

Medical Malpractice in Virginia

This is a transcript of a defense expert witness in a Fairfax, Virginia medical malpractice case involving the delayed diagnosis of rectal cancer. The name of the plaintiff has been changed in this transcript.

This video taped deposition was played at trial.

The case resulted in a verdict for the plaintiff of \$1,000,000.

This witness was one of many.

The plaintiff was represented by

Ben Glass
BenGlassLaw
3915 Old Lee Highway
22-B
Fairfax, VA 22030
703-591-9829



Note: Your case is different. Past results do not reflect future success. Each case is won or lost on its own merits.

This transcript is for educational purposes only. Do not use it for legal advice.

Benjamin W. Glass, III is a nationally recognized board certified personal injury, medical malpractice and disability insurance attorney in Fairfax, Virginia.

He is a much sought after speaker and author and has been featured in TRIAL magazine, Wall Street Journal Online and The Washington Post, among others. Ben is the author of twelve books including **The Truth About Lawyer Advertising** (available on Amazon.com).

Books by Ben Glass

Robbery Without A Gun –Why Your Employer’s Long-Term Disability Policy May be a Sham (www.RobberyWithoutAGun.com)

Five Deadly Sins That Can Wreck Your Injury Claim
(www.TheAccidentBook.com)

Why Most Medical Malpractice Victims Never Recover a Dime
(www.TheMalpracticeBook.com)

Don’t Gamble With Your Social Security Disability Benefits: What Every Virginia Resident Needs to Know To Win Their Social Security Disability Case (www.TheSocialSecurityBook.com)

The Truth About Lawyer Advertising
(www.TheTruthAboutLawyerAdvertising.com)

The Ultimate Success Secret (www.Ultimate-Success-Secret.com)

Carry Your Own Leash: The Entrepreneurs Guide to Autonomy and Success (www.CarryYourOwnLeash.com)

In addition to the above websites, you can find Ben Glass at the following websites:

www.BenGlassLaw.com

www.FairfaxAccidentAttorney.com

www.VirginiaMalpracticeNews.com

0001

1 VIRGINIA:
2 IN THE CIRCUIT COURT OF FAIRFAX COUNTY

3 ----- X

4 DAVID BROWNING, :

5 Plaintiff, :

6 v. : Law No.:

7 ALAN JOSHUA, M.D., : CL 2007-0002

8 Defendant. :

9 ----- X

10 Friday, January 18, 2008

11 Fairfax, Virginia

12 Videotape Deposition of

13 MICHAEL HATTWICK, M.D.

14 called for examination by Counsel on behalf of the

15 Defendant, pursuant to Notice, taken in the offices

16 of Michael Hattwick, M.D., 8501 Arlington

17 Boulevard, Fairfax, Virginia, commencing at

18 approximately 4:25 p.m., before Kim Brantley, a

19 Certified Shorthand Reporter and Notary Public in

20 and for the Commonwealth of Virginia, when there

21 were present on behalf of the respective parties:

22 * * * * *

0002

1 Appearances:

2 On behalf of the Plaintiff:

3 BENJAMIN J. GLASS, III, ESQUIRE

4 3915 Old Lee Highway - Suite 22B

5 Fairfax, Virginia 22030

6 (703) 591-9829

7

8 On behalf of Defendant:

9 CHARLES Y. SIPE, ESQUIRE

10 GOODMAN, ALLEN & FILETTI, PLLC

11 1020 Ednam Center - Suite 200

12 Charlottesville, Virginia 22903

13 (434) 817-2180

14

15 ALSO PRESENT: ALAN JOSHUA, M.D., Defendant

22

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8 E X H I B I T S

9 (Exhibit retained by Mr. Glass)

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0004

1 THE VIDEOGRAPHER: This is tape number
2 one of the video tape deposition of Dr. Michael
3 Hattwick, in the matter of David R. BROWNING versus
4 Alan Joshua, M.D., in the circuit court of Fairfax,
5 Virginia, case number CL 2007-0002821.

6 This deposition is being held at Dr.
7 Hattwick's office, 8501 Arlington Boulevard,
8 Fairfax, Virginia, on January 18th, 2008.

9 The time on the video screen is 4:25
10 p.m. The court reporter is Kim Brantley. The
11 videographer is Joey Thrower, both representing
12 Cavalier Reporting, Charlottesville, Virginia.

13 Will counsel please introduce yourselves for
14 the record.

15 MR. GLASS: Good afternoon. My name is
16 Ben Glass and I represent Dave BROWNING in this
17 case.

18 MR. SIPE: My names is Charles Sipe and
19 I represent Dr. Joshua, and for the record the
20 parties stipulate that we do not need to introduce
21 ourselves on camera.

22 THE VIDEOGRAPHER: Thank you.

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1 Will the court report please swear in
2 the witness.

3 P R O C E E D I N G S

4 Whereupon,

5 MICHAEL HATTWICK, M.D.,

6 called as a witness on behalf of the Defendant,

7 and, after having been duly sworn by the Notary

8 Public, was examined and testified as follows:

9 EXAMINATION BY COUNSEL FOR THE DEFENDANT:

10 BY MR. SIPE:

11 Q. Would you please, sir, state your name
12 and profession?

13 A. My name is Michael Albert Walter
14 Hattwick. I am a physician.

15 Q. And what is your specialty?

16 A. My specialty is internal medicine.

17 Q. And Dr. Hattwick, we're obviously in
18 your office today about a week before trial. Is
19 there -- did you have a personal conflict that
20 prevents you from being at trial?

21 A. That's correct. I had a long-time
22 commitment out of state for the -- actually the
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1 entire week of trial.

2 Q. Okay, thank you.

3 Dr. Hattwick, could you explain for the
4 jury, please, the specialty of internal medicine.

5 A. Internal medicine is the specialty of
6 taking care of adults, typically fifteen years or
7 older, for all conditions. It involves integrating
8 care and using specialists when appropriate, based
9 on primary care for adults.

10 Q. And are you currently practicing
11 internal medicine?

12 A. Yes, I am.

13 Q. And where is that?

14 A. In this office.

15 Q. And we're in Fairfax?

16 A. We're in Fairfax, Virginia, just
17 outside the beltway.

18 Q. What is the name of your business
19 entity?

20 A. The entity is now called Prosperity
21 Primary Care.

22 Q. And how long have you been practicing
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1 internal medicine?

2 A. I started in Virginia in 1977, so
3 thirty-one years.

4 Q. Okay. And how about at this location
5 with this -- with your current practice?

6 A. Seven years at this location.

7 Q. And prior to that where were you?

8 A. I was in another similar building
9 called Woodburn Medical Park, adjacent to Fairfax
10 Hospital.

11 Q. Could you walk us, please, through your
12 education beginning with your undergraduate
13 studies.

14 A. Yes. My undergraduate studies were at
15 Harvard University in Cambridge in chemistry and
16 physics.

17 Q. And when did you graduate?

18 A. I graduated from Harvard in 1964, and
19 then I went to Baylor University, College of
20 Medicine, in Houston, Texas, which is my hometown,
21 and I graduated from Baylor in 1968. I then came
22 actually here to Washington to the Georgetown

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1 University Service, DC General Hospital from '68 to
2 '70.

3 Q. And what was that for? Was that your
4 residency?

5 A. That was internship and residency,
6 one-year internship, one-year residence.

7 Q. And was that for internal medicine?

8 A. That was for internal medicine, that's
9 correct.

10 Q. And once you completed your residency,
11 what did you do?

12 A. After I finished two years of -- or one
13 year of residency there, two years of training at
14 DC General, then I went into the Public Health
15 Service. And I was active in the Public Health
16 Service for seven years. I went into the Centers
17 for Disease Control in Atlanta. I was supposed to
18 be called an epidemic and intelligence service
19 officer, basically, for seven years.

20 Q. Okay.

21 A. During that period I, actually up to a
22 couple of years in Atlanta, I was -- I went to
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1 London on a Public Health Service stipend or
2 educational grant or whatever and studied for a
3 year at the University of London, and that was
4 actually the final year of my internal medicine
5 residency.

6 Q. Was that the focus of your studies
7 during that year of internal medicine?

8 A. I had a joint appointment with internal
9 medicine and public health, and I was studying the
10 English national health system at the same time I
11 was studying internal medicine.

12 Q. Other than an M.D. degree from Baylor,
13 did you obtain any other degrees or certificates
14 from your studies in London?

15 A. Actually I did. I got eleven initials
16 after those. My service is the Royal College of
17 Physicians, member of the faculty of Community
18 Medicine and member of the Royal College of
19 Physicians. Those are all English degrees roughly
20 equivalent to the American board certification.

21 Q. And are you in fact board certified?

22 A. Yes, I'm board certified in two

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1 specialties.

2 Q. What specialties?

3 A. Internal medicine and preventive
4 medicine.

5 Q. What is the specialty of preventive

6 medicine?

7 A. Preventive medicine is a specialty that
8 actually is focused on preventing diseases and it
9 typically deals with diseases not only in
10 individuals but also in populations, in groups.
11 It might be the population of your practice or the
12 population of a city or state or the country or the
13 world.

14 Q. Can you explain a little bit for the
15 jury what it means to become board certified?
16 What process did you undergo to become board
17 certified, first in internal medicine and then in
18 preventive medicine?

19 A. Well there's a -- quite a formal,
20 well-structured educational program for board
21 certification in this country, in all specialties.
22 In internal medicine at the time I was going
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1 through it required three years of straight
2 internal medicine training. I did internship and
3 two years of internal medicine residency, and those
4 are in certified training programs, mine with DC
5 General Georgetown Service and the University of
6 London. Those training programs had certain
7 requirements that they teach, certain topics so if
8 you pass them, and so it's exactly an educational
9 process, but you're dealing with patients. So you
10 actually learn the practice of medicine, and then
11 you are required to pass an examination, board
12 certification examination, which is quite rigorous.

13 Q. Is that both written and oral?

14 A. Yes.

15 Q. Okay.

16 A. I believe it's just written now, but at
17 that time it was written and oral.

18 Q. And are those given -- the written and
19 oral portions given at different time intervals?

20 A. They are -- they're not exactly the
21 same city, no. That's correct, yes.

22 Q. Are you familiar, if there is a

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1 difference, what that difference is between or
2 among the training to become board certified in
3 surgery versus board certified in internal
4 medicine?

5 A. Well, yes, yes. They are very
6 different specialties. Up to the time you finish
7 medical school, basically, medical education is
8 very much similar for all physicians, but once you
9 enter post-M.D., once you graduate from medical
10 school, then if you are going to specialize, you're
11 going to a specialized training program. I went
12 into internal medicine, and you focus on internal
13 medicine. If you are going to go into general
14 surgery or a surgical specialty, you would not do a
15 medical internship and residency. You would do a
16 surgical internship and residency.

17 Internal medicine is a cognitive
18 specialty. Surgery is a practical specialty, so
19 internal medicine focuses on diagnosis, evaluation,
20 judgment of complicated conditions. Surgery more
21 common focuses on the process of doing surgical
22 procedures.

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1 Q. So once you graduate from medical
2 school, can an individual then go out and practice
3 as a physician?

4 A. You could practice as a physician, but
5 you would be a generalist. You would not be a
6 specialist. And -- that's what the board
7 certification process is really about, is to train
8 people to be, I guess, more proficient in
9 particular aspects of medicine.

10 Q. To specialize?

11 A. To be specialists in a particular
12 component.

13 Q. Right. Are you aware of approximately
14 how many practicing internal medicine physicians
15 there are in Virginia, say today?

16 A. I believe the number is around three

17 thousand, in that ballpark. Don't -- I'm not a
18 hundred percent sure, but I believe it's in that
19 ballpark.

20 Q. Now, other than internal medicine and
21 preventive medicine, do you have any other areas of
22 expertise?

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1 A. Well they're not board certifications,
2 but yes, I have -- because of my interest in
3 general medicine, and internal medicine, preventive
4 medicine I have sort of specialized in certain
5 areas that are part of that. Preventive medicine
6 has lead me into what's called integrative
7 medicine, which has been quite popular for the last
8 ten or fifteen years. So I have learned a fair
9 amount about that.

10 Q. What is integrative medicine?

11 A. Integrative medicine is understanding
12 what used to be called alternative medicine,
13 modalities that patients may use, herbs or
14 nutritional or acupuncture, so that when you are
15 treating the person you can fit that into the plan
16 and you know what to do with it. It's now
17 recognized actually as a kind of specialty.

18 Q. And is there another area,
19 evidence-based medicine?

20 A. Evidence-based medicine is an area I
21 have done quite a lot of work in. It's part of
22 internal or general medicine, but it is a very
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1 important part of how we practice medicine now in
2 the United States.

3 Q. And what is evidence-based medicine?

4 A. Evidence-based medicine is something
5 that started, that developed in the '80's in this
6 country and it basically is the effort to apply
7 scientific information to the practice of medicine.
8 In the early '80's -- 70's, '80's, people began
9 looking at the practice of medicine, trying to
10 answer the question "what is the appropriate way of

11 handling any particular problem," and it became
12 apparent that there were very few standardized,
13 evidence-based criteria for how you handle various
14 medical problems, and it was felt that it would be
15 helpful to develop those. During the '80's it was
16 somewhat controversial. People would talk about
17 evidence-based medicine as being "cook book
18 medicine," but it developed in the '80's. In the
19 late '80's, 1988, Congress well was concerned about
20 what would happen if the Medicare resources were
21 insufficient or they didn't have enough money to
22 pay for everything that was going on, and then they
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1 commissioned a study by an organization called the
2 Institute of Medicine, which is a think tank, a
3 national think tank that studies complex social
4 issues including medical issues, to answer the
5 question "what would happen if the quality of care
6 and Medicare in resources were limited," and that
7 study went on for two years. Part of that study,
8 the Institute of Medicine was required to visit a
9 physician -- physician offices, do site visits, and
10 for some reason they picked my office and they
11 visited my office and I introduced them to some
12 Medicare patients and talked to them about what I
13 thought the quality was. They liked what I said
14 and used my definition of "quality" in their report
15 and concluded at the end of the report, which was
16 1990, that the way that you get better quality and
17 lower cost is to use clinical practice guidelines.
18 So that was a conclusion.

19 Now the problem in 1990 was no one knew
20 what a clinical practice guideline was. It could
21 be anything, what you thought or what I thought, or
22 the American College of Orthopedic Surgeons
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1 thought. So Congress then says, "Well, if that's
2 what we need, we need to figure out what clinical
3 practice guidelines are." They then commissioned
4 two more studies to, number one, define what a

5 clinical practice guideline was, and, number two,
6 develop programs to actually develop these things,
7 and I was asked to serve as the internist on those
8 two committees.

9 That was my introduction to
10 evidence-based medicine and when I started I didn't
11 really know a hundred percent what it was. After a
12 while I got converted and I thought, that really
13 is -- really is useful. I served on that committee
14 for several years and obviously helped publish the
15 reports, and those two reports, and the follow-up,
16 have driven health care in this country since 1990.

17 So we now have a health care system
18 that is largely driven by these evidence-based
19 assessments of how you manage care, and I am sure
20 we will talk about some today.

21 Q. Now are you licensed to practice in
22 Virginia?

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1 A. Yes, I am.

2 Q. And have been since --

3 A. Since 1977.

4 Q. Okay. And do you belong to any
5 professional societies or organizations within the
6 specialty of internal medicine?

7 A. Yes. The major one is the American
8 College of Physicians. I've been a member since
9 many, many, many years, and I was the American
10 College of Physicians member on this -- I actually
11 didn't mention that. I was the American College of
12 Physicians member on the Blue Cross/Blue Shield,
13 Kaiser technology evaluation committees, which
14 actually helped develop some of these
15 evidence-based guidelines between 1990 and 1976.
16 So the American College of Physicians, the American
17 Society of Internal Medicine, the Virginia Society
18 of Internal Medicine, basically the internal
19 medicine organizations.

20 Q. Okay. And have you held any -- any
21 positions within any of these organizations?

22 A. Yes, I have been president of the
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1 Virginia Society of Internal Medicine. I've been
2 on the board of governors of the American College
3 of Physicians for the State of Virginia.

4 Q. What are some other medical related
5 activities that you have been associated with over
6 the years outside of these organizations?

7 A. Well, I've done a lot of consulting in
8 the field of evidence-based medicine as a result of
9 that experience with evidence-based medicine over
10 many years, and that's been to health plan
11 organizations, GW Emergency Health Plan, Kaiser, I
12 mentioned Blue Cross/Blue Shield, United. I've
13 been consultants to the accreditation
14 organizations, URAC. I've assisted independent
15 guideline development companies, developed
16 guidelines for unstable (inaudible), and use of CAT
17 scans and MRIs for back pain, that sort of thing.

18 Q. Where do you hold hospital privileges?

19 A. Inova Fairfax only.

20 Q. We touched on it in the very beginning
21 in terms of what is the practice of internal
22 medicine, but could you describe a little bit what
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1 your particular clinical practice is, and I mean
2 the types of patients that you typically see?

3 A. Well I --

4 Q. And the types of things you see them
5 for.

6 A. I'm an internal medicine physician. I
7 see myself as a generalist. I will take -- so I'm
8 basically treating people, human beings, males and
9 females age fifteen or over, usually, for whatever
10 condition they will represent with. And so it can
11 be anything from a sore throat or an in-grown
12 toenail to a heart attack or pancreatic cancer or
13 GI bleeding, you name it.

14 Q. And do you have a full-time practice?

15 A. I have a full-time practice, so I'm not

16 doing a lot of consulting now, so I have a somewhat
17 time-restrictive practice.

18 Q. Has your practice in terms of your
19 clinical patient care practice changed since the
20 timeframe of 2001, 2002?

21 A. No, I basically practice medicine the
22 way I've always practiced.

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1 Q. Over the past ten years, using that as
2 a benchmark, have you had occasion to evaluate and
3 treat patients with rectal bleeding?

4 A. Yes, I have.

5 Q. And have you had occasion, during that
6 same timeframe, to evaluate and treat patients with
7 hemorrhoids?

8 A. Yes, I have.

9 Q. Can you give us -- and the jury will
10 have heard some explanation, but can you give us a
11 definition or explain what a hemorrhoid is?

12 A. A hemorrhoid basically is a -- I
13 consider it a vein. It's a blood vessel, if you
14 will, that traverses the anal opening and it
15 carries blood to the anal opening. It can --
16 usually it's -- people aren't aware of it unless
17 you look at it. Physicians look at it when they
18 examine people, but it can get swollen, inflamed or
19 bleed and create a problem.

20 Q. And what are some of the treatments for
21 hemorrhoids?

22 A. Well that depends on what the problem

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1 is. If it's acutely inflamed and swollen and
2 painful, you sometimes -- you treat it with topical
3 things. Often it will resolve on itself but
4 sometimes it doesn't and will require surgery to
5 remove.

6 Q. But now do you do that surgery?

7 A. I do not do surgery.

8 Q. So what do you do in that circumstance?

9 A. Well, I would treat the hemorrhoid

10 initially and then if it didn't resolve, it was a
11 recurrent, significant problem, then I'd usually
12 refer them to a colorectal surgeon.

13 Q. Have you had occasion to recommend or
14 to utilize hemoccult blood testing?

15 A. Yes. We use that routinely.

16 Q. And can you explain for the jury,
17 please, what that is?

18 A. Hemoccults are little cards that you
19 can put a small amount of stool on it, either from
20 a finger tip or from a spatula, and then the card
21 can be turned over and opened and you can put a
22 chemical on it, and if there's blood present when
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1 we put it on the card, it will change color.

2 Q. You know, in a very crude but broad
3 analogy, is it somewhat like a personal pregnancy
4 test in that --

5 A. Yes, similar. Yes, it's something, you
6 put a drop of something on it. It turns color if
7 it's positive.

8 Q. And this is something, these cards that
9 you give to a patient, that then take home and do
10 this test themselves?

11 A. And you can do it in the office on a
12 rectal examination of the office, and a patient can
13 take them home. You could do both.

14 Q. And why do you do hemoccult blood
15 testing?

16 A. Well "hemoccults," or the word itself
17 "hemoccult," means -- "occult" means not seeing,
18 and "hemo" is blood. So it's a way of checking to
19 see if there's blood in a specimen which you cannot
20 see.

21 Q. What is the significance of blood maybe
22 in a stool of someone?

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1 A. Normally the bowel doesn't bleed, so if
2 there is a presence of blood in the bowel, then
3 that's a reason to do some evaluation, and if you

4 don't see blood, no visible blood, then the
5 hemoccult was designed to determine, even though
6 you can't see it, below the level of visibility it
7 may still be present.

8 Q. And over the past ten years, have you
9 had occasion to perform a flexible sigmoidoscopy?

10 A. Yes, I have.

11 Q. What is a flexible sigmoidoscopy?

12 A. A flexible sigmoidoscopy is a way of
13 looking at the distal part of the colon, that the
14 body has an organ called the colon that basically
15 has five parts: Rectum, sigmoid, descending colon,
16 transverse colon and ascending colon, and the
17 flexible sigmoidoscope is sixty centimeters long,
18 so as long as you look at the rectum, the sigmoid
19 and the descending colon.

20 Q. When you say distal, what are you
21 referring to?

22 A. Distal means the far end. So the
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1 colon, there are basically two categories of
2 colonoscopy: A distal colonoscopy, which is now
3 called a flexible sigmoidoscopy, and a total
4 colonoscopy which looks at the entire colon.

5 Q. Are there different types of flexible
6 sigmoidoscopy, meaning a retroflex?

7 A. The sigmoidoscope is basically the same
8 instrument as a colonoscope, except it's shorter.
9 It's sixty centimeters instead of two or three
10 times that long, and it has a tip that can be
11 steered. So, on a sigmoidoscope, or a colonoscope,
12 it's possible to move the tip around and you can
13 actually turn it backward a hundred and eighty
14 degrees, and that's called retroflexion.

15 Q. That's what I was going to ask you.
16 What's the difference between a flexible sigmoid --
17 a flexible sigmoidoscope and a colonoscope?

18 A. Length only.

19 Q. And what are the -- so what are the
20 reasons to do a colonoscopy? To get views further

21 into the --

22 A. Right. There are pros and cons of

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1 doing a colonoscopy. If you want to evaluate the
2 colon, the flexible sigmoidoscope, a distal
3 colonoscopy type examination, goes to sixty
4 centimeters, but it's pretty much a straight line.
5 There's a little wiggle, but you go sixty
6 centimeters.

7 To do the total colonoscopy, you got to
8 go to that point, and then you got to make a right
9 angle, then you got to make another right angle.
10 It's not only longer, it has to go around the two
11 right angle curves, and that creates potential for
12 more pain, for actually more complications,
13 perforations and those worries. It requires
14 anesthesia and obviously is more complicated.

15 So the sigmoidoscope is something that
16 is done, commonly, typically in an office without
17 anesthesia. A colonoscope will require you to go
18 to the hospital, have anesthesia and this and that,
19 distal perforations.

20 Q. What generally are the reasons to do a
21 flexible sigmoidoscopy?

22 A. Basically, I guess two categories: One
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1 is to evaluate a symptom which is in the distal
2 colon, and the other one is to do a screening
3 procedure for colon cancer, basically what the
4 screening procedure is for.

5 Q. And what types of things are you
6 looking for?

7 A. You're looking for any abnormalities.
8 So the common ones are hemorrhoids, diverticuli,
9 colitis.

10 Q. What is that?

11 A. What colitis?

12 Q. Yes, sir.

13 A. Colitis is an inflammation of the
14 colon. Diverticuli are little pouches on the

15 colon. We talked about hemorrhoids. Polyps are
16 another thing you can see with a sigmoidoscope or
17 colonoscope; colon cancers obviously.

18 Q. Now do you also -- have you also had
19 occasion to perform anoscopy?

20 A. Anoscopy, yes.

21 Q. What is anoscopy?

22 A. Anoscopy is a very short, rigid scope

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1 that is only about so long (indicating), and it
2 allows to you look through the anal verge. You can
3 see hemorrhoids a short distance into the rectum.

4 Q. Is it rigid?

5 A. It's rigid.

6 Q. So it's --

7 A. You can't steer it. It doesn't turn.

8 It's a rigid device.

9 Q. Kind of like a large syringe maybe?

10 A. Yes, something like that, except you
11 can open it, you can see through it.

12 Q. Okay, right. And what are the purposes
13 of doing anoscopy, anoscopy?

14 A. Anoscopy is obviously shorter distance.
15 You can do it quickly and you can do it generally
16 without a stool prep, where with a sigmoidoscopy
17 there has to be preparations because it's a more
18 complicated procedure.

19 Q. In your practice, have you had occasion
20 to refer patients for further evaluation by another
21 specialist?

22 A. Yes.

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1 Q. Such as a gastroenterologist or a colon
2 rectal surgeon?

3 A. Yes.

4 Q. Have you had occasion to refer patients
5 for a suspicion that you may have of -- or for
6 rectal cancer?

7 A. Yes.

8 Q. And generally why do you as an internal

9 medicine physician make such a recommendation for
10 referral?

11 A. Well, the most common would be that
12 I've done a procedure that showed something that --
13 showed a polyp or a lesion that I thought needed to
14 be biopsied. I can biopsy or do a biopsy of what
15 looks like a minor polyp, but for most lesions, if
16 I did a sigmoidoscopy, saw a lesion, I would then
17 refer it to a specialist.

18 MR. SIPE: At this time I'd offer Dr.
19 Hattwick as an expert in the field of internal
20 medicine to give opinions.

21 MR. GLASS: No objections.

22 BY MR. SIPE:

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1 Q. Dr. Hattwick, at my request have you
2 reviewed certain records and materials related to
3 care provided by Dr. Alan Joshua to Mr. David
4 BROWNING, both prior to and subsequent to January
5 2001?

6 A. Yes, I have.

7 Q. And specifically, did you review office
8 records of Dr. Joshua?

9 A. Yes, I did.

10 Q. Office records from Kaiser Permanente?

11 A. Yes.

12 Q. Records from Dr. Donald Colvin?

13 A. Yes.

14 Q. Do you know Dr. Colvin?

15 A. I do know Dr. Colvin, professionally.

16 Q. Have you had occasions to refer
17 patients to Dr. Colvin?

18 A. Yes, I do. He's one of the better
19 known colon rectal surgeons in this area.

20 Q. And have you also had occasion to
21 review certain deposition transcripts?

22 A. Yes, I have.

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1 Q. Mr. BROWNING?

2 A. Yes.

3 Q. Dr. Joshua?

4 A. Yes.

5 Q. The colon rectal surgeons --

6 A. Dr. Lee.

7 Q. Dr. Lee. Dr. Rosenberg?

8 A. I did not review that deposition.

9 Q. Okay. Based upon your review, have you
10 formed opinions regarding the care provided by Dr.
11 Joshua beginning January 2001?

12 A. Yes, I have.

13 Q. And when giving opinions, Dr. Hattwick,
14 if you could -- if you do not hold any of your
15 opinions to a reasonable degree of medical
16 probability, if you will tell us.

17 A. I will do that.

18 (Document was marked Deposition
19 Hattwick Joint Exhibit 1, for identification.)

20 Q. Okay. Now, in front of you is an
21 exhibit what will be or is marked as Joint Exhibit
22 1, which is Dr. Joshua's office chart. If you will
0032

1 look, please, to Page 24.

2 (Brief pause while witness peruses
3 document.)

4 A. All right.

5 Q. Now, in front of you, Page 24 is an
6 office visit from January 23, 2001?

7 A. That's correct.

8 Q. Now prior to that visit, had Dr. Joshua
9 had occasion to see Mr. BROWNING over a period of
10 years?

11 A. Yes, he had.

12 Q. And do you know when about that began?

13 A. Yes. These records reflect that Dr.
14 Joshua had been seeing Mr. BROWNING since roughly
15 1991, as a primary physician for a large number of
16 significant medical problems.

17 Q. Okay. Would Dr. Joshua be
18 characterized then as Mr. BROWNING's primary care
19 physician during that period of time?

20 A. Yes.

21 Q. And through 2001?

22 A. Throughout this period, yes.

0033

1 Q. Prior to January 23, 2001, does the
2 record indicate any visits or complaints for rectal
3 bleeding?

4 A. I did not see any records for rectal --
5 any notice of rectal bleeding prior to this visit.

6 Q. Okay. In looking at the notes from
7 January 23, 2001, what were Mr. BROWNING's chief
8 complaints at that time?

9 A. He came in with a complaint, according
10 to this record, of left flank pain radiating to the
11 groin.

12 Q. Okay. And let me ask you: Have you
13 formed an opinion as to whether or not Dr. Joshua's
14 history, physical exam, assessment and plan on
15 January 23, 2001, complied with the standard of
16 care?

17 A. Yes, I do believe it did.

18 Q. And there is a reference in that visit
19 of a complaint of bright red blood on tissue paper,
20 and not the stool.

21 A. That is correct.

22 Q. What is the significance of that

0034

1 complaint?

2 A. When there is bleeding in the stool it
3 has to come from some -- you're concerned about
4 which source. If there is the presence of bright,
5 red blood on the surface of the stool, that implies
6 to the source of the bleeding is the -- typically
7 the rectum, the far end of the colon, because the
8 blood is not mixed in with the stool. It's on the
9 surface and it's bright, red blood, it's from
10 higher up, the blood is dark rather than bright
11 red.

12 Q. And what is the significance to you of
13 Mr. BROWNING's complaint of "flank pain waxing and

14 waning"?

15 A. Well this -- Mr. BROWNING has a history,
16 if you go back through there, of a number of
17 different medical problems, including kidney
18 stones. Pain in the flank is pain in the upper
19 part of the stomach. So that would refer, and the
20 things that are there, the common things that are
21 there are the muscles, the upper part of the colon
22 and the kidneys.

0035

1 Q. Based upon Mr. BROWNING's -- would you
2 characterize the chief complaint or significant
3 complaint at the time of this visit as the report
4 of bright red blood on tissue paper?

5 A. No, absolutely not.

6 Q. What would be the most significant
7 complaint at that time?

8 A. Well his presenting complaint was flank
9 pain radiating to the groin and the presence of
10 changes in flatulence and roaming of the bowel,
11 loose stools, diarrhea, signs consistent with
12 gastroenteritis.

13 Q. And what did -- based upon those
14 complaints, what did the standard of care require
15 of Dr. Joshua in his evaluation and his assessment
16 at that time?

17 A. Let me just say what standard of care
18 means to me.

19 Q. Yes, sir.

20 A. In the context of an internal medicine
21 physician. Internal medicine physician, the
22 standard of care requires that they do an

0036

1 appropriate history, an appropriate physical
2 related to the history, make an appropriate
3 diagnosis related to history and the physical,
4 order appropriate tests if there are any needed and
5 then give an appropriate treatment, if any is
6 needed. And it starts with making -- doing a
7 history that's appropriate, meaning that your

8 history is related to the presenting complaints.

9 Q. Based upon your review of Dr. Joshua's
10 records did he meet the standard of care in the
11 taking of an appropriate history?

12 A. Yes, he did.

13 Q. How about with respect to the physical?

14 A. Same thing. He reports that he
15 examined the bowels and he found that they were
16 hyperactive, soft belly, so that's a typical
17 appropriate physical.

18 Q. Was Dr. Joshua's diagnosis, test and
19 treatment plan within the standard of care?

20 A. Yes, it was.

21 Q. Okay. Did the standard of care in --
22 at the time of the January 23, 2001 office visit
0037

1 require Dr. Joshua to refer Mr. BROWNING to a
2 gastroenterologist?

3 A. No.

4 Q. Under what circumstances would a
5 referral to a gastroenterologist be appropriate?

6 A. An internist will refer -- should refer
7 a patient to a specialist when a service is needed
8 or a diagnostic procedure is needed that's outside
9 of -- or beyond the internist's capability or
10 competence. There's nothing in this visit that is
11 outside the capability or competence of Dr. Joshua
12 or any typical internist, so there would be no
13 indication of referral to a specialist.

14 Q. Would a typical reason for referral to
15 a gastroenterologist be to have the
16 gastroenterologist perform a colonoscopy?

17 A. If that were indicated, yes.

18 Q. But that would be a reason to send --

19 A. That would be a typical reason for it
20 because that's a procedure most internists don't
21 do.

22 Q. In your opinion was referral for a
0038

1 colonoscopy necessary on January 23, 2001?

2 A. No.

3 Q. Why?

4 A. There were no presenting symptoms that
5 required, in my opinion, the necessity for doing a
6 colonoscopy. He presented with symptoms that
7 suggested acute problems that would resolve. A
8 colonoscopy would not have helped those problems
9 and if would have been an inappropriate test for
10 this particular presentation.

11 Q. Should -- did the standard of care on
12 January 23, 2001 indicate a suspicion for rectal
13 cancer at that time?

14 A. No, not specifically. No.

15 Q. What was Dr. Joshua's impression?

16 A. Viral gastroenteritis at that time.

17 Q. Was that appropriate?

18 A. Yes.

19 Q. And what was his plan, according to his
20 note?

21 A. A soft diet, which was discussed with
22 the patient, administration of fluids and time.

0039

1 Normally a viral gastroenteritis resolves itself
2 over a period of time without any medication.

3 Q. According to the note, Mr. BROWNING was
4 advised to return, if not better, within six or
5 more days?

6 A. Yes.

7 Q. Was that an appropriate --

8 A. Plan?

9 Q. Plan.

10 A. Yes.

11 Q. And is there any indication that Mr.
12 BROWNING came back or telephoned within that time
13 period?

14 A. There is not.

15 Q. If you will look, please, to Page 24.

16 A. Um-hum.

17 Q. According to the records, Mr. BROWNING
18 returned on February 14, 2001, for a complete

19 physical exam?

20 A. That's correct.

21 Q. And we all know what a complete
22 physical exam is. What generally in your opinion
0040

1 does a standard of care require in doing a complete
2 physical exam?

3 A. A complete physical exam basically is
4 looking at the entire patient rather than looking
5 at a specific problem. So as opposed to looking at
6 left flank pain or headache or whatever you're
7 saying, are there any problems that you're having
8 at the present time, and you'll look at all of
9 them, and you will do a physical examination that's
10 not focused on any one particular part of the body,
11 but it goes head to foot.

12 Q. And in your review of Dr. Joshua's
13 notes from the February 14, 2001 complete physical
14 exam, is it your opinion Dr. Joshua met the
15 standard of care in performing that exam?

16 A. Yes, he did a quite comprehensive
17 multi-phase physical history of physical
18 examination documented.

19 Q. Is there anything in the records from
20 this exam that indicate any new complaints of
21 rectal bleeding or digestive problems?

22 (Brief pause while witness peruses
0041

1 document.)

2 A. No, there's none, not that I see.
3 Let's see. He had -- he does mention occasional
4 heartburn, which is I guess a GI problem. It's a
5 different type of problem. No food intolerance, no
6 mucus or blood in the stool. So it specifically
7 notes no blood in the stool.

8 Q. Did Dr. Joshua perform a digital exam?

9 A. Yes, he did.

10 Q. If you look at Page 27.

11 A. Yes, he did.

12 Q. I think we know, but what is the

13 purpose of a physician performing a digital exam?

14 A. A digital exam is usually performed
15 primarily for the evaluation of the prostate in a
16 man. You can feel the actual prostate with your
17 finger. You also, however, feel the rectal
18 sphincter, the anal sphincter, and if there were
19 fissures or abnormalities there, you would be able
20 to feel those. But it's primarily for evaluation
21 of the distal part of the anal sphincter and
22 prostate.

0042

1 Q. What were the findings from Dr.
2 Joshua's digital exam of Mr. BROWNING?

3 A. His note says the "prostate is one
4 plus, no nodules, symmetric," which is normal.

5 Q. Were there any findings from the
6 digital exam that would suggest the presence of a
7 polyp or a hemorrhoid?

8 A. No, there were not.

9 Q. Is there anything from Dr. Joshua's
10 findings from his February 14, 2001 exam that
11 suggested rectal cancer?

12 A. No.

13 Q. In your opinion, did anything from Dr.
14 Joshua's finding from this visit necessitate a
15 referral to a gastroenterologist?

16 A. No.

17 Q. Or to a rectal surgeon, colon rectal
18 surgeon?

19 A. No.

20 Q. Why not?

21 A. Because there's nothing here indicating
22 there is any significant colorectal problem.

0043

1 Q. Were laboratory studies ordered?

2 A. Yes, they were.

3 Q. Okay, and why, generally, does a
4 physician order the laboratory studies? These are
5 blood tests?

6 A. These are blood tests and urine tests

7 commonly, but typically as part of a physical
8 examination you do a panel of blood tests of
9 cholesterol, chemistry tests, thyroid, and that's a
10 typical part of this -- what we call the complete
11 physical.

12 Q. If you look at Page 29 of the exhibit.

13 A. Yes.

14 Q. These are the results of the blood
15 test?

16 A. That's correct.

17 Q. And what did these show specifically?
18 What is significant with regard to bleeding, or the
19 presence or absence of bleeding?

20 A. Well he has a normal red blood cell
21 count, hemoglobin, hematocrit. Those are the
22 measures of blood in the body and those are normal
0044

1 so that he argued there had not been any
2 significant bleeding.

3 Q. What does MCV?

4 A. MCV is mean corpuscular volume. It's
5 the measure of the actual individual red cells,
6 whether they appear to be normal or abnormal. His
7 were normal.

8 Q. What does it mean for someone to be
9 called "anemic"?

10 A. Anemia means that one of those
11 measures, the ones I talked about, hemoglobin,
12 hematocrit, red blood count, are below normal.
13 Each one has their own realm of normality, but
14 anemia is blood counts below those levels.

15 Q. Would these suggest that Mr. BROWNING
16 was not anemic in February of 2001?

17 A. Mr. BROWNING was not anemic in February
18 of 2001.

19 Q. Now according to Dr. Joshua's notes,
20 part of his plan was to schedule a flexible
21 sigmoidoscopy.

22 A. That is correct.

0045

1 Q. Do you have an opinion, Dr. Hattwick,
2 at what point or at how many done a physician could
3 be characterized as experienced in doing flexible
4 sigmoidoscopies?

5 A. Well, there -- it's been a long time
6 since I was trained in it, but as I remember it was
7 felt that the first hundred you needed to be -- you
8 were learning; and then the next couple hundred
9 that you were getting, better, and then when you
10 get to three or four hundred, then you're an
11 expert, and then it's just routine.

12 Q. And approximately how many have you
13 done or do you do in a year?

14 A. I typically will do two a week, so --
15 two or three a week, so fifty weeks that's a
16 hundred a year, thirty years; three thousand.

17 Q. And what is your understanding of the
18 number Dr. Joshua had performed by the year 2001?

19 MR. GLASS: Let me just -- I'm going to
20 object to this and put this on the record, is that
21 I took Dr. Joshua's deposition and he told me that
22 answer was almost a hundred.

0046

1 Last week you sent me the errata sheet.
2 The errata sheet was signed months after the
3 deposition was taken. And so to the extent that
4 this doctor is now going to give an opinion based
5 upon a different number than the deposition that
6 was -- you know, where the errata sheet was signed
7 and submitted -- I didn't get it until now, but it
8 was signed months later, I object to that as being
9 the basis of the testimony.

10 MR. SIPE: You want me to go ahead and
11 answer?

12 MR. GLASS: Absolutely.

13 MR. SIPE: We can certainly discuss
14 this, and I am sure that we will, but that was in a
15 case that was non-suited. And so why or why not
16 that was not sent I have no idea. But, you know, I
17 don't see that we had any -- any obligation to have

18 provided that. It wasn't asked in any discovery,
19 any written discovery, and Dr. Joshua's deposition
20 was not taken in this action. So, you know, we can
21 both note our objections if need be.

22 MR. GLASS: And to be sure, I'm not
0047

1 objecting to the part that wasn't sent. I'm
2 objecting to the part that he changed it well after
3 the time for changing a deposition. It was signed
4 months after it was done.

5 MR. SIPE: And we can get testimony on
6 that from Dr. Joshua, but we --

7 MR. GLASS: Go ahead.

8 BY MR. SIPE:

9 Q. What is your understanding of the
10 number of flexible sigmoidoscopies Dr. Joshua had
11 done by the time -- or by the year 2001?

12 A. Well, I have learned, not from the
13 deposition, but from conversations with his lawyer,
14 that it was in excess of a thousand.

15 Q. Is that enough to be characterized as
16 someone experienced in doing flexible
17 sigmoidoscopies?

18 A. Yes, and I'd expect a number in that
19 range for a physician who has been in practice for
20 many years and does them regularly.

21 Q. If you look, please, back to Page 28,
22 or to Page 28.

0048

1 A. Yes, okay.

2 Q. What were Dr. Joshua's -- well let
3 me -- if you look at -- toward the end of the notes
4 on Page 28, it indicates that Dr. Joshua reviewed
5 the laboratory results with Mr. BROWNING?

6 A. Yes.

7 Q. Is that how you read that?

8 A. That's correct.

9 Q. Was that appropriate to do?

10 A. Yes, it was.

11 Q. Okay. And a flexible sigmoidoscopy was

12 then performed. What were the findings from that?

13 A. I'll just read them: "Flex sigmoid
14 done to sixty centimeters, internal hemorrhoid one
15 plus, no polyps, no diverticuli and no signs of
16 colitis."

17 Q. What is the significance of those
18 findings?

19 A. Well, first of all the fact that he did
20 the sigmoidoscopy to sixty centimeters, well that
21 means it was a distal colonoscopy and it got all
22 the way to the length of the scope, and that
0049

1 means -- that's important, and then the next
2 question is, was there anything abnormal, and he --
3 "The only abnormality I find were these enlarged
4 internal hemorrhoids and the absence of other
5 significant lesions."

6 Q. With respect to what is noted as to the
7 findings from the test, is the content of those
8 findings within the standard of care? Does it
9 include what you would expect it to include?

10 A. Yes. This is a very typical report for
11 a sigmoidoscopy.

12 Q. Based upon the findings from this
13 flexible sigmoidoscopy in February of 2001, did the
14 standard of care require a referral to any other
15 specialists?

16 A. No, no.

17 Q. And why not?

18 A. There's nothing on this test that
19 suggests that additional testing needs to be done.
20 So I see no reason here for referring him to any
21 other specialists at this time.

22 Q. In your opinion, was the diagnosis of
0050

1 hemorrhoid appropriate?

2 A. If he saw an internal hemorrhoid, then
3 it's appropriate to diagnose that, yes.

4 Q. Were doctor -- or Mr. BROWNING's
5 symptoms consistent with hemorrhoids?

6 A. Well, at this time, he had no rectal
7 symptoms. He had had a history of bright, red
8 blood on a previous visit, so these findings are
9 consistent with that story, you know, one episode
10 of bright red blood during an acute gastroenteritis
11 episode. The symptoms resolved at the time of this
12 sigmoidoscopy, had the presence of an internal
13 hemorrhoid, which would be a reasonable explanation
14 for that -- for those findings.

15 Q. Were hemocult tests, or hemocult
16 boxes given to Mr. BROWNING prior to this visit?

17 A. Yes, yes, they were. I believe he gave
18 him two -- several boxes, two boxes, or three boxes
19 maybe.

20 Q. If you look toward --

21 A. It says "stool guaiac times three," two
22 returned -- two were -- two returned normal -- one
0051

1 box appeared positive. Three is negative.

2 That's a little confusing. A stool
3 guaiac card has two little boxes. I believe that's
4 what he is referring to. So this indicates he gave
5 three of those cards, got two of the cards back.
6 Each card has two boxes, so that's four specimens.
7 Three of them were normal and one of them -- it
8 said "one box appears positive."

9 Q. What did the standard of care require
10 in response to one box having been returned
11 positive?

12 A. Well you want to evaluate what is the
13 cause of an abnormal test, and as I mentioned
14 before you can do a stool occult blood card to look
15 for blood that you don't see. In this particular
16 case we had a gentleman who had blood that you
17 could see. So it's not surprising if you can
18 visibly see blood that these cards are going to
19 be -- some of them are going to be negative, even
20 when you don't see -- I mean, positive even when
21 you don't see blood.

22 Not uncommonly we will not do a stool

0052

1 for occult blood when there's been recent bleeding
2 for that reason. In this case it had been a month
3 between, so it would be reasonable to do that.

4 Q. Does or did the presence -- does or did
5 the presence of one box being returned present --
6 being present require referral to a
7 gastroenterologist or to a colon rectal surgeon?

8 A. It didn't require referral to a
9 gastroenterologist or colorectal surgeon. It does
10 require an evaluation, and my understanding from
11 the record is that is one part of the reason why
12 Dr. Joshua did the sigmoidoscopy, was to evaluate
13 the history of bright, red blood and bleeding and
14 see if there were problems that needed to be dealt
15 with.

16 Q. Now according to the records, when was
17 Mr. BROWNING's next contact with Dr. Joshua?

18 A. Let me go back and get the dates here.

19 Q. If I can just help you out.

20 A. 2/16, I've got -- I've got them. I'm
21 back on Page 24?

22 Q. Yes, sir.

0053

1 A. Yes. So he had the physical on
2 February 14th, called the patient for follow-up on
3 the 16th, sigmoidoscopy was done on the 27th of
4 February, that same month, and then the next
5 contact looks like a telephone call contact with a
6 prescription of medications for what sounds like an
7 upper respiratory infection, and then the next
8 actual office visit looks like it was in July --
9 July 31st of 2001.

10 Q. And that appears to be an actual
11 in-patient visit?

12 A. That is correct.

13 Q. Is there any reference to complaints of
14 rectal bleeding on July 31st, 2001?

15 A. No. That visit was for a sore throat.
16 It was appropriately managed as a sore throat and

17 there is no mention of rectal bleeding or GI
18 problems.

19 Q. If I could have you, please, skip or go
20 to Page 31 --

21 MR. GLASS: If you are done with
22 twenty-four, could I see it?

0054

1 MR. SIPE: Sure, you could have mine.

2 MR. GLASS: Thanks.

3 MR. SIPE: That way that one's kept
4 together.

5 BY MR. SIPE:

6 Q. Page 31 of the exhibit I believe picks
7 up with the next visit.

8 A. That's correct.

9 Q. And that is when?

10 A. The next visit is August 3rd, 2001, and
11 that is for a sinus infection treated with
12 antibiotics and decongestant.

13 Q. That was an office visit?

14 A. That was a telephone visit.

15 Q. Okay.

16 A. Telephone contact.

17 Q. Okay.

18 A. The next in-office visit looks like it
19 was November 6th of 2001.

20 Q. Any suggestion or reference in either
21 of those two contacts with complaints of rectal
22 bleeding?

0055

1 A. No, there was not.

2 Q. All right. After November 6th, 2001.

3 A. I might make a comment, because you
4 haven't asked it, but if there is an internist, as
5 you go through these processes, these visits were
6 for the patient's ongoing problems. November 6th
7 was an evaluation for the cholesterol follow-up and
8 some other problems, and we were focusing obviously
9 on the rectal bleeding, but remember the internist
10 is taking care of the entire patient, so as he sees

11 the patient it's important that he's not only
12 focused on one condition.

13 Q. And does it appear that Dr. Joshua was
14 taking care of the entire patient?

15 A. That's right. In each visit, it's the
16 same process: "What's the appropriate history that
17 I need for this particular presentation," and then
18 take the appropriate history, the appropriate
19 physical. So you're always thinking about the
20 patient as a whole, and you're not focusing on one
21 specific problem unless the patient raises it.

22 Q. Yes, sir. What is the chief complaint
0056

1 or reason for the visit on December 6th, 2001?

2 A. This one was for complaints of
3 left-sided back pain.

4 Q. Okay. And then it looks like the next
5 visit was December 20th, 2001.

6 A. That's correct.

7 Q. And what was the chief complaint at
8 that time?

9 A. That was for a rash on the back and
10 arms.

11 Q. If I could ask you to look, please, on
12 Page 34.

13 A. Um-hum.

14 Q. Those appear to be laboratory results
15 from the November 6th visit?

16 A. That's correct.

17 Q. What do the hemoglobin, hematocrit and
18 MCV indicate from those tests?

19 A. Those were all normal. So there's no
20 indication here.

21 Q. It appears the next contact was March
22 1st, 2002, a phone --

0057

1 A. That's correct, telephone contact.

2 Q. And then on May 13th there was an
3 office visit. Is that correct?

4 A. That's correct.

5 Q. And what was -- what were Mr. BROWNING's
6 chief complaints at that time?

7 A. The chief complaint on May 13th was
8 rectal bleeding recently.

9 Q. And based upon that complaint, what did
10 the standard of care require of Dr. Joshua?

11 A. The same basic principal. You would
12 take an appropriate history. So in the case of
13 rectal -- recent rectal bleeding you would want to
14 know how frequently it happened and what are the
15 associated symptoms. He puts down "it stained his
16 shorts, stools are occasionally hard. That's the
17 associated, possibly contributing component, but in
18 general he is not constipated. He has had more
19 gas, no mucus in the stool." Those are questions
20 related to the possible causes of acute rectal
21 bleeding.

22 Q. What is the significance or why is it
0058

1 important to note whether or not there is mucus in
2 the stool?

3 A. The presence of mucus in the stool
4 would suggest an inflammation, which is one of the
5 parts of colitis.

6 Q. And it appears, doctor -- what tests
7 did Dr. Joshua perform on May 13th, 2007?

8 A. So on that -- that particular visit we
9 have a presenting complaint of rectal bleeding. We
10 have a history of that helps clarify what that
11 actually meant in that particular situation, and
12 the next step is the appropriate physical
13 evaluation, and for rectal bleeding appropriate
14 physical examination is anoscopy. So Dr. Joshua
15 then did anoscopy, which we called about earlier,
16 to evaluate what could be the cause of that rectal
17 bleeding.

18 Q. And what -- what were his findings?

19 A. He found that there was one internal,
20 visible hemorrhoid on the right side that was
21 slightly inflamed, and no external hemorrhoids, and

22 his impression was that this was bleeding internal
0059

1 hemorrhoids.

2 Q. Did the standard -- based upon the
3 findings from the physical and the anoscopy, did
4 the standard of care require at that point that Mr.
5 BROWNING be referred to either a gastroenterologist
6 or a colon and rectal surgeon?

7 A. No. At this point the standard of care
8 requires the use of Dr. Joshua's judgment for
9 evaluation. Given this particular history and this
10 particular findings and his knowledge of what had
11 happened with Mr. BROWNING, which more importantly
12 included a recent or a year ago flexible
13 sigmoidoscopy for rectal bleeding, which was
14 negative, which was done by himself, in that
15 combination I think it's well within the standard
16 of care for an internist to feel that no additional
17 referral was required.

18 Q. You mentioned, "use his judgment."
19 What is the concept of clinical judgment?

20 A. That's really basically what an
21 internist does. That's where we talked about
22 cognitive. As opposed to a surgeon, a surgeon sort
0060

1 of is trained to see something and do something.
2 An internist is trained to see things and think, to
3 make judgments and evaluate them, the risks and
4 benefit, pros and cons, likelihood of various --
5 various items. So that is what we are in medicine
6 to do, and we make those judgments based on the
7 history and the physical. That's why history and
8 physical are so important. So if you take an
9 appropriate history and do an appropriate physical,
10 then the internist's job is to use judgment,
11 clinical judgment, based on those, what's the right
12 assessment, and that requires judgment. There is a
13 range of assessments. No two physicians will
14 necessarily always agree on that, but a competent
15 internist, like Dr. Joshua, would make that process

16 and make a judgment, and it always should be based
17 on the history and the physical and be an
18 appropriate or reasonable conclusion based on those
19 things.

20 Q. You touched on it a bit, but how is
21 your approach as an internal medicine physician
22 different, if it is, from the approach of a
0061

1 surgeon?

2 A. Well, a surgeon would typically be
3 dealing with a specific problem.

4 Q. Such as?

5 A. Well take this one. Rectal bleeding, a
6 surgeon -- if it's rectal bleeding, I can open up
7 my textbook or my algorithm and say rectal bleeding
8 and do the following two or three things, and if
9 you find the following things are positive then you
10 do the following surgery. So there is a very -- I
11 don't like to think of it as a mechanical process,
12 but it's specifically oriented towards findings
13 that can be -- which are amenable to doing things
14 to -- a bulk of a physician's of an internist's
15 activity is deciding whether or not those things
16 are reasonable, because you can do things that are
17 not reasonable.

18 So our judgment is, is there
19 something -- something here that indicates that we
20 should have, say, a colonoscopy or another
21 endoscopy or an X-ray or a CAT scan, and that's
22 what we're always doing there. Every time a
0062

1 patient comes in, it's like, based on this history,
2 based on this physical, what procedures if any are
3 needed at this point. Often none is needed, and in
4 this case in my opinion none is needed.

5 Q. I suppose all doctors have in common
6 going to medical school?

7 A. That's correct.

8 Q. But in your opinion is the practice of
9 internal medicine related to the practice of colon

10 and rectal surgery?

11 A. Well they're very different
12 specialties. An internist is dealing with a whole
13 person, all of the problems that would present.
14 This gentleman had heart problems, cholesterol
15 problems, blood pressure problems, an episode of
16 rectal bleeding. There are a lot of different --
17 he had toenail infection problems.

18 So an internist is looking at all those
19 things and weighing the appropriate way of helping
20 this particular person.

21 Q. Let me ask you, Dr. Hattwick, I don't
22 know that we've touched on it, but why do
0063

1 hemorrhoids bleed?

2 A. Usually the two common causes of
3 hemorrhoids bleeding are constipation or a hard
4 stool. So they either get pushed out because
5 you're straining to move your bowels or the stool
6 itself is hard enough that it can cause an abrasion
7 or laceration and cause bleeding.

8 Q. Based on the record from May 13, 2002,
9 what was Dr. Joshua's plan?

10 A. His -- well --

11 Q. His --

12 A. That visit or --

13 Q. Yes, sir, his treatment plan at that
14 visit.

15 A. I might make a comment that the
16 patient --

17 MR. GLASS: Let me object. I didn't
18 object the first time. He's got to answer your
19 question instead of --

20 MR. SIPE: That's fine.

21 MR. GLASS: Instead of commentary.

22 THE WITNESS: I'm sorry.

0064

1 MR. GLASS: The objection is your
2 answer is not responsive to the question that my
3 friend asked.

4 THE WITNESS: Well at that visit the
5 patient actually, in addition to the rectal
6 bleeding, had problems with toenail fungus and
7 problems with tennis elbow, so there were actually
8 three problems that he was treating, and that's
9 very typical for an internist. So even though
10 there is a presenting complaint you may end up
11 treating two different things.

12 So he had a plan to treat the tennis
13 elbow with Myoflex and Naprosyn, Anusol for the
14 hemorrhoids, and a medication, Lamisil, for the
15 fungus; all appropriate.

16 BY MR. SIPE:

17 Q. What is Anusol?

18 A. Anusol is a -- it's a suppository that
19 has some steroid in it, cortical steroids and it
20 cuts down on the inflammation of hemorrhoids. It
21 helps them go away quicker.

22 Q. Was that an appropriate medication to
0065

1 prescribe?

2 A. Yes.

3 Q. In your review of the -- of Mr.
4 BROWNING's medical records, did you find that he had
5 a family history of rectal cancer?

6 A. I did not, no.

7 Q. And is that significant?

8 A. It can be. I mean, if there is a
9 family history, certainly we'd be more concerned
10 about colon cancer.

11 Q. According to the records, on June 11th,
12 2002, was a telephone order for refill of the
13 Anusol.

14 A. That's correct.

15 Q. Was that appropriate?

16 A. Yes. It's less than a month later.

17 Q. If you look to Page 36.

18 A. Um-hum.

19 Q. Please. When was, after the telephone
20 order of Anusol, when was the next office visit?

21 A. The next visit was November 21st, 2002.

22 Q. Okay. And what was the presenting

0066

1 complaint at that time?

2 A. That was for left knee pain in the

3 back.

4 Q. Okay. And was there any -- or is there

5 any notation of ongoing rectal bleeding at that

6 time?

7 A. No.

8 Q. Would you expect the Anusol that was

9 prescribed and then refilled to have any impact at

10 that time on the presence or absence of rectal

11 bleeding?

12 A. Well you would expect an inflamed

13 hemorrhoid that had bled and was treated with time

14 and Anusol to stop -- to go away, so that's -- this

15 is what I would expect to see.

16 Q. If you would please turn to Page 37 and

17 the next office note of December the 16th, 2002.

18 What is the chief complaint at that time?

19 A. A strain in his back or left side.

20 Q. There's reference to also a right groin

21 pain?

22 A. Yes. It goes down into the -- it says

0067

1 that after he felt some strain in the back and left

2 lumbar area last week he was -- he experienced

3 sharp pain in the right groin area.

4 Q. Is that in your opinion suggestive of

5 rectal cancer?

6 A. No.

7 Q. Or a tumor?

8 A. No.

9 Q. Did anything from any findings made at

10 the time of the December 16, 2002 visit require a

11 referral to either a gastroenterologist or a colon

12 rectal surgeon or any other specialty?

13 A. Certainly not to a gastroenterologist

14 but a colorectal surgeon who was doing a work-up

15 for this pain situation so there can be some CTs.

16 Q. Was that an appropriate test?

17 A. Yes.

18 Q. If you would look to, please, page --

19 well, we're still on Page 37. The next visit was

20 March 11, 2003.

21 A. That's correct.

22 Q. What was Mr. BROWNING's presenting

0068

1 complaints at that time?

2 A. He had complaint of cough, sinus

3 infection for one month and digestive problems

4 since he takes Zocor.

5 Q. What history did he give of blood with

6 his --

7 A. He does -- he reports hemorrhoids and

8 hard stools and blood with stools, a lot of gas and

9 constipation.

10 Q. Was -- again going through the

11 appropriate history exam, testing, referral,

12 treatment plan, was -- did Dr. Joshua meet the

13 standard of care in all of those, on March 11th,

14 2003?

15 A. Yes, I think he did.

16 Q. Okay. It appears Dr. Joshua scheduled

17 a complete physical exam.

18 A. That's correct.

19 Q. And was that appropriate?

20 A. Yes, it was.

21 Q. Okay. And I believe if you go to Page

22 44. With respect to -- and that was March the

0069

1 20th, 2003. Did Dr. Joshua perform a digital exam

2 at that time?

3 A. Yes, he did.

4 Q. Okay. And was that an appropriate test

5 to perform?

6 A. Yes. This was a complete physical.

7 It's for basically a general assessment of the

8 prostate. Rectal examination is part of that

9 general assessment, and once again he found a
10 prostate that was one plus with no nodules,
11 symmetrical, and no other problem.

12 Q. Would the findings be characterized in
13 your opinion, as normal findings?

14 A. Typical findings for a gentleman this
15 age, yes.

16 Q. Anything from the March 20, 2003
17 complete physical exam that would suggest the need
18 for a referral to another specialty?

19 A. No, I don't believe so.

20 Q. It appears that Mr. Joshua, if you turn
21 to Page 47.

22 A. Um-hum.

0070

1 Q. Or Mr. BROWNING, there were some
2 hemocult tests that were returned on April the
3 9th, 2003.

4 A. That's correct.

5 Q. What do they show?

6 A. Similar to the previous one. He had
7 two -- two hemocults. Two were negative, one was
8 positive.

9 Q. And again, the presence of one positive
10 return, did the standard of care require a referral
11 to another specialty based upon that finding?

12 A. No. He already knew from the --
13 through this history that this gentleman had
14 occasional visible bleeding, so to find an
15 occasional occult blood specimen is not surprising.

16 Q. I believe laboratory studies were -- or
17 blood studies, if you turn to Page 48, again what
18 does the hemoglobin, hematocrit and blood CB
19 indicate to you in March of 2003?

20 A. They are all still normal.

21 Q. If you could go back, please, Dr.
22 Hattwick, to Page 43, after March 11, 2003, and

0071

1 then the complete physical on March the 20th, when
2 were -- what was the next contact that Mr. BROWNING

3 had with Dr. Joshua?

4 A. It looks like he had a prescription for
5 a cholesterol medication on June 23rd, phoned in,
6 it looks like, and then he had a visit for
7 follow-up on July 1st of 2003.

8 Q. And what was the chief complaint, if
9 anything, on July 1st?

10 A. This was a follow-up. He put on a
11 medication for a fungus infection basically and
12 this was the follow-up primary for that. Also for
13 his blood pressure and for his -- what Dr. Joshua
14 calls the metabolic syndrome, which is a
15 combination of high blood pressure and high
16 cholesterol.

17 Q. And then after July 1st, when was the
18 next contact?

19 A. There was a telephone call on the 3rd
20 going over the results of the tests indicating that
21 the cholesterol were significantly elevated and
22 requesting a repeat cholesterol test within four
0072

1 months.

2 Q. And then an office visit on October
3 23rd, 2003?

4 A. That's the next office visit, that's
5 correct.

6 Q. And what were the presenting complaints
7 at that time?

8 A. That his blood pressure is still high.
9 It looks like no specific symptoms. He's still on
10 the Sporanox, and he has some trouble urinating.
11 It's more difficult to empty his bladder.

12 Q. Based upon those findings, were
13 urinalysis tests ordered?

14 A. Yes, there were.

15 Q. Was that an appropriate --

16 A. That was appropriate, yes.

17 Q. And with respect to the finding of,
18 "has difficult with his bowel movements," what's
19 the significance of that finding?

20 A. Well that can be a lot of things.
21 Constipation or -- in this case, Joshua -- Dr.
22 Joshua had already diagnosed the irritable bowel
0073

1 syndrome, and this is -- that's a fairly -- part of
2 that syndrome.

3 Q. What is irritable bowel syndrome?

4 A. Irritable bowel syndrome is where the
5 intestine, colon particularly, is irritable I
6 guess, so it sometimes over functions, sometimes
7 under functions, and you get typically alternating
8 periods of loose stool or diarrhea or constipation
9 associated with pain, typically.

10 Q. And in your opinion, was that finding
11 made by Dr. Joshua of irritable bowel syndrome
12 consistent with the medical record?

13 A. Yes, I think so.

14 Q. And it appears that that was the last
15 visit by Mr. BROWNING to Dr. Joshua, October 23,
16 2003.

17 A. That is correct.

18 Q. In your practice have you had
19 experience or occasion to palpate or diagnose a
20 polyp or tumor in the rectum?

21 A. I have had a couple of situations where
22 I could feel an abnormality on the digital, yes.
0074

1 Q. And do you have an opinion as to
2 whether there was a palpable tumor in February of
3 2001?

4 A. Well my opinion, based on a review of
5 the record, is there was not, because Dr. Joshua
6 actually palpated and didn't feel it.

7 Q. And how about March of 2002?

8 A. I would say the same thing based on the
9 fact there was an examination and nothing was felt.

10 Q. And in May of 2003?

11 A. On the physical, same process.

12 Q. Do you have an opinion as to whether
13 any lesion could have been seen by sigmoidoscope or

14 anoscope in February of 2001?

15 A. Well, Dr. Joshua actually looked, not
16 in February, but -- it wasn't February -- February
17 14th. So based on the fact that Dr. Joshua -- a
18 physician did a sigmoidoscopy, distal colonoscopy,
19 looked and did not see a lesion, my opinion is more
20 probably not there was not a visible lesion there.

21 Q. I believe the anoscope was in March of
22 2002?

0075

1 A. That's correct. To the extent to which
2 the anoscope goes deep enough to see something,
3 more probably than not there was not a visible
4 lesion within the reach of the anoscope.

5 MR. SIPE: Thank you, Dr. Hattwick.

6 EXAMINATION BY COUNSEL FOR THE PLAINTIFF:

7 BY MR. GLASS:

8 Q. Dr. Hattwick, good afternoon. My name
9 is Ben Glass.

10 A. Good afternoon.

11 Q. I represent Dave BROWNING. You looked
12 at the records very carefully?

13 A. I believe I did, tried to.

14 Q. You read the depositions very
15 carefully?

16 A. Yes, I tried to.

17 Q. In discussing this first visit in
18 January -- on January 23 of 2001, did you happen to
19 notice that the handwriting on that record is
20 completely different from Dr. Joshua's handwriting?

21 A. I did. I actually almost said
22 something. My understanding was that this was

0076

1 actually probably not Dr. Joshua. It was not
2 signed. It was one of his associates.

3 Q. Right, so the testimony you gave about
4 what Dr. Joshua did on the 23rd of January doesn't
5 really have anything to do with Dr. Joshua, right?

6 A. It has to do with a visit in his
7 records, but I do not have from the records

8 confirmation that it was his -- I understand from
9 the deposition that it was one of his associates.

10 Q. It was doctor -- it was Jeff Long,
11 right?

12 A. I'm going based on the deposition.

13 Q. Do you agree that a hundred and thirty
14 thousand Americans are diagnosed every year with
15 colorectal cancer?

16 A. I don't know about the number, but I'm
17 not surprised that that would be the case.

18 Q. And do you agree that fifty-five
19 thousand will die of the disease?

20 A. That's -- I don't have any reason to
21 disagree with the number. Certainly people will
22 die of it.

0077

1 Q. Do you agree that colorectal cancer is
2 the second leading cause of cancer death in the
3 United States?

4 A. It could well be, yes.

5 Q. And that it is the third most prevalent
6 cancer overall?

7 A. In men.

8 Q. And that six percent of the American
9 population will develop colorectal cancer?

10 A. At some time in their life.

11 Q. And do you agree that with new onset
12 rectal bleeding that it is important to find the
13 source of the bleeding?

14 A. Yes, I do.

15 Q. Because there are benign sources and
16 there are lethal sources?

17 A. Just in general bleeding is abnormal
18 and you want to find the cause of an abnormal --
19 abnormal finding.

20 Q. Now in your practice, do you screen for
21 colorectal cancer?

22 A. Yes, now -- I do screen for colorectal

0078

1 cancer. Yes, I do.

2 Q. Following the guidelines of adults once
3 they hit age fifty, do you recommend that they be
4 screened for colorectal cancer?

5 A. That's right. This goes back to the
6 evidence-based process, but there are guidelines
7 and have been guidelines for screening for
8 colorectal cancer that have actually developed in
9 this country over that period of the early '80's to
10 today. They've changed somewhat, but the current
11 guidelines call for screening adults beginning at
12 age fifty with one of a series -- with either stool
13 for occult bloods, sigmoidoscopy, barium enema or a
14 colonoscopy. That's the current guideline.

15 Q. In your practice, otherwise
16 asymptomatic men who are hitting fifty, do you send
17 them off for a colonoscopy?

18 A. I don't send them all. I have that
19 discussion. I try to do one of those four things
20 on everybody. Patients who have no family history
21 of colon cancer, have no apparent problem, I will
22 commonly do a sigmoid -- or they may request I do a
0079

1 sigmoidoscopy. If you remember my discussion
2 earlier, colonoscopy has a higher risk of
3 complication than sigmoidoscopy. So unless there
4 is a reason to justify the higher risk, it's not
5 necessarily the test to do. It is being more --
6 done more frequently now, so I'm probably referring
7 more for colonoscopy, if the patient requests. I
8 used to.

9 Q. One of the reasons that you screen for
10 colorectal cancer is that you agree that early
11 detection can help save lives?

12 A. That's the reason for screening, yes.

13 Q. And early detection of colorectal
14 cancer affords a patient a chance to have a polyp
15 removed before it is a cancer?

16 A. That's correct.

17 Q. We didn't really talk about this
18 earlier, but basically the pathway of a rectal

19 cancer goes from a normal rectum generally through
20 a process including the development of a polyp,
21 right?

22 A. There's a process that goes from
0080

1 normality to cancer, and the belief is that it
2 usually goes from normal tissue to overactive
3 tissue that's not malignant, and then to cancer.
4 The overactive tissue that's not malignant can be a
5 polyp. A polyp is something that sticks out. But
6 it also can be a sessile lesion, and in Mr.
7 BROWNING's case, it looks like it may well have been
8 a sessile lesion.

9 Q. And to be clear, a polyp is not cancer.
10 It is a pre-cancerous change?

11 A. There is a whole range of polyps. You
12 can have benign polyps, you can have pre-cancerous
13 polyps and you can have malignant polyps. A polyp
14 is just a description of a form. It just means
15 something that sticks out.

16 Q. And not all polyps will go on to be a
17 cancer. Is that correct?

18 A. That's correct.

19 Q. However, if in screening you find a
20 polyp, you will attempt to remove it, if it's
21 within your area of expertise, or you will refer
22 the patient to have the polyp removed?

0081

1 A. That's correct.

2 Q. Because you want to err on the side of
3 being safe?

4 A. Yes, and the belief is that polyps, if
5 left alone, are more likely to go on -- that are
6 not removed are likely to go on and become a
7 cancer.

8 Q. The removal of a polyp can affect in
9 essence a cure of the potential that that polyp
10 would have gone on to cancer?

11 A. Yes, it's a preventive polypectomy is
12 what we call it.

13 Q. All right. And one of the other things
14 that we will look at on screening is the presence
15 of what you call "occult bleeding"?

16 A. Yes.

17 Q. Right?

18 A. And your question?

19 Q. And one of the reasons that you screen
20 for that with these fecal occult guaiac tests,
21 guaiac tests, is that you can find bleeding before
22 the patient has any symptoms whatsoever?

0082

1 A. That's right. If the patient has no
2 bleeding, then the stool for occult blood is a more
3 sensitive way of saying is there blood in the
4 stool. It's not useful if there's bleeding,
5 because you can see the bleeding.

6 Q. In fact, one of the reasons that we
7 screen is because we can find cancer even before
8 the patient has any symptoms that he notices.

9 A. That's correct.

10 Q. And do you agree that generally this
11 process from normal tissue to a cancer takes a long
12 time, a rectal cancer?

13 A. There is some controversy about that,
14 but we believe that it takes a number of years to
15 transform, yes.

16 MR. GLASS: Why don't we take a break,
17 because I understand we're down to a couple of
18 minutes on the tape.

19 THE VIDEOGRAPHER: We're going off the
20 record. The time is 5:45. This marks the end of
21 video tape number one in the continuing deposition
22 of Dr. Michael Hattwick.

0083

1 (Brief recess taken.)

2 THE VIDEOGRAPHER: This marks the
3 beginning of video tape number two in the
4 continuing deposition of Dr. Michael Hattwick.

5 We're going back on the record. The time is 5:48.

6 BY MR. GLASS:

7 Q. If in your screening of someone for
8 colorectal cancer you find a positive finding, you
9 try to track down why you have a positive finding,
10 right?

11 A. That's correct.

12 Q. You don't tell them, "Come back in
13 three years. These things are slow growing. It
14 won't make a difference"?

15 A. Right, that's correct.

16 Q. Now most rectal bleeding is not from
17 cancer.

18 A. That's correct.

19 Q. A patient comes to you and says, "I've
20 got bleeding from my rectum." Without knowing
21 anything else about the patient, you know the
22 chances are it's not from a cancer?

0084

1 A. Statistically, that's correct.

2 Q. But if it is from a cancer, you want to
3 know that?

4 A. You want to know the cause, certainly
5 you want to know if it's cancer.

6 Q. And if it's from a polyp that's causing
7 the bleeding?

8 A. You'd like to know that.

9 Q. You want to know that.

10 Now, we all have hemorrhoids, right?

11 A. We all have hemorrhoidal veins.

12 Q. So if we did an anoscope on someone who
13 is -- doesn't have any complaints about itching or
14 pain in the anus, you would see the hemorrhoidal
15 veins?

16 A. You see hemorrhoidal veins, yes.
17 Hemorrhoids, themselves, usually mean that the
18 veins are either enlarged or inflamed or painful or
19 bleeding.

20 Q. In terms of evaluating hemorrhoids:
21 Does a flexible sigmoidoscopy -- is that a good
22 tool for evaluating a hemorrhoid?

0085

1 A. Yes.
2 Q. Not all hemorrhoids bleed?
3 A. That's correct.
4 Q. And not all inflamed hemorrhoids bleed?
5 A. That's correct.
6 Q. And just because you see a hemorrhoid
7 that is inflamed, it doesn't mean that it has bled?
8 A. That is correct.
9 Q. Or will bleed?
10 A. That is correct.
11 Q. If a patient, when you see a
12 hemorrhoid, you do one of your exams and you see a
13 hemorrhoid and a patient comes back later with
14 another complaint of bleeding from the rectum, you
15 can't just assume that the bleeding is from the
16 hemorrhoid you saw in the past?
17 A. No. You have -- you have -- if there's
18 bleeding you have to find the source of the
19 bleeding. Once you have found the source of the
20 bleeding, then you can make some assumptions
21 subsequently, and that's what happened in this
22 case.

0086

1 Q. Basically once you have seen -- what's
2 the opposite of occult bleeding? Bright bleeding?
3 A. Physical bleeding.
4 Q. Physical bleeding?
5 A. Yes.
6 Q. Once you have seen that, it's
7 unnecessary to give the patient a hemoccult test.
8 A. It is superfluous. I think I mentioned
9 that earlier, that if you see -- if you see visible
10 bleeding you're going to expect to have those
11 hemoccult cards. Some of them will be positive.
12 So it's superfluous. I don't know that
13 it's meaningless, but it is superfluous.
14 Q. A hemoccult test doesn't give you, in
15 and of itself, any information at all about the
16 source of the bleeding?
17 A. That's correct, it does not.

18 Q. It just tells you there is bleeding.

19 A. That's correct.

20 Q. And we generally use it, as we've
21 talked about already to help --

22 A. It's a screening test.

0087

1 Q. -- the patient and the doctor --

2 A. Right.

3 Q. -- find bleeding before the patient
4 notices it?

5 A. That's correct.

6 Q. You mentioned that you thought that
7 this was a sessile lesion?

8 A. Yes.

9 Q. Right?

10 A. Yes.

11 Q. Right? Your scientific basis for
12 saying that is what?

13 A. It really comes I think from the
14 description that Don Colvin gave, I believe when he
15 finally discovered that the lesion was
16 circumferential, it seemed to go around the wall of
17 the colon, rather than sticking into the wall of
18 the colon. That in my mind suggests that it's
19 spreading. "Sessile" means it's in the wall rather
20 than protruding outside the wall. And that would
21 also explain why it might not have been visible a
22 year or two earlier.

0088

1 Q. In fact the basis for your opinion that
2 it was not detectable by palpation or by flexible
3 sigmoidoscopy is simply that Dr. Joshua didn't
4 detect it?

5 A. A physician looked and didn't see it,
6 and in my mind that tells me that it was not seen
7 and probably not visible.

8 Q. So are you of the view that any time a
9 physician does not detect a tumor, a lesion, that
10 means that the tumor or lesion is not detectable?

11 A. Detectable is different than seen, but

12 my opinion is that a competent physician's job is
13 to look at things and decide whether he sees them
14 or not, and if a competent physician looks and
15 doesn't see it, more probably than not, in my
16 opinion, it's not seeable.

17 Q. During the course of Dr. Joshua's
18 treatment of the -- let's just say the bleeding
19 issue from January, February of 2001.

20 A. Yes.

21 Q. On to October of 2003, none of Mr.
22 BROWNING's complaints were about burning or itching
0089

1 of the anus?

2 A. I believe that's correct, yes.

3 Q. He did not complain of a painful anus?

4 A. That's correct.

5 Q. His only symptom or sign of --
6 attributable to hemorrhoids, if they're
7 attributable to hemorrhoids at all, was the
8 bleeding?

9 A. That's correct.

10 Q. And I think you testified about this on
11 direct examination, but when he was given
12 suppositories he actually refilled the prescription
13 for suppositories, right?

14 A. Yes.

15 Q. Suggesting that he was still bleeding?

16 A. That there were -- that's probably
17 correct, for that period of time, yes.

18 Q. It wasn't because it was itching; it
19 wasn't because it was painful. It was bleeding?

20 A. I don't know whether those symptoms
21 were present, but there is another document that
22 they were there. The presentation was bleeding.
0090

1 My comment that that's -- the characteristic of
2 internal hemorrhoids is mostly external. The
3 external ones are the ones that hurt and itch. The
4 internal ones are the ones that bleed. That's just
5 the way it works.

6 Q. Right. Internal hemorrhoids, the
7 only --

8 A. Sign is bleeding typically.

9 Q. Right.

10 Now, in terms of a colonoscopy, do you
11 agree that it's the Gold's standard for diagnosing
12 colorectal cancer?

13 A. Yes, I believe so.

14 Q. Some of the advantages that you as an
15 internist get with referring a patient out for a
16 colonoscopy is, now there's another set of eyes,
17 looking at your patient's --

18 A. Yes, that's actually not why I do that.
19 As I mentioned earlier, to me a sigmoidoscopy is a
20 distal colonoscopy, but I can't make those turns.
21 So it's not that I don't trust my eyes. It's that
22 I can only see up to sixty centimeters. So I'm
0091

1 going to refer out so that someone can make the
2 turn. And then -- I think my eyes are good enough,
3 if I could make the turns, I'd see that. But it's
4 not -- it's not a matter of distrusting, needing a
5 second set of eyes. It's needing someone to do the
6 procedure.

7 Q. Colonoscopies also have the ability to
8 magnify the colon?

9 A. Well, a sigmoidoscopy -- you can get
10 very good visibility in that. A sigmoidoscope is
11 the same instrument as a colonoscope, other than
12 the length. So you get a good picture -- you get
13 as good a picture with the sigmoidoscopy scope up
14 to that sixty centimeters, in my opinion.

15 Q. So there is no advantage for a
16 gastroenterologist using the colonoscopy to put the
17 picture up on the screen and being able to magnify
18 the screen, no advantage over a flexible
19 sigmoidoscopy?

20 A. No, not in my opinion, no.

21 Q. Is there anything you get with a
22 referral to a gastroenterologist for a colonoscopy

0092

1 is another set -- a finger to do the digital rectal
2 exam?

3 A. Yes.

4 Q. Going back now to that February of 2001
5 visit, Dr. Joshua, at the end of that visit, did
6 not find a source for the bleeding, right?

7 A. You're talking about the complete
8 physical before he did the sigmoidoscopy?

9 Q. Yes. The physical was done on the
10 14th.

11 A. Right. And at the end of that visit he
12 had not -- he did not find the source for bleeding
13 and he scheduled the sigmoidoscopy.

14 Q. And he asked for the --

15 A. Stool for occult blood.

16 Q. I'm sorry?

17 A. The stool for blood.

18 Q. Right, the testing that wouldn't have
19 told him anything that he didn't already know?

20 A. From his perspective, correct -- I
21 don't know -- maybe I should be -- remember there
22 are two visits: One visit where he had visible

0093

1 bleeding on January, and then a follow-up visit
2 when the physical was done. At the time of the
3 physical there was no history of physical bleeding,
4 so it wasn't inappropriate to give stool for occult
5 blood cards, and it would have been possible that
6 they'd have been negative, but given the history
7 it's not surprising that one of the four was trace
8 positive. So I'm not critical of the fact that he
9 gave cards.

10 Q. The flexible sigmoidoscopy was
11 scheduled because Dr. Joshua was suspicious that
12 there might be a lesion?

13 A. Yes, that he was trying to find out
14 what is the source of the history of bleeding, and
15 I think that's basically it. He says in the
16 deposition that he was doing that as well as

17 screening, so there really were kind of two things
18 going on, but from my point of view, finding the
19 source of the bleeding certainly is as important as
20 anything else.

21 Q. And did you read in the deposition that
22 Dr. Joshua said that he had never in the past
0094

1 discovered a polyp or an adenoma or tumor by
2 digital rectal exam in any of his patients?

3 A. I believe so, yes.

4 Q. And on that flexible sigmoidoscopy,
5 what he saw was one non-bleeding hemorrhoid that he
6 called, "not very impressive."

7 A. I don't know where he said "not very
8 impressive," but he did find one non-bleeding
9 hemorrhoid. That's correct.

10 Q. He doesn't know if that hemorrhoid had
11 ever bled in the past?

12 A. He does not know that from that
13 examination. The important thing on the
14 sigmoidoscopy is actually the negatives. So here's
15 a gentleman who comes in with bright, red blood.
16 So it's clear from the history that there is a
17 source of bleeding that should be in the distal --
18 in the rectum of the sigmoid, probably, certainly
19 in the distal colon to be bright red blood, and
20 then he does a procedure that looks at the distal
21 colon and finds no polyps, no diverticuli, no
22 cancer, no colitis and a hemorrhoid. So by the
0095

1 process of elimination, most likely the source of
2 bleeding, more probably than not, in this case was
3 the hemorrhoid.

4 Q. But he really had no idea at all at end
5 of that flexible sigmoidoscopy whether the
6 hemorrhoid was the source of the bleeding?

7 A. I don't know that I agree with that.
8 The reason you do the sigmoidoscopy is to -- to go
9 through this differential and the negatives are
10 every bit as important as the positives.

11 Q. In fact it was no better than a 50/50
12 chance that the hemorrhoid that he saw in that
13 flexible sigmoidoscopy had been the source of Mr.
14 BROWNING's bleeding?

15 A. I don't know that you could say that.
16 I said more probably than not, given the fact that
17 no other pathology was found, I think more probably
18 than not that there is a reasonable conclusion that
19 a hemorrhoid was the source. A hemorrhoid, maybe
20 not that hemorrhoid, but a hemorrhoid was the
21 source of the bleeding.

22 Q. Let's look at the May 13, 2002 visit.

0096

1 Now the complaint there said he's had "rectal
2 bleeding recently every other day almost."

3 A. Um-hum.

4 Q. Do you remember that?

5 A. Yes.

6 Q. That it stained his shorts?

7 A. That's correct.

8 Q. It's a pretty significant presentation?

9 A. That's correct.

10 Q. And Dr. Joshua, did you see in his
11 deposition that he said he had no sense for how
12 long this had been going on?

13 A. Well it says "every other day about."
14 It doesn't say how long.

15 Q. Right. And the stools are hard?

16 A. Um-hum.

17 Q. And that's a change in Mr. BROWNING's
18 bowels?

19 A. I guess I wasn't thinking about it in
20 terms of things he had, but it's the first time I
21 see that specifically noted. That, as I went
22 through that, was to help me understanding why he

0097

1 thought there was bleeding. Hard stools typically
2 are the precipitant for profuse bleeding from
3 hemorrhoids.

4 Q. And you told us that the "no mucus with

5 stool" means he wasn't having gastritis?

6 A. He wasn't having colitis.

7 Q. Colitis, I'm sorry.

8 A. You have gone through that same
9 differential, if you have got bright red blood,
10 could be a polyp, could be diverticulitis, could be
11 cancer. But I've looked and I didn't see a cancer,
12 didn't see a polyp, didn't see colitis, didn't see
13 diverticulitis, but I did see a hemorrhoid. So
14 more probably than not, that's the cause of the
15 bleeding. I think that's the process that you go
16 through.

17 Q. Between bleeding from a hemorrhoid and
18 bleeding from a cancerous lesion, the bleeding from
19 the cancerous lesion is obviously the more serious
20 of the sources?

21 A. Obviously, if there is a cancerous
22 lesion, yes.

0098

1 Q. He does on May 13th this anoscopy?

2 A. Um-hum.

3 Q. And again he sees a hemorrhoid, doesn't
4 know if it's the same hemorrhoid as the one he saw
5 before. He notes that it's slightly inflamed?

6 A. Yes.

7 Q. Right? It's not bleeding then.

8 A. Yes.

9 Q. Can't tell whether it's ever bled in
10 the past?

11 A. That particular one, yes.

12 Q. Or whether it will ever bleed in the
13 future?

14 A. Right.

15 Q. Now his impression is "bleeding
16 internal hemorrhoid".

17 A. Yes.

18 Q. That's just a guess, isn't it?

19 A. No, no. Because he's done a procedure.
20 He's done this flexible sigmoidoscopy. He's looked
21 within a reasonable period of time internally.

22 The judgment issue here is, should I do another
0099

1 sigmoidoscopy or should I do a colonoscopy, or
2 should I do a barium enema, and you will always
3 make those judgements, and if the presentation is
4 consistent with what your previous history and the
5 subsequent history presents, then it's reasonable
6 to make a judgment that most likely this is again
7 the same thing that I saw last year. Last year I
8 did look. Last time I didn't know it was a
9 hemorrhoid until I did the sigmoidoscopy. Now the
10 question is should I do another one.

11 Q. There is absolutely no evidence that
12 this hemorrhoid is bleeding or had bled?

13 A. There is the evidence that you have.

14 (Interruption from outside noise.)

15 MR. SIPE: Let's go off the record
16 real quick.

17 THE VIDEOGRAPHER: We're going off the
18 record. The time is 6:05.

19 (Brief recess taken.)

20 THE VIDEOGRAPHER: We're going back on
21 the record. The time is 6:06.

22 BY MR. GLASS:

0100

1 Q. I don't remember what my last question
2 was. Let me ask a different question: Dr. Joshua
3 was just making an assumption that the hemorrhoid
4 that he saw had bled?

5 A. No, I think he was making a judgment
6 based on his knowledge of the history and the
7 results of the sigmoidoscopy, which he had done
8 himself, and the results of the anoscopy, which he
9 did himself. So he has both history and physical
10 information and he's made, what in my opinion, is
11 appropriate clinical judgment.

12 Q. And no follow-up with fecal occult
13 blood testing at this visit?

14 A. There would be no point in that because
15 there is visible blood.

16 Q. The notation, "slight inflammation,"
17 tells us nothing about the size of that hemorrhoid?

18 A. Just indicates that the hemorrhoid is
19 abnormally inflamed. So that's abnormal.

20 Q. There was no diagnostic test ever done
21 on Mr. BROWNING before he was diagnosed with rectal
22 cancer that found a bleeding source?

0101

1 A. Oh, I don't agree with that. He had
2 the flexible sigmoidoscopy, which in my opinion
3 indicated more probably than not that an internal
4 hemorrhoid was the source of the bleeding, based on
5 the history that it was bright, red blood and the
6 physical findings that he did not have a visible
7 polyp, cancer, diverticulitis or colitis.

8 So that's not an assumption. That's --
9 that's a reasonable, medical judgment.

10 Q. There was no diagnostic test that
11 showed the source of the bleeding.

12 A. I don't agree with that.

13 Q. The March 2003 visit.

14 A. Yes.

15 Q. He's back now with more blood in his
16 stools?

17 A. Yes.

18 Q. Part of his complaint?

19 A. March, 2003? Yes.

20 Q. No examination for hemorrhoids at that
21 visit?

22 A. That's correct. This is a visit for

0102

1 cough, sinus infection, digestive problems. So
2 this is a visit where there were multiple problems,
3 one of which was, again, the presence of hard
4 stools and blood in stools.

5 Q. And bleeding is not a sign of irritable
6 bowel syndrome?

7 A. It's not specifically a sign of
8 irritable bowel syndrome.

9 Q. In March -- on March 20th he comes back

10 for the complete physical, comprehensive physical
11 exam and he has a digital rectal exam?

12 A. Yes.

13 Q. And you're of the view that the lesion,
14 which we know he had, was not palpable in March?

15 A. Was not palpated in March. We know
16 that.

17 Q. Was not palpated?

18 A. Yes.

19 Q. Was it palpable?

20 A. I don't know. I don't think anyone
21 knows.

22 Q. What is your view, if you have a view,
0103

1 an opinion, as to what the size of the lesion was
2 in March of 2003?

3 A. I have no way of --

4 MR. SIPE: Let me just note he wasn't
5 designated and he wasn't asked that.

6 THE WITNESS: Yes.

7 BY MR. GLASS:

8 Q. So this palpable, non-palpable, let
9 me --

10 A. Palpable has -- palpable has to do with
11 how far in it is. Because your finger, if you do
12 any digital rectal, you can only go so far, and if
13 there was a lesion within the length of his finger,
14 then it might well have been palpable. All I know
15 is that it wasn't palpated, therefore more probably
16 than not the lesion was not palpable at that
17 length. More proximal to that, you know, you can't
18 put a finger in that deep. So I don't have an
19 opinion about that.

20 Q. You understand where the lesion was
21 ultimately found, don't you?

22 A. There is some variation, but somewhere
0104

1 between three or nine or ten centimeters from the
2 rectal verge.

3 Q. And you understand how it was first

4 found, right?

5 A. It was found by the Kaiser physician
6 when he did the examination.

7 Q. So he did a digital rectal exam?

8 A. At that time. This was in 2004.

9 Q. So is it your view that the lesion was
10 beyond the reach of Dr. Joshua's finger?

11 A. If there was a palpable lesion in 2003,
12 it's my opinion that more probably than not at that
13 time it was beyond the length of his finger, yes.

14 Q. Do you place any reliance in this case
15 on the absence of findings on the CT scan?

16 A. Not very helpful, no, not really.

17 Q. Because -- have you had the experience
18 of knowing that someone has a lesion by feeling it
19 or some other examination --

20 A. Yes.

21 Q. -- and yet having not --

22 A. CT --

0105

1 Q. Let me finish.

2 A. I'm sorry.

3 Q. Having that lesion not be visible on CT
4 scan?

5 A. Yes. A CT scan is not a particularly
6 sensitive way of looking for colon cancer.

7 Q. So you would not rely on the absence of
8 findings on the CT scan to reassure you as a
9 physician that there's no lesion in the rectum?

10 A. Yes. I don't think I'd put much weight
11 either way.

12 Q. Now, just ninety days before this
13 lesion, this tumor -- this cancer was ultimately
14 diagnosed, he sees Dr. Joshua in the office?

15 A. Yes.

16 Q. Of October 23rd?

17 A. Yes.

18 Q. That's three months before -- almost to
19 the day before diagnosis.

20 A. Yes.

21 Q. Right?

22 A. Yes

0106

1 Q. Can you explain why on that visit there
2 is no sign or symptom in your view of a cancer that
3 we ultimately know three months later was quite
4 large?

5 A. Why there were no symptoms?

6 Q. Right.

7 A. Well cancers typically, commonly are
8 asymptomatic in the colon area. So that's --
9 that's not surprising.

10 Q. When it was -- do you remember what its
11 size was when it was diagnosed from the Kaiser
12 records?

13 A. It was in the -- I'd have to go back
14 and look at the numbers, but it was three to --
15 there were obviously different numbers, three to
16 five or seven centimeters.

17 Q. When it is described as an irregular,
18 fungated mass, what does that mean?

19 A. That means at that time -- well,
20 remember they're looking at it. This is not from
21 the finger, but if you look at it then you'd see I
22 guess an irregular border, and "fungating" means

0107

1 that it has a rough surface I suppose is why you'd
2 say that.

3 Q. When they describe it as an exophytic,
4 e-x-o-p-h-y-t-i-c, what does that mean?

5 A. That means it looks like grass or
6 something sort of growing out of the wall of the
7 colon.

8 MR. GLASS: That's all the questions I
9 have.

10 MR. SIPE: I have a couple redirect.

11 THE WITNESS: Okay.

12 EXAMINATION BY COUNSEL FOR THE DEFENDANT:

13 BY MR. SIPE:

14 Q. In your review of all the records and

15 materials in this case, you had a copy and you
16 reviewed both Dr. Joshua's medical record and Dr.
17 Joshua's deposition transcript, correct?

18 A. Yes, I did.

19 Q. And in Dr. Joshua's deposition
20 transcript, which was done in a -- much earlier
21 than today, correct?

22 A. Yes.

0108

1 Q. Dr. Joshua was asked -- and there's
2 never been any dispute about who saw Mr. BROWNING in
3 January of 2001?

4 A. Not to my knowledge.

5 Q. I mean, if that's -- that's my -- a
6 misspeak on my part.

7 A. I think you misspoke.

8 Q. Yes, sir.

9 A. I just didn't want to contradict you.

10 Q. Yes, sir. Thank you.

11 You were asked a couple -- or to agree
12 or disagree with certain statistics with regard to
13 death rate, et cetera, for this gentleman with
14 colon rectal cancer.

15 A. Yes.

16 Q. Do you have an opinion as to whether
17 the colon rectal cancer that Mr. BROWNING was
18 diagnosed with -- will he die from that?

19 A. Based on what I've seen in the records,
20 more probably than not Mr. BROWNING has a good life
21 expectancy. It looks like the cancer was caught in
22 time and hopefully will not come back.

0109

1 Q. You reviewed the surgical pathology of
2 Dr. Colvin?

3 A. Yes.

4 Q. Were there clear margins?

5 A. Yes, there were.

6 Q. What does that mean?

7 A. That means it looks like all of the
8 cancer was removed and there are also no positive

9 nodes. There was no evidence of metastasis or
10 spread, so that's very good.

11 Q. You were asked a number of questions
12 about whether or not Dr. Joshua, I believe the
13 phrase was "tracked down" the source of the
14 bleeding.

15 A. Yes.

16 Q. And that Mr. BROWNING was never told,
17 "All right, come back in three years."

18 Was Mr. BROWNING ever told by Dr. Joshua
19 to come back in three years?

20 A. There's an issue here that's a little
21 confusing I think, because -- we should distinguish
22 between screening for colon cancer and evaluating
0110

1 bright, red blood, rectal blood. So the screening
2 guidelines called for procedures that are repeated,
3 for sigmoidoscopy, every three to five years or
4 colonoscopy every five to ten years. Those are
5 guidelines that are based on people who do not have
6 bleeding. No that's a screening test just for the
7 average comer.

8 In this case, Dr. Joshua did these
9 sigmoidoscopy, in my opinion, not just to screen,
10 which it's appropriate to screen, but to evaluate
11 the source of the bright, red bleeding, and in my
12 opinion the sigmoidoscopy appropriately did that.
13 He did look for cancer; he did look for polyps. He
14 did look for colitis; he did look for
15 diverticulitis. He did not see any of those. He
16 did see a hemorrhoid. That's the appropriate
17 standard way to go about making a diagnosis.

18 Q. And in answering one of Mr. Glass'
19 questions about the timeframe from January of 2001
20 until October of 2003, I wanted to make sure there
21 was no confusion about -- was Dr. Joshua, during
22 that entire period of time, and we've been through
0111

1 the records as to how many visits or telephone
2 calls, was he continually following Mr. BROWNING for

3 rectal bleeding?

4 A. He was following Mr. BROWNING for all of
5 his medical problems, one of which, based on his
6 evaluation, was the presence of hemorrhoids, which
7 bled intermittently. So that was part of what he
8 was following him for.

9 Q. Was the --

10 A. Certainly he was not only following him
11 for that.

12 Q. Was the bleeding persistent for that
13 entire period of time?

14 A. No. It looked like it was -- on many
15 of the visits there was no mention of the bleeding
16 at all.

17 Q. Were Mr. BROWNING's symptoms consistent
18 with internal hemorrhoid bleeding?

19 A. Yes.

20 Q. Why?

21 A. Because internal hemorrhoid bleeding
22 typically is bright red blood on the outside of
0112

1 stool or on the toilet tissue. It's important if
2 that happens to do an evaluation to rule out other
3 more serious causes, including colon cancer, and
4 you do that by doing some procedure. The
5 procedures that are available are anoscopy,
6 sigmoidoscopy, total colonoscopy. In this case the
7 lesion was in the rectal verge, so either a
8 sigmoidoscopy, distal colonoscopy or total
9 colonoscopy were the only -- only procedures that
10 were beneficial, and Dr. Joshua did that.

11 Q. You were asked a question about the
12 fact that one of the Kaiser doctors was able to
13 palpate the lesion. Based on that, did you have an
14 opinion then obviously that it was not palpable by
15 Dr. Joshua? And I believe your opinion was it must
16 not have been?

17 A. Yes, the "visible" and "palpable"
18 language is a little -- to me is a little tricky,
19 but basically, if it wasn't felt, then it wasn't

20 felt, so it wasn't palpated. So someone with a
21 longer finger maybe felt something. Maybe it could
22 have been with a different finger. I don't know.

0113

1 Q. Do we know how long the finger of the
2 Kaiser physician was?

3 A. We do not.

4 Q. Let me just -- you were asked about the
5 Kaiser. Let me show you a record from March 18,
6 2004 which will be a part of the joint exhibit.

7 Does the pertinent history indicate how
8 close to the anal verge the tumor was palpated?

9 A. This says three centimeters from the
10 anal verge.

11 Q. So that's three centimeters, and if you
12 can hold it up, what's three centimeters?

13 A. Well three centimeters is about half
14 the length of my finger, but the anal verge is the
15 inside of the anal sphincter, so you've got a
16 distance to get there, so. But obviously I believe
17 they felt it. So that's --

18 Q. And do we know how long Dr. Joshua's
19 finger is in terms of if he was physically capable?

20 A. I do not, no.

21 Q. So in terms of your opinion as to
22 whether he was physically capable of palpating, do

0114

1 you have an opinion as to whether he could or
2 couldn't?

3 A. Well, if it was palpable -- if it was
4 palpated in 2004 by the Kaiser physician, and I'll
5 assume that the Kaiser physician's finger is the
6 same length as Dr. Joshua's, it's my opinion that
7 more likely than not Dr. Joshua would have also
8 palpated it in 2004.

9 Q. The confusion was, and I wanted to make
10 sure we have your opinion, is it your opinion that
11 Dr. Joshua didn't feel a lesion in either 2001,
12 2002, 2003, because his finger wasn't long enough?

13 A. No. Well he didn't -- he didn't feel

14 it because the lesion wasn't within reach of his
15 finger. I think that's more probable than not.

16 Q. Was the lesion that was ultimately
17 palpated beyond the reach?

18 A. Well there's different time frames.
19 Dr. Joshua's examination was a year before 2004 and
20 this was a large lesion in 2004, so it obviously
21 grew between 2003, 2004. So I don't think anyone
22 can say how far it was from the anal verge in 2003,
0115

1 more than three centimeters.

2 Q. Could the origin be at a certain point
3 and then grow down, out?

4 A. Yes. The way it works is there will be
5 an initial lesion, and then it's going to grow
6 circumferentially from that, not only towards the
7 anal verge, but also around the colon, and that's
8 what -- that's what this colon -- we talk about a
9 sessile lesion. It's in the wall and it's going to
10 grow, and as it grows it will grow like a ring,
11 getting bigger and, as it does that, one part of
12 that ring is going to be moving towards the rectal
13 verge. And in 2004, based on the examination it
14 reached three centimeters.

15 MR. SIPE: Thank you.

16 MR. GLASS: Nothing further.

17 THE VIDEOGRAPHER: We're going off the
18 record. The time is 6:22. This marks the end of
19 video tape number two and the conclusion of this
20 deposition of Dr. Michael Hattwick.

21 (Whereupon the videotape deposition of
22 Michael Hattwick, M.D., was concluded at 6:22 p.m.)
0116

1 CERTIFICATE OF NOTARY PUBLIC

I, KIM M. BRANTLEY, the officer before whom
2 the foregoing deposition was taken, do hereby,
certify that the witness whose testimony appears in
3 the foregoing deposition was duly sworn by me; that
the testimony of said witness was taken by me in
4 stenotype and thereafter reduced to typewriting

our office at the above-referenced address so that
8 we may incorporate them into the original
transcript.

9 If you do not have a copy of the
transcript available for your review, please
10 contact this office at (703) 837-0076 and make an
appointment to come in and read the original. The
11 Rules allow 21 days for this review. However, if a
court date is pending, it should be done right
12 away. If you choose not to read your transcript,
the original may be filed at the request of counsel
13 without your signature at the time of the trial or
hearing in this matter.

14 Thank you for your prompt attention.

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