Geary?

A No.

Q And I understand the next sentence, that you believe that a patient is going to present with

abdominal symptoms within -- what did you say? I don't want to put words in your mouth.

A 24 to 30 hours.

Q 24to 30 hours if this perforation had occurred intraoperatively?

Okay. I'm over on page 3 now, Dr. Cane. You say there was no failure to timely recognize the perforation, and that's because you hold the opinion that this perforation did not occur intraoperatively, correct?

A That's correct.

Q You then go on to say, "The patient's colon was unknowingly compromised through lysis of adhesions, which led to ischemia, necrosis, and a subsequent perforation," correct?

A Correct.

Q And it is your opinion, is it not, Doctor, that by 10:30 in the evening on August 30th, this patient's colon had perforated?

A It was beginning to leak.

Q And is it your opinion that the ischemia and the necrotization of the bowel wall can happen that quickly?

A May I explain?

Q You may. Well, let's -- with the -- if

you can, give me a "yes" or a "no," and then, by all means, explain.

A Yes.

Q Is it your opinion that it happens that quickly?

A Yes, uh-huh.

Q Okay. And you would like to explain. Please do.

A The unique situation that this patient had was the significant diverticulosis. And in -- with the adhesions involving the sigmoid, that region where she stayed away from, just moving adhesions around can stretch -- do you understand what a diverticulum is?

Q I do.

A Okay. If you stretch the diverticulum and there is inflammation there, stool trapped in the diverticulum pocket, you have inflammation and inflammation can predispose to necrosis and weaken the wall of the neck of the diverticulum. There's one -- adhesiolysis in the region of that, and you put a little tension on that, you weaken the serosa, which is outside the bowel, which is inflamed, and later on it can autoamputate.

Q Did --

A This is a phenomenon that can definitely

occur, otherwise patients would have ruptured diverticula and die.

Q I understand. Rather --

A That's an injury with no surgery.

Q Doctor, where in the medical chart do you see any evidence from Dr. Geary or Dr. Rahman that this patient suffered a diverticular-related necrotic perforation?

A She had a perforation that was the size of the tip of one's finger, correct?

Q By the time Dr. Rahman got into her abdomen, he was able to put his finger in the hole. Does he describe any diverticulitis types of signs or symptoms in his dictation?

A Sometimes you can't make that definition.

Q That wasn't my question. Did he?

A That information is in the chart.

Q The operative report from Dr. Rahman: Does it mention anything about this perforation being related to diverticular symptoms?

A He couldn't. He doesn't have to.

Q Did he?

A He did not.

Q And is there any pathology from his first surgery that would indicate diverticular disease in

the area of this perforation?

A When it autoamputates -- a pathologist can't look at that, if it amputates at the base of the diverticulum and say, "This is due to a perf," unless he sees thermal injury. If it's a laceration, you'll see the laceration. It's clean. If there were vegetative fibers around the area and necrosis but no signs of thermal injury, no signs of cautery effect, you can't find a pathologist that will tell me or you that this was not a result of a diverticulum being ripped off. You can't.

Q Okay.

A You can't. You can't. I defy you to find one.

Q Did Dr. Rahman even excise any tissue from the perforation and send it to pathology?

A He submitted a section of sigmoid. He submitted it when he removed that part of the sigmoid. The pathologist is the one that made reference to the size of the hole. The pathologist made that point.

Q Is it your understanding and your testimony that there is tissue pathology, tissue pathology from Dr. Rahman's surgical repair of this patient on September 2nd?

A Well, I don't -- I recall reading it.

About 10 centimeters or so of sigmoid was removed. I don't know what page it was on, but it was removed. A portion of the sigmoid was actually removed.

Q And is it described in any way as being riddled or otherwise affected with diverticular disease?

A Well, the CT scan mentioned that.

Q That wasn't my question.

A Well, no, because he didn't need -- he wasn't focused on that, to be honest with you. I wouldn't have been focused on it either. I would have been focused on it on purpose, on the hole. There was an omission on his part and that was an omission that was of importance.

Q Well, what are you relying on specifically in support of your opinion that this was an -- what did you call it? -- autoamputate secondary to diverticular disease?

A And secondary to the manipulation of surgery.

Q Tell me what it is, what are you relying upon? We've looked at Dr. Geary's operative report.

A Right.

Q And from that, I take it, you gather that there was some bowel manipulation?

A That's right.

Q Okay. What else in this chart are you relying upon in support of the proposition that this perforation was diverticular-disease related?

A Are you denying that she had diverticular disease?

Q I'm not answering the questions today, Doctor. You are.

A Let me make a statement. She had diverticular disease.

Q Okay.

A Confirmed by the radiologist. Confirmed. Not one, but multiple.

Q Okay. Diverticulitis or diverticulosis?

A Diverticular disease.

Q Which one?

A Diverticulosis is not inflammation, but diverticulitis is inflammation.

Q Yes, sir.

A And I'm saying that she had diverticulitis in the area where the hole occurred.

Q And I want you to tell me what you are relying upon in support of that proposition.

A I'm relying on the size of the hole, where it was located underneath the sigmoid colon, the fact

that she had the surgery, and I'm giving a reasonable degree of experience in making that statement. I'm basing it on my experience, my surgical experience and what I found in the chart and the pathology that she had. It gives me reasonable doubt.

Q Reasonable doubt of what?

A That that perf was not caused by any instrumentation or a laceration.

Q Explain what that means. What gives you reasonable doubt?

A First of all, I don't see any evidence in the path report there was a knife laceration. There was no evidence in the path report that there was a cautery effect that caused a thermal injury, where there is a burn injury or cautery from electrosurgery, or even the Harmonic scalpel, because when you look on the path report, if there is thermal injury, the pathologist will refer to that and describe the reason and the nature of the burn injury. It has a characteristic appearance on pathology, thermal injuries do. A knife injury has a characteristic look, as well.

Q A knife injury that was inflicted two, three, four, five days earlier?

A Yeah. Absolutely. Absolutely.

Q Are you going to be able to look at it and go, "Uh-huh, a knife did that"?

A As opposed to a round hole that you put the tip of your finger in. And remember, I read the path report, too.

Q What does the word "iatrogenic" mean to you, Doctor?

A Induced by a surgeon.

Q The surgeon?

A Or physician. Iatrogenic is --

Q And Dr. Rahman describes this injury in his chart dictation on two separate occasions as "iatrogenic," doesn't he?

A But he doesn't back it up.

Q I didn't ask you that. I said that's what he said at the time before there were any lawsuits --

A Yes, sir.

Q -- and any lawyers.

A Yes, he does, but I don't agree with him.

Q Say again?

A I don't agree with that.

Q I know you don't. I'm figuring that out quickly.

A He couldn't back it up. I would have agreed with him if he could back it up.

Q Well, when you say he didn't "back it up," you mean he didn't accept your and my understanding of the meaning of that word at his deposition?

MR. BOONE: Objection.

A To me, to "back it up" is you need a pathologist report on that. I want a third nonbiased opinion. Someone who is an expert in making those kinds of decisions.

BY MR. LEWIS:

Q And there is no pathology from the August 29th surgery, is there?

A I beg to differ with you.

Q Can you put your hands on it for me?

A The pathologist didn't look at the segment of colon that was removed.

Q Is there a pathology report from the August 29th, 2005, surgery?

A You mean Dr. Geary's report?

Q No. A pathology report.

I'm sorry. Is there a -- I misspoke. You're right. Is there pathology -- is there a pathology report from the repair surgery that Dr. Rahman performed?

A There is a report when they removed the segment of the colon.

Q Whatever he did on September 2nd, is there a pathology report that you reviewed?

A Yeah. May I look at the September 2nd surgery?

Q At his operative report?

A Sure. The pathology report.

Q I don't have one. If you've got one, I would very much like to see it.

A May I take a look?

Q You can look at my -- there is not one in here, but sure, you can look. What do you want to look at?

A His surgery.

Q His, his op report?

A Yes.

Q Okay. Hold on.

A Immediately behind the op report should be a path report.

Q These aren't organized the same way that Mr. Boone's were. Here is his op report. I'll just give you the whole book, Doctor.

A Thank you very much.

Q I'm not very good with hands these days.

(Discussion off the record.)

THE DEPONENT: I'm referring to the

pathology report where the pathology reported the vegetative material in the colon. Are you familiar with that?

BY MR. LEWIS:

Q Show me.

A Oh, you're not familiar with that one?

Q All I'm really interested in, because I couldn't find any, Doctor, is a pathology report from Dr. Rahman's September 2nd surgery.

A Okay. Okay. No.

Q Well, have you got your set here? It's a secret piece of yellow paper that you're not supposed to look at.

A I have to go find my -- how is this organized?

Q By hospitalization.

MR. BOONE: Off the record.

(Discussion off the record.)

BY MR. LEWIS:

Q Doctor, what I found was a February of '06 --

A Okay.

Q -- path report, which I think is what you were referring to.

A Let me take a look at this, please. Thank

you.

Q Yes, sir, and I apologize for not being able to get my hands on it sooner.

A Uh-huh.

Q Have you had an opportunity to review that now, Doctor?

A Yes.

Q Is that the path report that you were referring to earlier?

A Yes, that's the one.

Q And this is the pathology from the surgery that was performed in February of 2006?

A Right.

Q So back to my original question. Are you aware of any pathology from Dr. Rahman's September 2nd, '05 surgical procedure?

A Only his description of it.

Q So not to beat a dead horse, I want to be sure that I understand everything that you're relying upon in support of your proposition -- that's my word, not yours -- that this lady's perforation was diverticular-disease related, number one, the fact you are of the opinion that Dr. Geary manipulated the bowel during her procedure.

A Right.

Q And number two, the pathology report from February 23rd of '06, refers to diverticular disease.

A No, that doesn't refer to that.

Q Okay. Then what --

A The CT scan -- there's a report in here from the radiologist that refers to multiple diverticula.

Q And when was that CT performed?

A That was during the hospitalization.

Q Which one?

A The hospitalization where -- not the hospitalization, the second one, but the first one.

Q The February '06 one?

A No, not that one.

Q Dr. Geary's hospitalization? Dr. Rahman's hospitalization?

A Dr. Rahman's hospitalization -- Dr. Geary's hospitalization.

Q Yeah, I called that one a Dr. Rahman hospitalization, but your description is much more accurate. This is an abdominal CT?

A Yes. Uh-huh.

Q I'm looking at one dated September 2nd without contrast, and there's no mention of diverticular disease with that one. Here's one

without contrast. That's pelvic, and there is no mention of diverticula there. There's a line placement.

A May I look?

Q Yeah. Absolutely, because I'm not finding that either.

MR. LEWIS: Let's go off.

(Discussion off the record.)

MR. LEWIS: Okay. We're back on.

BY MR. LEWIS:

Q Now, what you're telling me, Doctor, is that in addition to your assumption that Dr. Geary manipulated the bowel during her procedure --

MR. BOONE: Objection to form.

BY MR. LEWIS:

Q -- your -- the other thing that you are basing your opinion on that this perforation was secondary to diverticular disease is a February of '06 barium enema?

A Confirming the presence of diverticular disease in the sigmoid colon.

Q Let me see if I can find that.

A 2-02-06.

Q Whose record does that appear in? Do you remember?

A February '06.

Q Yeah, but she's not in the hospital in February -- she doesn't go into the hospital in February of '06 till the 23rd, so it must be in somebody's office chart. Do you remember whose?

A It's a barium enema report.

Q Do you think it was in Dr. Rahman's?

A Yeah, I think it was Dr. Rahman's.

Q I don't have it. But it is a February of '06?

A February 2nd, 2006, radiology report of a barium enema.

Q Right. Right. And when you went back into your office, did you put your hands on that? I don't want it if it's got any writing on it or anything that's privileged, but if it doesn't, could you produce that for me? I mean, did you just go back in and look at it?

A It's got writing on it.

Q All right. Well, at least tell me who did it, where it was done so I can find it.

(Discussion off the record.)

A Chesapeake General Hospital.

BY MR. LEWIS:

Q Who was the ordering surgeon? Rahman?

A Yeah, I think it's Rahman.

Q And that is 2-02-06?

A Chesapeake General Hospital.

Q Barium enema?

A Barium enema showing diverticulitis of the sigmoid colon.

Q Yes, sir.

A I should say, multiple diverticula of the sigmoid colon.

Q Okay. So we've got the manipulation of the bowel and a February of '06 barium enema?

A Confirming diverticulosis of the sigmoid colon.

Q Anything else you're relying on to support your opinion that this lady's perforation was secondary to diverticular disease?

A The pain she was having.

Q What pain?

A She was having pelvic pain prior to the surgery.

Q Before Dr. Geary's surgery --

A That's right.

Q -- where she was never diagnosed with diverticulysis -- diverticular disease prior to that surgery, was she?

A It doesn't mean she doesn't have it. She had it, though.

Q I understand. But she was never diagnosed. Anything else?

A It's often missed.

Q Anything else?

A No.

Q That's it? Her complaints of pain?

A Right.

Q The fact that Dr. Geary manipulated the bowel, and a February '06 barium enema?

A Right.

Q Back to Exhibit No. 2, Dr. Cane, about halfway down that first paragraph this disclosure notes that, "If a perforation the size of the tip of a little finger had occurred during Dr. Geary's surgery, she would have easily recognized the complication." Is it your opinion, Dr. Cane, that the size of the perforation as described by Dr. Rahman is the size of the perforation when it first occurred?

A Yes.

Q What do you base that opinion upon?

A Well, I'm trying to think of reasons why it would enlarge.

Q How about necrosis?

A It would just make the edges -- she didn't have time for necrosis to cause that type of damage, to make it larger. The colon wall is pretty thick. You would have to have changes around the edges, it would indicate necrosis, but not make the hole bigger.

Q So if the absence of diverticular disease, your opinion is that this perforation could not have happened due to ischemia and resultant necrosis postoperatively, correct?

A Well, there is -- I'm not going to accept another theory that if there was some weakening of the wall of the colon where there was no perf with some deserosalization, because there are three layers, through peristalsis and violent contractions of the colon, that gradually it could open up, yes.

Q That's not in Exhibit No. 2 anywhere?

A No. No. You asked me a question, I answered it.

Q Okay. But that is not your opinion of what happened in this case, is it?

A No, it's not.

Q Okay.

A And, again, to answer your question, a hole that size, as it says attributed to me, the leakage would have been rather copious through a hole

that size. You're talking about almost 2 centimeters. The tip of one's little finger is almost 2 centimeters. We're talking something like this.

Q What you're holding up is quite a bit bigger around than the tip of my little finger.

A Well, look. I mean, watch carefully. This is my little finger. I'm taking it out.

Q Okay.

A So I'm just saying that a hole this size, it's going to be hard for the bowel to contain contents in there. It's going to come on out, especially when irrigating.

Q Well, when's the last time --

A A pinhole is a different thing now.

Q When was the last time this patient ate prior to Dr. Geary's surgery?

A It doesn't -- I'm not saying feces. I'm saying contents, because there are going to be liquid contents in the bowel.

Q In the sigmoid colon?

A Absolutely.

Q Do you know when this patient last ate before this surgery?

A It doesn't matter.

Q That wasn't my question.

A Okay. Probably --

Q Do you know?

A No. I'm just saying routine. I don't know.

Q You don't know?

A Routinely we say, Don't eat anything after midnight the night before surgery. But let's say she hasn't eaten for two days prior to the surgery. There is going to be liquid contents in the colon, not feces, so I'm with you on that point. Not feces, I'm not saying that, but liquid.

Q Did Dr. Geary do a bowel prep on this patient?

A I didn't read anything about bowel prep.

Q Should she have?

A No, that's not the standard of care.

Q It's not?

A No.

Q Okay. Do you when you are performing laparoscopic surgery on a patient who has been surgerized four times previously in the last four years?

A I do bowel preps on all my patients, because I have referrals from other gynecologists, et cetera, because I'm anticipating some significant

problems.

Q You get referrals from doctors like Dr. Geary, whose patients have persistent abdominal pain in spite of multiple laparoscopic procedures?

A Who have had four or five surgeries, yes.

Q Those get sent to you?

A Right.

Q And when you are going to operate on a patient like Mrs. Davis was operated on in August of '05, you do a bowel prep, because you're anticipating a difficult case?

A Because I've never operated on them before. They are not my patient.

Q Okay. The fact that you have never operated on them before, why does that result in a bowel prep being done by you?

MR. BOONE: Just a minute. Can I just have a standing --

MR. LEWIS: Yes.

MR. BOONE: I know relevance. What he does and standard of care are two different things.

MR. LEWIS: You can have a standing objection to the fact that I am sitting here.

BY MR. LEWIS:

Q What is it about the fact that you have

never operated on the patient that leads you to say, "I want a bowel prep"?

A Because I haven't seen the inside of the abdomen before in terms of the extent and nature of their disease, so I'm sort of going in not knowing what to expect.

Q How about a patient that comes to you abdomicia(phonetic), when you're doing the first surgery this patient has ever had? When I say "surgery," I'm talking about lysis of adhesions.

A On a virgin belly?

Q Yeah. Do you bowel prep those?

A No.

Q Do you bowel prep any of them?

A Oh, yes.

Q If you bowel prep a patient -- strike that. It doesn't matter.

Well, Doctor, I think I misspoke earlier, for which I apologize.

The middle paragraph of page 3 of Exhibit 2 does posit a serosal weakening of a possible cause of this bowel perforation.

A Right.

Q So now do I understand it that you are positing two ways this could have happened?

A Well, basically it's saying the same thing.

Q Okay.

A Because if, you know, as I mentioned before, when I talk about the base of the diverticulum, if there is any tension on it, you can cause a weakening of the serosa.

Q Okay.

A So basically we're talking about the same thing making two different spots, the same type of phenomenon.

Q Do you know where -- well, let's look at page 4 real quickly. The last paragraph of your designation basically says you're going to disagree with the plaintiff's experts.

A Now, which page 3?

Q Page 4, I'm sorry, at the top. The last page of your designation.

A Okay.

Q And you're aware that it's the plaintiff's contention that this perforation occurred intraoperatively, and that Dr. Geary failed to recognize it?

A Correct.

Q Is there anything else about the

plaintiff's opinions that you disagree with that you haven't already talked with me about today?

A Well, that Dr. Geary did not adhere to the standard of care.

Q I understand that. But that's all part and parcel of the fact that it's the plaintiff's contention that she inflicted the injury, correct?

A That's correct.

Q Doctor, can you tell me where on this patient's sigmoid colon the perforation occurred?

A I don't -- I mean, if I recall, Dr. Rahman made his comments about it, it was in the sigmoid colon --

Q Right. But --

A -- in the lower segment of the sigmoid colon.

Q Lower section? Let's see if we can find that.

A I don't want to misspeak on that. It wasn't the rectum.

Q I know that.

A It was the sigmoid colon. It wasn't the transverse colon, it wasn't the right colon, the cecum. It was in the sigmoid colon.

Q I'm looking at his op report, "A hole was

noted in the sigmoid colon admitting the tip of little the finger."

A Right.

Q Does he give us any other description as to where on the sigmoid colon he found this perforation?

A Well, you've got to remember now, in terms of anatomy, he's being explicit here, because you have -- the rectum is about this long. And then after the rectum, you have the sigmoid colon.

Q How long is the sigmoid colon?

A The sigmoid colon is probably about this long.

Q How long is that? 10, 12 inches?

A Yes.

Q And along that transverse colon, could you tell me where this injury occurred?

A He, he didn't, Dr. Rahman didn't say.

Q Right. So you don't know, correct?

A That is correct.

Q All right. I was looking at Netter's, Dr. Netter's anatomy book earlier today, Doctor, and I came across Plate No. 285 --

MR. LEWIS: And, Mr. Boone, I'll be glad to mark this as an exhibit if you would like.

MR. BOONE: Sure.

BY MR. LEWIS:

Q -- but Plate 285 -- and I'm going to need that one back. You can't keep it -- Plate 280- --

A Is this the same one that you're looking at?

Q Yes. Doctor, before I start blabbering about it, why don't you take a look at Plate 285?

A Okay. May I take a look?

MR. BOONE: And this is from the text that you referenced before --

THE DEPONENT: Uh-huh.

BY MR. LEWIS:

Q Frank Netter's --

A Uh-huh.

Q -- Textbook of Anatomy?

A Right.

Q Pretty well accepted in the medical community?

A Right.

MR. BOONE: Objection.

BY MR. LEWIS:

Q What Plate 285 purports to show is variations in positions of a patient's sigmoid colon, and Dr. Netter divides it into four categories:

Typical; short, straight and oblique; looping to the right; and ascending high into the abdomen.

Based upon your training and experience, Doctor, do you have an opinion as to whether Dr. Netter's recitation of common variants of the position of the sigmoid colon is accurate?

MR. BOONE: Objection. Doctor -- you haven't established that the doctor said this is a reliable authority, and therefore you cannot question him about this.

BY MR. LEWIS:

Q Doctor --

MR. BOONE: Doctor, I'll ask you not to answer that question.

BY MR. LEWIS:

Q Doctor, do you think Dr. Netter's anatomy book is, is reasonably medically accurate in its anatomical depictions?

MR. BOONE: Objection to the form.

I think you have to establish -- you believe he opines it's a reliable authority as opposed to --

MR. LEWIS: I don't, but it's neither here nor there. I'll give you an objection to all the questions.

BY MR. LEWIS:

Q Is Netter, in your view, a reliable authority in terms of visualization of various parts of the human anatomy including the sigmoid colon?

A I'd say it's fairly reliable.

Q All right. Do you agree with his categorization of the four normal variations of the position of a patient's sigmoid colon, or is this not an area of your expertise?

A I can only base it on what I've seen.

Q Fine. Based upon what you've seen, do you think these four variations of colon position are reasonably accurate?

MR. BOONE: Objection.

A They may not be the only variations.

BY MR. LEWIS:

Q Okay. But they are four variations that are known to you?

A I've seen them.

Q Okay. Which of these four, if any, did Mrs. Davis present with?

A They didn't, Dr. Rahman didn't comment and neither did Dr. Geary.

Q And so you don't know?

A No.

Q Okay.

A Just like Dr. Rahman didn't mention the diverticula --

Q Yes, sir, I understand.

A -- that she had.

Q Doctor, from time to time in your medical practice, do you receive correspondence from lawyers asking for copies of your chart?

MR. BOONE: Did you make that an exhibit, Jim?

MR. LEWIS: I did not. If you want me to, I will.

A Occasionally, when a patient's in an accident, et cetera.

BY MR. LEWIS:

Q And when you receive those requests, do you routinely pull the file and review it?

A Not always.

Q Have you ever, when you've received a request from a lawyer for a copy of your chart, gone in and supplemented your chart entries? Added things?

A No.

Q Are you aware that Dr. Geary did that in this case?

A No.

MR. BOONE: Objection.

BY MR. LEWIS:

Q Pardon me?

A No.

Q You did not know? Didn't you read her deposition?

A We're talking about her technique that she used?

Q No. I'm talking about when she got a lawyer letter she went back and added entries to Mrs. Geary's -- Mrs. Davis's medical chart. Do you remember her talking about that in her deposition?

A I'm not clear on that one.

Q Well, then, assume for me that she testified that she did on, I believe, three different entries. Do you think that is an appropriate thing for her to have done?

MR. BOONE: Objection. Do you want to show him the entries?

A If you would show me the entries, I can make a response to that.

BY MR. LEWIS:

Q Well, I'm not prepared to do that. You can't answer my question in the abstract?

A I don't know what kind of -- I don't know

what she entered.

Q I thought you read her deposition.

A What did she enter?

Q Things like -- I can't remember, and I don't want to put words in her mouth. Things like, Discussed risks, something like that.

A I read that. I read that.

Q Do you think it was appropriate for her to go back months after that chart entry was originally made and add an entry like that?

MR. BOONE: Objection.

A If she discussed them, yes.

BY MR. LEWIS:

Q But you've never done that, have you?

A Well, I've never had to do that. But if she discussed them, I think it's appropriate.

MR. BOONE: Shall we mark that now?

MR. LEWIS: Sure.

MR. BOONE: And did you say you had an extra for me, or did I keep it already?

(Marked Dr. Cane Exhibit No. 3.)

BY MR. LEWIS:

Q Doctor, this is a little bit of an unfair question, but if you can answer it, I want you to. As you know, the reason for my coming here today is to

find out what opinions you intend to share with our jury, and, although I certainly don't presuppose to be able to read Mr. Boone's mind, but you understand the issues in this case, have you and I discussed all of the issues that you think exist in this case in one form or other?

A I think so.

Q When I leave here today, you're not going to turn around to Mr. Boone and go, "Gosh, I cannot believe that he didn't ask me about X," because if you are, I want to know what X is, and I'll ask you about it.

A I think we, correct me if I'm wrong, but I think we covered most points that I wanted you to cover or ask me about as relates to how a delayed perforation can occur where it didn't happen during the surgery.

Q Intraoperatively.

A Right. It was postoperative.

Q Let me ask you this, Doctor: How many patients that you surgerized suffered delayed perforations that you believe occurred after your procedure was completed, like what occurred to Ms. Davis? How many of those have you had in your practice?

A Well, in 34 years, I've had one.

Q One?

MR. BOONE: Objection to the use of the word "like Ms. Davis."

BY MR. LEWIS:

Q By that I mean a laparoscopic lysis of adhesions where there was no evidence intraoperatively of a bowel perforation, but the plaintiff suffered one later. You've had that happen once?

A Once. And I've read about it happening. And then I know about a couple of friends of mine who were, themselves -- these were both men --

Do you want the original? Who gets the original?

Q The original goes to her.

A Copy to him?

Q I have one, but I'll take another one if you'd like.

A -- and so what I'm saying is, they're two doctor friends of mine. One went on a trip and he ruptured a diverticulum and almost died, just like her.

Q After he had gone, and you helped take care of the patient?

A No. No. He was a friend of mine. I've

lectured with him before. He's from Marietta, Georgia. He doesn't live in the same state. He's a famous guy --

Q Uh-huh.

A -- Dr. Bill Seay. He was involved in the first laparoscopy gallbladder surgery that was done with Bill McCarney, in the world. And Bill Seay was traveling. He told me when he was traveling, he got deathly ill. He had a ruptured diverticulum. Just like this patient, he almost died.

Q Was he status post laparoscopic lysis of adhesions?

A No. What I'm saying is it can occur spontaneously.

Q I know that, in a patient with diverticular disease.

A Yeah. So -- but he didn't have diverticulitis at the time that he was traveling. It just happened spontaneously. So what I'm trying to say is that another guy in Petersburg, another doctor, GYN doctor, the same thing happened. He had a colostomy and all that stuff, just like that.

Q Was he status post laparoscopic lysis of adhesions?

A No. He was a healthy young man.

Q Okay.

A He was in his thirties when it happened.

Q My question is, because it's my understanding, Doctor, and correct me if I'm wrong, but your opinions in this case begin with the fact that Dr. Geary manipulated the bowel during her procedure, thereby either interrupting blood supply or causing a serosal weakening to the bowel wall?

A Okay.

Q But neither one of your friends had that piece to the puzzle, because they weren't status post surgery patients, were they?

A What I'm trying to say is it can happen. I don't think you're following my thought process.

Q I think I am. I just want to make sure you understood my question.

A Yeah, I understand your question. But my point that I'm trying to make is that if it can happen spontaneously in a 35-year-old man who's not had a manipulation, it can certainly happen more expeditiously in a person who had the same diverticular disease with manipulation.

Q Okay. Well, let's talk about the one patient that it happened to you in. How long ago was it?

MR. BOONE: Note my standing objection.

MR. LEWIS: Yes.

A About 15 years ago.

BY MR. LEWIS:

Q And did that patient carry a diagnosis of diverticulitis or diverticular disease when you treated her?

A Yes, she did.

Q So she had a preoperative diagnosis of diverticular disease?

A Well, this woman had a preoperative condition of diverticular disease.

Q Well, I understand that, but she had never been diagnosed, correct?

A Because she has never been diagnosed doesn't mean she didn't have the disease.

Q I understand. In this patient of yours, what surgical procedure did you perform on her?

A Lysis of adhesions and, amazingly, she had multiple surgeries, too.

Q And --

A She'd been referred by another gynecologist and had multiple surgeries.

Q And this was a laparoscopic procedure?

A Laparoscopic. That's exactly right.

Q And you did not appreciate any bowel perforation intraoperatively?

A Absolutely.

Q Absolutely not?

A Absolutely not.

Q And how long after the procedure did the patient become symptomatic consistent with a bowel perf?

A Within about 30 hours.

Q 30 hours?

A Yeah. A couple days.

And what happened is I was lucky. I mean, she was lucky. It sealed off, and she -- because the body can do that -- she developed a fistula after surgery. "Fistula" meaning that it started leaking out --

Q Sure.

A -- through the incision.

Q Sure.

A But she was fortunate, because it had a way out. Had she not had a way out -- guess what? -- it would have been the same situation like hers.

Q Yes, sir, like Mrs. Davis?

A Yes, but she had to have surgery again.

Q That's the only patient that's happened to

you in?

A That's why it's so vivid in my mind in terms of -- that's why I can understand the mechanics of it, because I've been there. Been there and done that.

MR. LEWIS: All right. Doctor, I don't have any other questions. Thank you for your time.

THE DEPONENT: Thank you, sir.

THE COURT REPORTER: Do you wish to read and sign your deposition?

THE DEPONENT: I want to read it.

And further this deponent saith not.

(The deposition was concluded 4:54 p.m.)

o0o

I, the undersigned, _____,

do hereby certify that I have read my foregoing deposition and that, to the best of my knowledge, said deposition is true and accurate (with the exception of the following corrections listed below):

Page/Line	From	To	Reason

_____

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_____ _____

Date JAMES H. CANE, M.D.

COMMONWEALTH OF VIRGINIA, to wit:

COUNTY/CITY OF _____:

Subscribed and sworn before me this _____ day of _____, 2009.

My commission expires:_____/_____/_____.

Notary Registration Number: _____.

_____
Notary Public

COMMONWEALTH OF VIRGINIA AT LARGE, to wit:

I, Dorothy J. Lewis, CCR, Notary Public in and for the Commonwealth of Virginia, Notary Registration Number 323751, and whose commission expires October 31, 2010, do certify that the aforementioned appeared before me, was sworn by me,

and was thereupon examined by counsel; and that the foregoing is a true, correct, and full transcript of the testimony adduced.

I further certify that I am neither related to nor associated with any counsel or party to this proceeding, nor otherwise interested in the event thereof.

Given under my hand and notarial seal at Richmond, Virginia, this 26th day of July, 2009.

_____

Dorothy J. Lewis, CCR - Notary Public
Commonwealth of Virginia

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