03-CV-00113-M

THE HONORABLE MARSHA J. PECHMAN

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON AT SEATTLE

KYLE W. STEPHENSON, and MICHAEL K. STEPHENSON, his son,

Plaintiffs,

v.

THE UNITED STATES OF AMERICA,

Defendant.

NO. CO3-0113P

PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AGAINST THE DEFENDANT UNITED STATES OF AMERICA

ORAL ARGUMENT REQUESTED

NOTE ON MOTION CALENDAR: FRIDAY, DECEMBER 5, 2003

I. RELIEF REQUESTED

COME NOW the plaintiffs, by and through their attorneys of record, Morrow & Otorowski, and respectfully request that the Court grant Plaintiffs' Motion For Summary against the defendant, United States of America.

II. BACKGROUND

The Plaintiff, Kyle W. Stephenson, 61 years old, is an honorably discharged Vietnam veteran who served the United States of America as a helicopter combat pilot. During his tour of duty in Vietnam, Kyle Stephenson's helicopter was shot down twice and he was wounded in combat.

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Kyle Stephenson is a remarkable man and a highly decorated soldier. [1]

As a father, Kyle raised his son, Michael Stephenson, as a single, loving parent. Kyle Stephenson is a bright person with an I.Q. of 147. He was also a gifted athlete. The Atlanta Braves selected Kyle to play professional baseball, however, an injury ended his baseball career early.

Kyle Stephenson now lives his life with the consequences of the poor care he received at the hands of the VA Medical Center. He also lives with the knowledge that his health care needs were repeatedly not met over the years while his treatable pre-cancerous condition transformed into cancer. An exasperating factor in the evolution of this preventable disease process was that no health care provider ever gave Kyle Stephenson any information about his pre-cancerous polyps so that he could have taken steps to change the course of events.

III. STATEMENT OF FACTS

JANUARY 1987

On January 23, 1987, Kyle Stephenson presented to the defendant's health care facility at the Veterans Administration Medical Center in Seattle, Washington for a Compensation and Pension Examination. The Compensation and Pension Examination is a comprehensive medical evaluation and examination, which is part of the VA Medical Center's process for determining whether or not

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[1] Kyle Stephenson was awarded the following medals:
1. The Bronze Star for Valor: This award is the third highest honor a soldier can receive. Only the Silver Star for Valor and the Medal of Honor are higher. Kyle Stephenson received this medal when he flew his helicopter into enemy territory over Chu Lai and rescued the crew of another shot down helicopter. He and his co-pilot successfully saved the lives of every soldier that had been shot down.
2. The Distinguished Flying Cross: This award is given for spectacular feats in flight. Kyle Stephenson received this prestigious award when he successfully rescued a troop of soldiers whose plane had been shot down and were surrounded under heavy enemy fire in the region of Chu Lai.
3. The Bronze Star for Service: This high medal is awarded to a soldier for serving his country with honor.
4. The Purple Heart: Kyle was awarded the Purple Heart when he was shot through the leg while flying a helicopter and managed to safely land the helicopter and his crew.
5. The Meritorious Service Medal: This medal is one of the highest medals a soldier can receive for distinguished service as a soldier.
6. The Air Medal: Awarded for continuous flying time logged during battle.

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certain medical conditions of the veteran qualify as a disability and are therefore compensable claims.

The Compensation and Pension Examination of the veteran addresses all physical systems including specific medical problems. The examining physician, Dr. Courtney Nevitt, along with approximately ten (10) other health care providers, evaluated Mr. Stephenson for a wide variety of medical conditions and problems.

The documents representing Mr. Stephenson's visit with Dr. Nevitt consist of five pages. Two pages are dated January 23, 1987, two pages are undated, and one page, which is the second page of an incomplete, two page document is dated March 6, 1987 as the date of dictation and is marked "page 2" at the top. (*See* EXHIBIT 1 TO DECLARATION OF ADAM MORROW, DR. NEVITT'S COMPENSATION & PENSION EXAMINATION, REPRESENTING ALL FIVE PAGES.)

One (1) of the eleven (11) parts of Dr. Nevitt's examination of Kyle Stephenson, consisted of a rectal examination in response to his ongoing complaints of rectal bleeding. Dr. Nevitt charted, "The patient has never had a workup for this problem and has always assumed that he has hemorrhoids." (*See* EXHIBIT 1, AT PG 1, TO MORROW DECLARATION.)

Based on Kyle Stephenson's rectal examination, Dr. Nevitt charted the following on page two of the undated medical record under the heading PHYSICAL EXAM:

> There was a 1-cm. x 1-cm., soft, movable mass felt anteriorly. This could represent a hemorrhoid or a polyp. Stool was brown and guaiac positive.

See EXHIBIT 1, AT PG. 4, TO MORROW DECLARATION.

Under ASSESSMENT: the record states "Guaiac-positive stools and an abnormal rectal exam. Most likely, patient has hemorrhoids. A barium enema will be done to evaluate this problem. GI will also be consulted for further assessment and management of this problem." (*See* EXHIBIT 1, AT PG. 4, TO MORROW DECLARATION, *emphasis added.*)

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Under PLAN: the record states "Audiometry will be ordered. A barium enema and GI consult will be ordered and other diagnostic tests as per the Agent Orange Protocol will be ordered." (*See* EXHIBIT 1, AT PG. 4, TO MORROW DECLARATION.)

Dr. Nevitt's March 6, 1987 dictation for the above January 23, 1987 examination is a single page that has "page 2" at the top. This dictation is substantively different from Dr. Nevitt's undated version of the same physical examination with respect to Mr. Stephenson's abnormal rectal examination. Under the heading PHYSICAL EXAM the record states,

> Rectal exam: 1 cm x 1 cm soft, movable mass, probably represents a polyp.
> Stool was brown and guaiac positive.

See EXHIBIT 1, AT PG. 5, TO MORROW DECLARATION, *emphasis added.*

Under the heading ASSESSMENT, the record states,

> Problem #2. Abnormal rectal exam with guaiac positive stool – Certainly, the patient requires further workup for this problem. A barium enema and a GI consult will be requested.

See EXHIBIT 1, AT PG 5, TO MORROW DECLARATION.

Under the heading PLAN, the record states in part,

2) Air contrast barium enema and GI follow up.

See EXHIBIT 1, AT PG. 5, TO MORROW DECLARATION.

On the same day January 23, 1987, Dr. Nevitt filled out and signed a Consultation Sheet to the GI (gastrointestinal) physician requesting additional studies for Kyle Stephenson. Under the heading "REASON FOR REQUEST" Dr. Nevitt wrote "Flex sigmoidoscopy" and "guaiac + stool." (*See* EXHIBIT 2 TO MORROW DECLARATION.)

Also on January 23, 1987, Dr. Nevitt signed and filled out a document referred to as "RADIOLOGIC CONSULTATION REQUEST/REPORT" (Barium Enema Report). Under the heading "SPECIFIC REASON(S) FOR THE REQUEST" the record states "guaiac + stool" and "?

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rectal polyp vs. hemorrhoid." In addition, the request form also states "Air Contrast Barium Enema" with the words "Air Contrast" crossed out. (*See* EXHIBIT 3, AT PG. 1, TO MORROW DECLARATION.)

The gastrointestinal consultation ordered by Dr. Nevitt was not carried out. Neither were the Flexible Sigmoidoscopy or the Air Contrast Barium Enema.

The sigmoidoscopy, the Air Contrast Barium Enema, and the gastrointestinal consultation were ordered based on Kyle Stephenson's documented, abnormal colorectal findings.

In addition, Dr. Nevitt did not tell Kyle Stephenson that she found an abnormal rectal mass, or that she had colorectal cancer within her differential diagnosis, or that she wanted to have Mr. Stephenson evaluated by a GI specialist. (*See* EXHIBIT 1 TO MORROW DECLARATION; AND DECLARATION OF KYLE W. STEPHENSON DATED 10/27/03.)

The words "flexible sigmoidoscopy" do not appear anywhere on Dr. Nevitt's five page medical record. The Flexible Sigmoidoscopy request was made on a separate request form (*see* EXHIBIT 2 TO MORROW DECLARATION). Kyle Stephenson was told, as evidenced by Dr. Nevitt's medical record, "most likely, [he] the patient has hemorrhoids" (EXHIBIT 1, AT PG. 4, TO MORROW DECLARATION; DECLARATION OF KYLE W. STEPHENSON.)

The only test carried out for Kyle Stephenson was a single contrast barium enema, not the ordered Air Contrast Barium Enema. In following through with this single contrast study (one of ten procedures Kyle Stephenson went through following his Compensation & Pension Examination), he was told "most likely, [he] the patient has hemorrhoids," and submitted himself to the procedure in order to be eligible to receive a compensable disability for service related hemorrhoids. (*See* EXHIBIT 1, AT PG. 4, TO MORROW DECLARATION.) Kyle Stephenson was not told what is contained in Dr. Nevitt's March 6, 1987 version of Kyle's medical record, nearly six weeks after the examination, which states, "Rectal exam; 1 cm x 1cm soft, movable mass, probably represents a polyp." (EXHIBIT

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1, AT PG. 5, TO MORROW DECLARATION, *emphasis added*.)

Kyle Stephenson underwent the nine (9) additional medical evaluations and studies from January 29, 1987 thru February 18, 1987, following his January 23, 1987 Compensation and Pension Examination (*please see* EXHIBIT 37 TO MORROW DECLARATION, A LIST COMPRISING ALL EXAMINATIONS AND PROCEDURES KYLE STEPHENSON SUBMITTED TO WITH CORRESPONDING MEDICAL RECORDS; AND DECLARATION OF KYLE W. STEPHENSON.) Including the single contrast barium enema, Kyle Stephenson underwent the following medical studies and/or evaluations:

1) January 29, 1987 - Special Orthopedic Examination conducted by Dr. James W. Miller;
2) January 29, 1987 - ECG Cardiac Report Requested by Dr. Courtney Nevitt;
3) January 29, 1987 – Audiology Evaluation and Summary report Requested by Dr. Courtney Nevitt;
4) January 29, 1987 – Chest x-ray requested by Dr. Courtney Nevitt and conducted by Drs. Krizan and Harley;
5) January 29, 1987 – Lumbar Spine x-ray requested by Dr. James W. Miller and conducted by Drs. Krizan and Dr. Harley;
6) January 29, 1987 – Complete Clinical Laboratory Report requested by Dr. Courtney Nevitt;
7) No date – ENT examination by Dr. Harold Hughes;
8) February 5, 1987 – Social Industrial History Post Traumatic Stress Disorder Compensation and Pension Examination conducted by Peggy Larson, MSW;
9) February 5, 1987 - Barium Enema requested by Dr. Courtney Nevitt; and
10) February 18, 1987 – Special Psychiatric Evaluation for Post Traumatic Stress Disorder conducted by Dr. Phillip Plattner.

FEBRUARY 1987

On February 5, 1987 Mr. Stephenson presented to the VA medical center and underwent a single contrast barium enema and not the ordered air contrast study. The barium enema report states, "Please note that small rectal lesions cannot be entirely excluded on this single contrast study." (*See* EXHIBIT 3, AT PG. 1, TO MORROW DECLARATION.)

The single contrast barium enema failed to identify the 1 cm. x 1 cm. rectal mass palpated by Dr. Nevitt, which was the reason for ordering the barium enema. In addition, there was no follow

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through by any health care provider, including Dr. Nevitt, with regard to the mass palpated by Dr. Nevitt in Kyle Stephenson's rectum.

However, the single contrast barium enema study did identify a second abnormal mass. This second and distinct mass was located in Mr. Stephenson's descending colon. The barium enema report is stamped in red, bold, capital letters "ABNORMAL NEW FINDING." The body of the report states in part the following:

> Single contrast barium enema was performed in the usual manner. There is a 7 mm., smooth, lobulated sessile polyp in the descending colon approximately 15 cm. distal to the splenic flexure. No other abnormality was demonstrated...Please note that small rectal lesions cannot be entirely excluded on this single contrast study. Further evaluation of the polyp in the descending colon by endoscopy and biopsy is recommended. The G.I. resident has been informed of this finding.

See EXHIBIT 3 TO MORROW DECLARATION.

Kyle Stephenson was not informed of this second abnormal mass identified in his colon. (*See* DECLARATION OF KYLE W. STEPHENSON AT PG. 2; *also see* EXHIBIT 38 TO MORROW DECLARATION, ANATOMICAL ILLUSTRATIONS REVIEWED AND SUPPORTED BY ALL OF PLAINTIFFS' EXPERTS AND ATTACHED TO THEIR DECLARATIONS.)

The defendant's heath care providers stated the following on the February 5, 1987 Barium Enema Report:

> ...Further evaluation of the polyp in the descending colon by endoscopy and biopsy is recommended.

See EXHIBIT 3 TO MORROW DECLARATION.

The defendant's health care providers did not carry out the endoscopy and biopsy of the polyp in the descending colon. Kyle Stephenson was not told of the "ABNORMAL NEW FINDING" or of the recommendation for further evaluation and biopsy of this polyp in the

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descending colon.

During this period of time, Kyle Stephenson submitted to every medical study and evaluation, a total of ten, that the VA required him to undertake.

In summary, in early 1987, after identifying two abnormal colorectal masses in a 45-year-old man with complaints of rectal bleeding over a period of years, the defendant had ordered and failed to carry out the following: 1) a GI (gastrointestinal) consult; 2) a flexible sigmoidoscopy; 3) an Air Contrast Barium Enema; 4) an endoscopy of the polyp in Mr. Stephenson's descending colon; and 5) a biopsy of the polyp in Mr. Stephenson's descending colon;

MAY 1987

On May 15, 1987, the defendant issued a rating decision which states the defendant reviewed Mr. Stephenson's medical records, including medical records pertaining to any claimed disabilities related to his rectal problems. (*See* EXHIBIT 4 TO MORROW DECLARATION.) The defendant denied Mr. Stephenson any disability benefits related to hemorrhoids. In reviewing Mr. Stephenson's medical chart, the defendant's agents did not notify Mr. Stephenson he had been diagnosed with two distinct, abnormal, colorectal masses detected in January and February of 1987. The defendant did not notify Mr. Stephenson that a flexible sigmoidoscopy, a GI consultation, an air contrast barium enema, an endoscopy, and a biopsy were previously ordered and not carried out.

MAY 1989

On May 22, 1989, Kyle Stephenson requested to be seen at the VA Medical Center with complaints of ongoing, increased rectal bleeding and worsening hemorrhoids *(See* EXHIBIT 5 TO MORROW DECLARATION.)

On May 25, 1989, Kyle Stephenson presented to the General Surgery Department at the VA Medical Center where he was seen and treated by a third year medical student, H. Miller, UWIII.

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(*See* EXHIBIT 6 TO MORROW DECLARATION.) After the medical student's signature on the May 25, 1989 Progress Note is the signature of the VA Chief of Surgery, H. Radke, M.D. Excluding Dr. Radke's signature, the entire chart note representing the examination is in the medical student's handwriting. (*See* EXHIBIT 7, AT PG. 2, ¶ 5, TO MORROW DECLARATION.)

Kyle Stephenson presented as a 46-year-old male with a history of ongoing, increased rectal bleeding with two abnormal colorectal polyps documented in his VA medical records. The VA medical student documented that Mr. Stephenson's medical problems were not updated. The VA medical student did not obtain Mr. Stephenson's medical chart for review. The defendant's relevant medical record states:

> PROBLEM LIST UPDATED [ ] YES [X] NO
>
> S: 46 y.o. male in excellent health presents via PEC referral for int. hemorrhoids. Had long history of hemorrhoids treated with tucks, sitzs baths, now worsening since Jan. 89. Increased bleeding with BM, also now protrusion requiring manual reduction. Inquiring about treatment.
>
> O: No ext. tags. Spastic sphincter tone. 1 large int. hemorrhoid at 4 o'clock, some excoriation of anal mucosa by anoscopy. Swollen crypts.
>
> A: 46 year-old male in excellent health with 1 internal hemorrhoids and cryptitis.
>
> P: Metamucil increase stool bulk, hydration, decrease strain, avoid spices, sitz baths.
> RTC 1 month.
>
> H. Miller- UWIII
> HM Radke

See EXHIBIT 6 TO MORROW DECLARATION.

JUNE 1989

On June 29, 1989, the medical record in Kyle Stephenson's chart states, "Chart Review", "Hemorrhoids under Rx", "Failed to Report", and "Reschedule." HM Radke – Chief of Surgery (*see*

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EXHIBIT 8 TO MORROW DECLARATION).

1993

On August 19, 1993, Kyle Stephenson passed bright red blood through his rectum and went to see a physician named Dr. Richard A. Hogan. The relevant medical record states:

> OBJECTIVE: BP 150/94, P 100 and regular. Rectal exam – there is a very marked amount of clot in the rectum. When I started to do an anoscopy I simply got lots of dark red clot out. After some cleaning out, I feel what feels like a polypoid or fungating lesion on the posterior wall resting anteriorly into the rectal channel. I asked Dr. Salmon to take a look and he also looked and in spite of the use of a number of swabs, we never could get a good look at it because it seems to be constantly oozing. The lesion is certainly too high it would seem to be a hemorrhoid. I have referred him to Dr. Davis in Bremerton who will see him later today.

See EXHIBIT 9 TO MORROW DECLARATION.

On August 19, 1993, Dr. Joe Jack Davis, a general surgeon, examined Kyle Stephenson. The medical record states:

> PROBLEM: Bloody discharge from rectum.
>
> HISTORY: The patient is a 46 year-old male who has been in good health. Yesterday evening, he felt as if he dirtied his underwear after passing gas and when he checked, he found his underwear soiled with blood. He sat on the toilet and passed what he describes as bright blood, causing him considerable alarm. He sought medical attention with Dr. Richard Hogan at Group Health Silverdale, and it was Dr. Hogan's opinion (with curbside consultation with Dr. Les Salmon) that the patient likely had a rectal tumor, and he was referred for general surgical evaluation.
>
> Mr. Stephenson really has no significant history otherwise. He does say he feels bloated at the present time, but he has avoided bowel movement since yesterday because of his fear of seeing more blood. Otherwise, he has had no change in bowel habits. He has a remote history of hemorrhoids and fissures. He has no family history of colon or rectal cancer.
>
> OBJECTIVE: Abdominal exam is unremarkable. Inspection of the anal region shows no external abnormalities. Digital rectal examination shows

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a tumor mass several centimeters proximal to the dentate line lying posteriorly. This feels like an ulcerated cancer with a villous component.

Anoscopy was attempted to obtain tissue. This was unsuccessful because of the volume of old blood within the rectum.

ASSESSMENT: I feel this patient has rectal cancer that will eventuate in abdominoperineal resection. We discussed this superficially, and made plans by telephoning Dr. Hogan to have the patient meet with Dr. Hogan again tomorrow for flexible sigmoidoscopy for biopsies. The next step will be dependent upon the results of that biopsy.

See EXHIBIT 10 TO MORROW DECLARATION.

On August 20th, 1993, Kyle Stephenson returned to see Dr. Richard A Hogan for a sigmoidoscopy with biopsy. The medical record states:

PROCEDURE NOTE: Sigmoidoscopy with biopsy

The patient, who was seen yesterday for bleeding, was seen by Dr. Joe Jack Davis, who agreed that this is probably an epiphytic tumor, originating from the posterior wall of the rectum.

Today I introduced the sigmoidoscope and then retroflexed it on itself in the rectum. I could visualize the tumor quite well. It is a projecting growth from the posterior wall of the rectum. It has a central necrotic gray-white base with the rim of the tumor having a lot of smooth but somewhat erythematous and friable margins projecting out into the lumen of the rectum. Numerous biopsies were taken from the projecting portions from the base of the shaggy ulcer, and from the outside of the tumor where the projections merge into the more normal appearing mucosa. All of these were submitted for pathologic examination. The patient tolerated the procedure well. We did not attempt to go beyond 20 cm. or out of the rectum. There was really no active bleeding at the time we visualized the tumor and there did not appear to be any significant bleeding after biopsy. We will await the reports of the pathology.

PLAN: The patient will be admitted and prepared for possible surgery. Will have a full-scale colonoscopy at that time followed up by appropriate surgery.

See EXHIBIT 9 TO MORROW DECLARATION.

On August 31, 1993, Dr. Pankaj Sharma, Board Certified in Gastroenterology and Internal

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Medicine, carried out a colonoscopy on Kyle Stephenson. The Colonoscopy Report states in relevant part:

> INDICATIONS: Rectal mass. The patient is being considered for surgery. Colonoscopy was requested prior to surgery to rule out synchronous lesion.
>
> FINDINGS: In the descending colon there was about a 1 cm. polyp which was pedunculated. It was removed with the help of a snare, using electrocauterization...Polyp was retrieved and sent to Pathology. The remainder of the descending colon and sigmoid colon appeared to be unremarkable. In the rectum the patient had another small polyp. Further distally, close to the anorectal verge, the patient had about a 5 cm. size lobulated, ulcerated mass lesion. No biopsies were obtained. No attempt was made to remove the rectal polyp and it will be part of a surgical resection.
>
> ASSESMENT:
> (1) Malignant neoplasm of the rectum.
> (2) Colon polyps.
>
> PLAN:
> (1) Await histology report.
> (2) Surgery as planned.
> (3) If this patient does not have any evidence of metastatic disease, he should have repeat colonoscopy examination in six months and every year for at least five years.

See EXHIBIT 11 TO MORROW DECLARATION.

The pathology report dated September 1, 1993 for Kyle Stephenson's descending colon states:

> **Benign Tubulovillous Adenoma (Adenovillous Polyp)**

See EXHIBIT 12 TO MORROW DECLARATION, *emphasis added.*

Polyps fall into two pathologic categories. They are either pre-cancerous (adenomas or neoplastic) or they have no malignant potential (hyperplastic or nonneoplastic). (*See* DECLARATION OF SIDNEY J. WINAWER, M.D., AT PG. 18, LN. 16-18, PREVIOUSLY FILED WITH THE COURT.)

In addition, pre-cancerous polyps are further classified into three subcategories. They are

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either tubular, tubulovillous, or villous. Tubular polyps have the lowest risk of malignant transformation of the three classifications of pre-cancerous polyps. Tubulovillous polyps have the second highest risk of malignant transformation while villous polyps present the highest risk of malignant transformation. (*See* DECLARATION OF SIDNEY J. WINAWER, M.D., AT PG. 18, LN. 19-21.)

Kyle Stephenson's previously identified polyps were pre-cancerous. Kyle Stephenson's colorectal cancer, which was a 5 cm tumor prior to its surgical removal in 1993, began as a pre-cancerous, villous adenoma. (*See* DECLARATION OF SIDNEY J. WINAWER, M.D., AT PG. 19, LN. 3-5; EXHIBIT 13 TO MORROW DECLARATION; DECLARATION OF PANKAJ SHARMA, M.D., PG. 10, LN. 10-15, PREVIOUSLY FILED WITH THE COURT; AND DECLARATION OF OLIVER BIGGERS, M.D., PG. 8, LN. 7-8, PREVIOUSLY FILED WITH THE COURT.)

The surgical pathology report dated September 3, 1993 states:

Tumor arises in pre-existing villous adenoma

See Exhibit 13, AT PG. 13-2, TO MORROW DECLARATION, *emphasis added.*

Villous adenomas, with the highest potential risk for malignant transformation, are slow growing and take ten to twelve years to transform into cancer. (*See* DECLARATION OF SYDNEY J. WINAWER, M.D., AT PG. 33, LN. 16-17.) Dr. Nevitt, in her recent deposition, testified that she tells her patients that polyps take ten years to transform into cancer. (*See* EXHIBIT 14, AT PGS. 109, 111 & 112, TO MORROW DECLARATION.)

On September 1, 1993, Dr. Joe Jack Davis performed an abdominoperineal resection on his patient, Kyle Stephenson.

Dr. Davis' surgical operative report states the following in relevant part:

> CLINICAL ABSTRACT:
> Digital rectal examination revealed a tumor just above the anal canal. Subsequent flexible sigmoidoscopy with biopsy documented adenocarcinoma. Preoperative colonoscopy showed several other polyps,

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> one managed colonoscopically, the other low enough to be resected with the proctectomy.

See EXHIBIT 15, AT PG. 1, TO MORROW DECLARATION.

Dr. Davis removed 24 cm. of Kyle Stephenson's rectum and colon, including his anus and sphincter. His natural orifice was permanently sewn shut and an artificial opening called a stoma was created in Kyle's abdomen. Kyle Stephenson's colostomy is permanent and irreversible. For the rest of Kyle Stephenson's life, his bodily waste will empty out of the artificially created opening in his abdomen into a plastic bag. In addition, the surgical removal of Kyle Stephenson's cancer and the reconfiguration of his normal anatomy has left him permanently impotent. Unfortunately, impotence is often a consequence of this surgery when nerves affecting sexual function are destroyed.

Post-surgically Kyle Stephenson developed a large tear in the muscle tissue of his abdomen called a peristomal hernia as a result of gravitational forces exerted over time by his colostomy appliance on his abdominal stoma. The presence of the peristomal hernia makes it difficult for Mr. Stephenson to obtain a good seal between his stoma and his colostomy hardware. The peristomal hernia has caused extremely embarrassing public experiences where the fecal content of his bag has spilled onto his body and the floor. Because of the shame involved with these mishaps, Mr. Stephenson seldom ventures into the public domain and has essentially become a recluse. The VA found Mr. Stephenson to be "Housebound" as a result of his colostomy disability. (*See* VA RATING DECISION DATED 2/22/02, ATTACHED TO MORROW DECLARATION AS EXHIBIT 36, AT PG 6-7, SECTION 4.)

1999

On December 27, 1999, believing that his exposure to Agent Orange during the Vietnam War may have caused his rectal cancer, Mr. Stephenson signed and submitted a document entitled "Statement in Support of Claim" stating the following:

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> I am filing for a service connected disability claim for Carcinoma of the rectum due to exposure to Agent Orange while in country (Vietnam) as a helicopter pilot, Chu LAI RVM, 176 AHC from February of 1970 through February of 1971

See EXHIBIT 5 TO DECLARATION OF KYLE W. STEPHENSON.

2000

On August 28, 2000, Mr. Stephenson went to see a counselor named Barbara Williams for a vocational rehabilitation assessment. Ms. Williams had possession of Mr. Stephenson's VA file. During the course of the meeting, Ms. Williams was reading some of the records contained in his VA file and came across one of Dr. Nevitt's chart notes. She told Kyle that an abnormal rectal mass had been documented in his medical record that appeared to be suspiciously related to Mr. Stephenson's later diagnosis of colorectal cancer. Ms. Williams showed Kyle the medical record and he was shocked. This was the first time that Kyle Stephenson was told or had heard about any colorectal masses that had been found by the VA in 1987. Ms. Williams made him a copy of the VA medical document and Kyle Stephenson took it with him to show his surgeon, Dr. Joe Jack Davis. (*See* DECLARATION OF KYLE W. STEPHENSON, AT PG. 9, LN. 12 TO PG. 10, LN. 13.)

2001

In a letter dated May 8, 2001, Ms. Williams wrote to the defendant VA and stated in relevant part the following:

> During my review of medical records, which I believe were contained in the veteran's CER folder, **I noticed something that appeared suspiciously related to his later diagnosis of colon cancer. I showed this to Mr. Stephenson and a copy of this medical report was provided to him.**

See EXHIBIT 16 TO MORROW DECLARATION, *emphasis added*.

Upon learning this information concerning the abnormal mass that was discovered in 1987, Mr. Stephenson immediately went to see his surgeon, Dr. Joe Jack Davis, with the VA medical

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record given to him by his counselor, Ms. Williams, to inform Dr. Davis about this disturbing discovery. (*See* DECLARATION OF KYLE W. STEPHENSON AT PG. 10, LN. 6-13.)

Dr. Davis told Mr. Stephenson that the VA failed to properly treat and follow Mr. Stephenson for his rectal abnormalities identified in 1987. (*See* EXHIBIT 17 TO MORROW DECLARATION.) Dr. Davis informed Mr. Stephenson that he would not have developed rectal cancer or needed his colostomy had the VA followed through with the tests that they had ordered. (*See* DECLARATION OF KYLE W. STEPHENSON AT PG. 10, LN. 11-12; DECLARATION OF JOE JACK DAVIS, M.D., AT PG. 8, LN. 16-17, PG. 9 LN. 4-9, PREVIOUSLY FILED WITH THE COURT.)

Dr. Joe Jack Davis stated the following in his September 7, 2000 medical records regarding his patient, Kyle Stephenson:

> REASON FOR CONSULTATION: **Patient self-referred to discuss** association of colorectal cancer with Agent Orange and to talk about **new revelations associated with his rectal cancer** .
>
> HISTORY: ... Several weeks ago he contacted this office regarding our help in trying to establish whether his chronic exposure in Vietnam to Agent Orange might have been linked with his rectal cancer. He has provided me with a list of diseases associated with chronic exposure to Agent Orange. Colorectal cancer is not on that list.
>
> He also brings with him a copy of a document out of his VA medical record showing that in 1987 he was examined by a physician in the VA who documented the presence of a 1 cm rectal polyp plus guaiac positive stool. That physician recommended additional investigation including colon contrast study and sigmoidoscopy, but neither of these tests were ever carried out.
>
> ...
>
> ASSESSMENT: **Obviously diagnosis of Mr. Stephenson's rectal cancer was delayed by failure of proper investigation of the colorectum once it was determined the patient had a rectal polyp and guaiac positive stool in 1987. I mentioned to Mr. Stephenson that in the world outside the federal system, that such a story would be grounds for medicolegal action with all the cards in favor of the patient**....

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See EXHIBIT 17 TO MORROW DECLARATION, *emphasis added.*

On March 14, 2001, Plaintiffs' counsel filed the required Tort Claim with the Veterans Administration, which supplied the defendant, et.al., with the facts known at that time which formed the basis of Mr. Kyle Stephenson's claim and his minor son, Michael Stephenson's claim for destruction and loss of the parent/child relationship. (*See* EXHIBIT 18 TO MORROW DECLARATION.)

On a document entitled C&P Exam Detail Report, dated September 10, 2001, the defendant requested the opinion of a Board Certified Gastroenterologist named A.J. Thompson with respect to whether the VA failed to timely diagnose and treat Mr. Stephenson's colorectal masses, and if so, whether the failure was the cause of Mr. Stephenson's progression to rectal cancer. The VA issued the following document:

> Veteran is claiming compensation based on VA failure to furnish proper medical care following VA Comp and Pen exam in January 1987 and barium enema done in February 1987, which found soft, movable, rectal mass and guaiac positive stool. No record of GI consult found on CAPRI. Veteran underwent abdominoperineal resection for carcinoma in 1993.
>
> **Please provide your medical opinion, with reasoning, on a more likely as not basis, as to whether or not VA failed to timely diagnose and properly treat the rectal mass in 1987, and that this caused the continuance or natural progression of Mr. Stephenson's rectal cancer**. See copy of 38 CFR 3.361 in the claims file. **The CAPRI record, and the information available on the C&P exam report do not show that Mr. Stephenson was** scheduled for the recommended GI consult or **notified that an abnormality was found.**

See EXHIBIT 19 TO MORROW DECLARATION, *emphasis added.*

On September 25, 2001, Board Certified Gastroenterologist, Dr. A.J. Thompson, at the request of the defendant VA Medical Center, stated the following in a document entitled Compensation and Pension Exam Report, regarding Kyle Stephenson:

> We are asked to determine if the VA failed to timely diagnose and properly treat the rectal mass found in 1987, and if this caused the

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continuance and natural progression of Mr. Stephenson's rectal cancer.

Yes, the VA failed to timely diagnose and properly treat the rectal mass found on rectal examination in 1987, which progressed to rectal cancer, requiring abdominoperineal resection of the rectum.

A note of 3/6/87 describes on rectal examination a 1 cm. x 1 cm. soft moveable mass. The stool was GUAIAC positive. The note describes a "barium enema and a GI consult will be requested."

The veteran had had occasional hematochezia since 1970, which was attributed to hemorrhoids. He had no follow-up for the problem until 1987. A barium enema 2/5/87 at the Seattle hospital noted that "there is a questionable mass, smooth lobulated sessile polyp in the descending colon approximately 15 cm-distal to the splenic flexure." Further evaluation of the polyp in the descending colon by endoscopy and biopsy is recommended. The GI resident will be notified of these findings. The VA records do not indicate GI evaluation was obtained. He presented to his private physician in December 1993 with recurrent rectal bleeding, with the findings on rectal examination of a tender mass several centimeters proximal to the dentate line posteriorly. "This mass feels like a ulcerated cancer with a villous component."

Colonoscopy on 8/31/93 disclosed "close to the anal verge a 5 cm in size lobulated ulcerated mass lesion" which certainly was the mass felt in the rectal examination at the VA in 1987, additionally, apparently benign polyps were found in the mid descending colon and rectum the pathology report of 9/1/93 describes adenocarcinoma of the rectum, well differentiated grade, 1/3, with invasion of the muscularis propria, but no extension to the peritoneal surface of the regional nodes, no evidence of vascular lymphatic or paraneural invasion.

A J Thompson, M.D.
Gastrointestinal Specialist (Board Certified)

See EXHIBIT 20, TO MORROW DECLARATION, *emphasis added*.

2002

On February 20, 2002, Dr. Thompson rendered the following opinion with respect to Kyle Stephenson:

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Examination Results
OPINION AS REQUESTED 02/20/02

On a more probable than not basis the recurrent rectal bleeding noted in the service in 1970 was due to benign bleeding polyps, which subsequently became larger, became ulcerated, and underwent malignant transformation and metastases. Colon cancer is a slow growing cancer.

A J Thompson, M.D.
BOARD CERTIFIED GI SPECIALIST
BOARD CERTIFIED GENERAL INTERNAL MEDICINE SPECIALIST

See EXHIBIT 21 TO MORROW DECLARATION.

On March 14, 2001, Plaintiffs' counsel timely filed the required Tort Claim on behalf of the plaintiffs' Kyle Stephenson, and his minor son, Michael Stephenson. (*See* EXHIBIT 18 TO MORROW DECLARATION.)

On July 24, 2002, the defendant issued its NOTICE OF FINAL DENIAL letter to the Plaintiffs' previously submitted Tort Claim. (*See* EXHIBIT 22 TO MORROW DECLARATION.)

2003

On January 21, 2003, plaintiffs filed their Complaint in Federal Court pursuant to the Federal Tort Claims Act and applicable federal law. (*See* EXHIBIT 23 TO MORROW DECLARATION).

On April 7, 2003, Plaintiffs' counsel received the Defendant's Answer to the Complaint. (*See* EXHIBIT 24 TO MORROW DECLARATION.) In its Answer, the Defendant **admitted** the following facts:

1. Dr. Nevitt's rectal examination of Kyle W. Stephenson on January 23, 1987 was abnormal, revealing a 1 cm. x 1 cm. soft, movable mass, felt anteriorly, which Dr. Nevitt stated could represent a hemorrhoid or a polyp (See paragraph 3.6 of Complaint and Defendant's Answer).

2. Dr. Nevitt charted on a document dated March 6, 1987, that the soft, movable mass was probably a polyp (See paragraph 3.7 of Complaint and Defendant's Answer).

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3. As a result of Kyle W. Stephenson's abnormal rectal examination, on January 23, 1987, Dr. Nevitt requested a barium enema for Kyle W. Stephenson (See paragraph 3.13 of Complaint and Defendant's Answer).

4. As a result of Kyle W. Stephenson's abnormal rectal examination, on January 23, 1987, Dr. Nevitt requested a gastrointestinal consultation for Kyle W. Stephenson (See paragraph 3.14 of Complaint and Defendant's Answer).

5. As a result of Kyle W. Stephenson's abnormal rectal examination, on January 23, 1987, Dr. Nevitt requested a flexible sigmoidoscopy for Kyle W. Stephenson (See paragraph 3.15 of Complaint and Defendant's Answer).

6. The defendant did not carry out a flexible sigmoidoscopy on Kyle Stephenson (See paragraph 3.23 of Complaint and Defendant's Answer).

7. The Radiologic Report on Kyle W. Stephenson's barium enema, from the Seattle Veterans Administration Medical Center, dated February 5, 1987, noted a 7 mm., smooth, lobulated, sessile polyp in the descending colon, approximately 15 cm. distal to the splenic flexure (See paragraph 3.16 of Complaint and Defendant's Answer).

8. The words "ABNORMAL NEW FINDING" were stamped in red ink and capitalized on both pages of Kyle W. Stephenson's February 5, 1987 barium enema report (See paragraph 3.17 of Complaint and Defendant's Answer).

9. As a result of the polyp found during the February 5, 1987 barium enema, further evaluation of the polyp in the descending colon by endoscopy and biopsy was recommended (See paragraph 3.18 of Complaint and Defendant's Answer).

10. The recommended endoscopy and biopsy was intended to evaluate the polyp found on Kyle W. Stephenson's February 5, 1987 barium enema (See paragraph 3.19 of Complaint and Defendant's Answer).

11. The biopsy of the polyp found on Kyle Stephenson's February 5, 1987 barium enema was never carried out by the Veterans Administration Medical Center in Seattle, Washington (See paragraph 3.20 of Complaint and Defendant's Answer).

On May 27, 2003, Plaintiffs' counsel also received Defendant's Responses to Plaintiffs' First Interrogatories and Requests for Production. (*See* EXHIBIT 25 TO MORROW DECLARATION.) The Plaintiff asked the defendant whether it asserts 1) that one or more of the defendant's health care providers informed Kyle Stephenson about the rectal polyp palpated by Dr. Nevitt on January 23, 1987; 2) that his February 5, 1987 barium enema revealed a polyp in his descending colon; 3) that

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further evaluation of the polyp in the descending colon by endoscopy and biopsy was recommended by the defendant; 4) and that the defendant's health care providers informed Mr. Stephenson that colon and/or rectal polyps exposed him to risk of developing colorectal cancer. The defendant repeatedly responded that it could not reasonably provide the requested underlying information without resorting to speculation and therefore, the defendant was without sufficient knowledge or information to reasonably answer the Interrogatories stating the following:

> Any attempt to answer Interrogatory 8 either "yes" or "no" would involve speculation because of the length of time which has elapsed since February 5, 1987. As stated above, the Defendant do not have the means to reasonably reconstruct, at this time, what the providers did or did not say to Mr. Stephenson on February 5, 1987. The February 5, 1987 event, which Plaintiff has raised in Interrogatory No. 10 occurred more than 16 years ago, and the health care providers who witnessed the event are no longer employees at VA Puget Sound Health Care System. Accordingly, the Defendant is without sufficient knowledge or information to reasonably answer Interrogatory No. 10

See EXHIBIT 25, AT PG. 5, LN. 10-17, TO MORROW DECLARATION, DEFENDANT'S ANSWER TO INTERROGATORY NO. 10, *emphasis added.*

> The Defendant is without sufficient knowledge or information to answer either "yes" or "no" to Interrogatory No. 4 because of the passage of time. The occurrence cited in Interrogatory No. 4 occurred on or about February 5, 1987, more than 16 years ago and the health care providers who witnessed the event are no longer employees at VA Puget Sound Health Care System, so Defendant could only speculate on what the providers discussed with Mr. Stephenson during and immediately after his barium enema.

See EXHIBIT 25, AT PG. 2, LN. 19-24, TO MORROW DECLARATION, DEFENDANT'S ANSWER TO INTERROGATORY NO. 4, *emphasis added.*

On May 27, 2003, plaintiffs' counsel received Defendant's Responses to Plaintiffs' First Requests for Admission. The Defendant admitted the following:

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REQUEST FOR ADMISSION NO. 5: Admit that Dr. Courtney Nevitt requested that a flexible sigmoidoscopy be carried out on Kyle Stephenson following his January 23, 1987 examination.

RESPONSE: Admitted

REQUEST FOR ADMISSION NO. 6: Admit that the defendant's health care providers did not carry out a flexible sigmoidoscopy on Kyle Stephenson following his January 23, 1987 examination by Dr. Courtney Nevitt.

RESPONSE: Admitted

REQUEST FOR ADMISSION NO. 8: Admit that Dr. Nevitt requested a GI consultation take place for Kyle Stephenson following his January 23, 1987 examination.

RESPONSE: The United States admits that Dr. Nevitt requested a GI consultation to perform a flexible sigmoidoscopy.

REQUEST FOR ADMISSION NO. 10: Admit that Kyle Stephenson did not have a GI consult following his January 23, 1987 examination by Dr. Courtney Nevitt.

RESPONSE: Admitted

REQUEST FOR ADMISSION NO. 52: Admit that the defendant described Kyle Stephenson's polyp in his descending colon as an "ABNORMAL NEW FINDING" on his February 5, 1987 barium enema.

RESPONSE: Admitted

REQUEST FOR ADMISSION NO. 40: Admit that the defendant's health care providers requested further evaluation by endoscopy and biopsy of the polyp identified in Kyle Stephenson's descending colon on his February 5, 1987 barium enema.

RESPONSE: Admit that the barium enema report dated February 5, 1987, included a request for endoscopy and biopsy "of the polyp in the descending colon."

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REQUEST FOR ADMISSION NO. 42: Admit that the defendant's health care providers did not carry out any further evaluation of the polyp identified in Kyle Stephenson's descending colon by barium enema on February 5, 1987.

RESPONSE: Admitted

REQUEST FOR ADMISSION NO. 43: Admit that the defendant's health care providers did not biopsy the polyp identified in Kyle Stephenson's descending colon by barium enema on February 5, 1987.

RESPONSE: Admitted

REQUEST FOR ADMISSION NO. 55: Admit that the defendant's health care providers did not inform Kyle Stephenson that the February 5, 1987 barium enema revealed a polyp in his descending colon.

RESPONSE: The United States admits that the VA records do not document any communication to plaintiff informing him that the February 5, 1987, barium enema revealed a polyp in his descending colon. After reasonable investigation, the United States cannot reasonably determine whether or not the radiologists verbally informed plaintiff at the time of the barium enema on February 5, 1987.

REQUEST FOR ADMISSION NO. 56: Admit that colon and/or rectal polyps can be pre-cancerous.

RESPONSE: Admitted

REQUEST FOR ADMISSION NO. 57: Admit that pre-cancerous colon and/or rectal polyps place the person who has these polyps at risk for developing cancer.

RESPONSE: Admitted

REQUEST FOR ADMISSION NO. 58: Admit that the defendant did not inform Kyle Stephenson that colon and/or rectal polyps can develop into cancer.

RESPONSE: The United States admits that the VA records do not document any communication to plaintiff informing him that the February 5, 1987, barium enema revealed a polyp in his descending colon. After reasonable investigation, the United States cannot reasonably determine whether or not any individual employee, at some time, did or did not inform Mr. Stephenson that colon and/or rectal polyps can develop into cancer.

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REQUEST FOR ADMISSION NO. 59: Admit that the defendant advised Kyle Stephenson that his ongoing rectal problems were due to hemorrhoids.

RESPONSE: The United States admits that in May 1989 its employees advised plaintiff that his ongoing rectal problems were due to several causes, including hemorrhoids.

See EXHIBIT 26 TO MORROW DECLARATION.

The Court's Order Regarding Initial Disclosures required disclosure to occur on March 28, 2003. The Court entered a Minute Order on March 18, 2003 granting an extension of time to file the Joint Status Report by May 2, 2003, thus extending the date of Initial Disclosures to occur on April 25, 2003. (*See* EXHIBIT 27 TO MORROW DECLARATION.) The plaintiffs' disclosed to the defendant the identities of all witnesses, including the identities of expert witnesses. (*See* EXHIBIT 28 TO MORROW DECLARATION.)

Also on April 25, 2003 plaintiff received defendant's disclosure (*see* EXHIBIT 29 TO MORROW DECLARATION). The defendant listed four fact witnesses. The defendant failed to list or identify a single expert witness.

On June 2, 2003, plaintiffs' counsel wrote a letter to defense counsel notifying defendant it did not disclose expert witnesses pursuant to the Court's Order and the Federal Rules, and requested that the defendant disclose its expert witnesses. (*See* EXHIBIT 30 TO MORROW DECLARATION).

On June 11, 2003, defense counsel responded by letter stating:

> This letter is written in response to your letter dated June 2, 2003, in which you presented three questions regarding the initial disclosures and discovery responses. In response to your first question regarding the disclosure of experts, please be advised that the United States has to date, not secured experts, and therefore, is not in a position to disclose expert testimony or identity.

See EXHIBIT 31 TO MORROW DECLARATION.

Plaintiffs' counsel responded by letter dated June 12, 2003 requesting to confer under Fed.

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R. Civ. P. 37 and Local Rule 37 W.D.Wash. regarding defendant's failure to disclose the identity of any expert witness. In addition, plaintiff also furnished defense counsel with a copy of Plaintiffs' Supplemental Disclosure for newly acquired expert witness, Dr. Sharma, who was a prior treating doctor of Kyle Stephenson. (*See* EXHIBIT 32 TO MORROW DECLARATION.)

On June 17, 2003, the parties conferred pursuant to Fed. R. Civ. P. 37 and Local Rule 37 W.D.Wash. Defense counsel again stated he had not secured any expert witness to date, he would furnish plaintiffs' counsel with the identity of any expert witnesses when he retained expert witnesses, and that he did not have a requirement to disclose the identity of expert witnesses. (*See* MORROW DECLARATION AT PG. 2, ¶ 5.)

On October 17, 2003 plaintiffs' counsel deposed Dr. Courtney Nevitt (*see* EXHIBIT 14 TO MORROW DECLARATION). Dr. Nevitt testified in part: that she had no recollection of Kyle Stephenson (*see* EXHIBIT 14, AT PG. 10, LN. 24-25); she had no recollection of her examination of Kyle Stephenson (*see* EXHIBIT 14, AT PG. 11, LN. 2-10); she had cancer within her differential diagnosis when she examined Kyle Stephenson based on his history of rectal bleeding, the palpated rectal mass, and the guaiac positive stool (*see* EXHIBIT 14, AT PG. 44, LN. 19-22 & PG. 51, LN. 4-22); that a physician cannot assume a patient's rectal bleeding is due to hemorrhoids until cancer is ruled out (*see* EXHIBIT 14, AT PG. 47, LN. 19-22); that Kyle Stephenson required a full look at his colon (*see* EXHIBIT 14, AT PG. 53, LN. 22-23); she ordered a flexible sigmoidoscopy, a GI consult, an air contrast barium enema (*see* EXHIBIT 14, AT PG. 53, LN. 13-20); none were carried out and she does not know how that occurred (*see* EXHIBIT 14, AT PG. 120, LN. 3-12 & PG. 121, LN. 15-21); the forms she requested for the ordered studies were given by her to an administrative person who would make sure the studies were carried out (*see* EXHIBIT 14, AT PG. 61, LN. 2-7); the sigmoidoscopy was an important test and should have been carried out (*see* EXHIBIT 14, AT PG. 61, LN. 15-20); she believes

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she had two versions of her C&P examination because her first dictation was lost and so she re-dictated a second version based on her notes on the patient (*see* EXHIBIT 14, AT PG. 67, LN. 19 TO PG. 68, LN. 3); she could have kept patient medical records in a location separate from the patient's chart (*see* EXHIBIT 14, AT PG. 70 LN. 12-15); the air contrast barium enema is more accurate than the single contrast barium enema (*see* EXHIBIT 14, PG. 56, LN. 14-19); a chest x-ray was ordered for Kyle Stephenson in Dr. Nevitt's name but Dr. Nevitt did not order the film (*see* EXHIBIT 14, AT PGS. 96, 97, 100, LN. 1-11); when a physician uses a clock to describe a lesion in the rectum she would not know the orientation without knowing the position of the body (*see* EXHIBIT 14 TO MORROW DECLARATION, AT PG. 103, LN. 14-15); she tells her patients it takes ten years for a pre-cancerous polyp to transform into cancer (*see* EXHIBIT 14, AT PG. 109, LN. 8-14; PG. 111, LN. 20-25; PG. 112, LN. 1-4 & PG. 113, LN. 1-6); Mr. Stephenson's rectal cancer arose from a pre-existing rectal polyp (*see* EXHIBIT 14, AT PG. 110, LN. 22-25 TO PG. 111, LN. 1-7, 14-25); It was below the standard of care not to work-up Kyle Stephenson based on his rectal abnormality with a colonoscopy (*see* EXHIBIT 14, AT PG. 119, LN. 24 TO PG. 120 TO LN. 2); she didn't know on May 25, 1989, H. Miller was a third year medical student (*see* EXHIBIT 14, AT PG. 125, LN. 13 TO PG. 126, LN. 10); and the rectal mass she palpated in 1987 was the same area where the rectal cancer was found in 1993 (*see* EXHIBIT 14, AT PG. 122, LN. 3-13.)

The Court's Order Setting Trial Date & Related Dates listed October 22, 2003 as the deadline for expert reports. (*See* EXHIBIT 33 TO MORROW DECLARATION.)

On October 22, 2003 plaintiffs filed with the Court and served defendant with copies of nine (9) signed and dated expert witness reports.

On October 23, 2003 plaintiffs received a document from the defendant entitled "United States' Disclosure of Expert Witnesses." The defendant disclosed the identity of the following three

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expert witnesses: 1) Dr. David A. White – Oncologist; 2) Laura Vadman, C.E.T.N. – Enterostomal Therapist; and 3) Dr. Richard P. Billingham – Colon and Rectal Surgeon. (*See* EXHIBIT 34 TO MORROW DECLARATION.)

Dr. White submitted a signed two-page report stating in part, "To reach these opinions I have needed nothing more than reliance upon my education and experience and quick review of standard oncology texts." Dr. White also stated, "I am puzzled how the BE (barium enema) was scheduled and performed and the GI evaluation was not. Was the veteran given papers and the responsibility to schedule exams?" (*See* EXHIBIT 34, AT PG. 5-6.)

Ms. Vadman submitted a signed report consisting of two paragraphs and stated in part "A colostomy has been called by many people to be an inconvenience, but not an impediment to their daily activities." (*See* EXHIBIT 34, AT PG. 16.)

The defendant failed to submit a report for Dr. Billingham as required under the Court's Order Setting Trial Date and Related Dates.

IV. QUESTION PRESENTED

Whether this Court should grant Plaintiffs' Motion for Summary Judgment against the defendant, when the defendant's facility, the VA Medical Center and its staff, repeatedly failed to act as reasonably prudent health care providers, under circumstances where the defendant's staff found two distinct pre-cancerous polyps, one in Kyle Stephenson's rectum and the other in his colon, on two separate occasions, and which resulted in the ordering of a gastrointestinal consultation, a flexible sigmoidoscopy, an air contrast barium enema, an endoscopy, and a biopsy, none of which were ever carried out, and were mandatory in order to appropriately evaluate, remove and monitor Kyle Stephenson's pre-cancerous polyps in a reasonably prudent manner, and where the defendant failed to inform and warn Kyle Stephenson of his pre-cancerous condition identified by the

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defendant so that he could make necessary and critical decisions in order to avoid the preventable course of events.

V. EVIDENCE RELIED UPON

This Motion relies upon the pleadings and files herein, the attachments hereto, the Declaration of Kyle W. Stephenson with exhibits; the Declaration of Sidney J. Winawer, M.D., with exhibits; the Declaration of Phyllis A.M. Hollenbeck, M.D., with exhibit; the Declaration of Oliver R. Biggers, M.D., with exhibits; the Declaration of Barney M. Dlin, M.D., M.Sc., with exhibits; the Declaration of Joel C. Konikow, M.D., with exhibits; the Declaration of Joe Jack Davis, M.D., with exhibits; the Declaration of Pankaj Sharma, M.D., with exhibits; defendant's Answer; defendant's Responses to Plaintiffs' Requests for Admission; defendant's Answers to Plaintiffs' Interrogatories; the Declaration of Adam D. Morrow Regarding Conversation with Littlejohn counsel, LR 37 Conference with Defense Counsel and Exhibits.

VI. AUTHORITY AND ARGUMENT

A. STANDARD OF REVIEW

1. Standard Of Review For Summary Judgment.

An order of summary judgment is proper where there are no genuine issues of material fact for trial and the moving party is entitled to judgment as a matter of law. Davis v. Bendix, 82 Wn. App. 267 (1996). See also CR 56(c). The moving party bears the initial burden of showing the absence of genuine issues of material fact. Young v. Key Pharmaceuticals, 112 Wn.2d 216 (1989). A material fact is one on which the outcome of the litigation depends, in whole or in part. Ford v. Hagel, 83 Wn. App. 318 (1996). If the moving party meets this burden, then the non-moving party must set forth specific facts showing there is a genuine issue for trial. Young, at 226. The nonmoving party cannot rely on mere allegations or denials and must produce competent medical

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testimony. Adcox v. Children's Orthopedic Hosp. & Med. Ctr., 123 Wash.2d 15 (1993). The court must consider these facts in the light most favorable to the non-moving party, and summary judgment should be granted, as a matter of law, if it can be said, after considering all of the evidence most favorably to the nonmoving party, that reasonable persons could reach but one conclusion. Davis, at 272.

There are no genuine issues of material fact in the instant case. The defendant has admitted the facts necessary to grant Plaintiffs' Motion for Summary Judgment. The defendant was repeatedly negligent over several years as a matter of law in failing to carry out multiple ordered medical procedures, studies, and consultations, after the defendant had identified two abnormal masses in Kyle Stephenson's colorectal tract, and in failing to inform Kyle Stephenson of the abnormalities found by the defendant, including the failure to inform Kyle Stephenson of the significance of the abnormalities found by the defendant. Summary judgment should be granted as a matter of law.

2. Standard Of Review For Expert Testimony

The general rule in Washington is that in medical malpractice cases, expert testimony is required on issues of standard of care and causation. Reese v. Stroh, 128 Wn.2d 300 (1995). A medical expert must express more than personal opinion and must demonstrate that the expert is familiar with the general standard at issue rather than express a personal professional standard and expectation. White v. Kent Medical Center, 61 Wn. App. 163 (1991). The medical expert must state the opinion with a reasonable degree of medical certainty to take it out of the realm of conjecture and speculation. O'Donoghue v. Riggs, 73 Wn.2d 814 (1968). The reason for the strict requirement of 'reasonable medical certainty' is based upon the requirement of relevancy; medical testimony is simply regarded as irrelevant if the medical expert cannot say, with reasonable medical certainty, what the cause of the injury was. 5C K. Tegland, Wash.Prac., Courtroom Handbook on Washington

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Evidence, 278 (1996). "To defeat a motion for summary judgment, the expert testimony must be based on facts in the case, not speculation or conjecture." Seybold v. Neu, 105 Wn. App. 666 (2001).

Plaintiff has come forward with seven Declarations from highly qualified and respected physicians in the pertinent medical specialties, including the Declaration of Dr. Sidney J. Winawer, who is personally responsible for achieving monumental discoveries in colorectal cancer and its prevention. Dr. Winawer is considered by his peers to be the authority on the colorectal subjects relevant to this lawsuit. In addition, two of plaintiffs' seven experts were Kyle Stephenson's treating physicians who felt duty bound to render expert opinions in this case based on the defendant's repeated negligent conduct. All of plaintiffs' experts have declared this case to be one of the strongest examples of medical negligence they have encountered.

The defendant repeatedly failed to exercise that degree of care, skill, and learning expected of reasonably prudent health care providers under circumstances where two pre-cancerous polyps were identified by the defendant, and the defendant then failed to carry out the procedures ordered and failed to inform Kyle Stephenson of these pre-cancerous conditions.

There are no genuine issues of material fact in this case. The defendant, by fact and by its admissions, was negligent in its medical care and treatment of Kyle Stephenson. The defendant's departures were the direct and proximate cause of Mr. Stephenson's progression from pre-cancerous colorectal polyps into rectal cancer according to all of the credible evidence and testimony available as set forth in this motion and accompanying Declarations. Summary Judgment should be granted as a matter of law.

B. LIABILITY

Colorectal cancer is the second leading cause of cancer death in America. The association

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between polyps and cancer in the medical literature is overwhelming. It is undisputed that the vast majority of colorectal cancers evolve from benign adenomas or pre-cancerous polyps. The adenoma-carcinoma sequence has been discussed and widely accepted in the world medical literature for more than 50 years. Plaintiffs' highly qualified medical experts include Dr. Sidney Winawer, a pioneer in the field of gastroenterology, who held the position of Principal Investigator of the National Polyp Study, and Principal Investigator of the National Colonoscopy Study. Dr. Winawer has confirmed the validity of the adenoma-carcinoma sequence in many textbook chapters and journals, including his landmark paper in the 1993 *New England Journal of Medicine*. (*See* DECLARATION OF DR. WINAWER AT PG. 33, LN. 10-11.)

1. In January 1987, the defendant found an abnormal mass in Kyle Stephenson's rectum, failed to inform him of the mass or its significance, and ordered a flexible sigmoidoscopy, a gastrointestinal consultation, and an air contrast barium enema, and none were carried out

On January 23, 1987, Mr. Stephenson presented to Dr. Courtney Nevitt with a history of rectal bleeding over many years. Dr. Nevitt's record also states, "The patient has never had a workup for this problem and has always assumed that he has hemorrhoids." (*See* EXHIBIT 1 TO MORROW DECLARATION.) During the course of her rectal examination, Dr. Nevitt palpated a mass in Mr. Stephenson's rectum. Dr. Nevitt's March 6, 1987 dictation and transcription for her January 23, 1987 examination stated under the heading PHYSICAL EXAM "Rectal exam: 1cm. x 1 cm. soft, movable mass, probably represents a polyp." (*See* EXHIBIT 1 TO MORROW DECLARATION.) Dr. Nevitt was correct in this statement. Mr. Stephenson had a polyp in his rectum. However, in another document of the medical records she authored for the same January 23, 1987 examination, Dr. Nevitt was unsure whether the mass was a hemorrhoid or polyp. Additionally, Dr. Nevitt had also concluded that the mass was a hemorrhoid, for the same January 23, 1987 examination. The finding of this mass, to a high degree of probability was a polyp, and required careful follow-up, evaluation and

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biopsy. (*See* DECLARATIONS OF DR. WINAWER, DR. SHARMA, DR. DAVIS, AND DR. BIGGERS; AND EXHIBIT 20 TO MORROW DECLARATION.)

Following Kyle Stephenson's abnormal rectal examination, Dr. Nevitt correctly ordered a flexible sigmoidoscopy, a gastrointestinal consultation, and an air contrast barium enema. The VA Medical Center's health care providers failed to perform the flexible sigmoidoscopy, failed to carry out the ordered air contrast barium enema, and failed to carry out the ordered gastrointestinal consultation.

The only test that was carried out by the VA Medical Center's health care providers was a single contrast barium enema, not the ordered air contrast barium enema. For someone with a potentially serious condition, i.e., a palpated rectal lesion, a barium enema without air contrast was an inadequate study for visualizing and examining the rectum for rectal lesions In fact, the lesion was not identified by the barium enema study and the report itself acknowledges the limitation of the single contrast barium enema's ability to identify rectal lesions. (*See* DECLARATION OF DR. WINAWER AT PG. 24, LN. 14-19.)

The sigmoidoscopy, had it been done, would have identified the pre-cancerous polyp in the rectum. Once identified, reasonably prudent medical care required that the polyp be removed and biopsied. The VA and its health care providers were negligent in failing to follow through with the ordered GI consultation, the air contrast barium enema, and the flexible sigmoidoscopy. It was imperative to identify and remove all polyps in Mr. Stephenson's colon and rectum. The abnormal findings required a colonoscopy to fully visualize the rectum, sigmoid, and remainder of the colon. Had this been accomplished, Mr. Stephenson would have avoided the subsequent development of rectal cancer from his pre-cancerous polyp (*See* DECLARATION OF DR. WINAWER, PG. 24, LN. 20 TO PG. 25 LINE 7; DECLARATIONS OF DR. SHARMA, DR. DAVIS, DR. BIGGERS, DR. KONIKOW, AND DR.

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HOLLENBECK, PREVIOUSLY FILED WITH THE COURT; AND EXHIBIT 20 TO MORROW DECLARATION.)

2. <u>In February 1987, the Defendant found a pre-cancerous polyp in Kyle Stephenson's colon that the defendant labeled an "ABNORMAL NEW FINDING" and failed to remove or biopsy the polyp and failed to inform Kyle Stephenson of the abnormality or its significance</u>

On February 5, 1987, a second opportunity arose for the VA health care providers to ensure that Kyle Stephenson receive proper care, and to prevent the progression of his pre-cancerous polyps into cancer.

The barium enema report is stamped in red, bold, capital letters "ABNORMAL NEW FINDING." Such an emphatic label made it incumbent upon the VA health care providers to inform Kyle Stephenson of his medical abnormality and to provide timely and appropriate treatment. The report states the following:

> Single contrast barium enema was performed in the usual manner. There is a 7 mm., smooth, lobulated sessile polyp in the descending colon approximately 15 cm. distal to the splenic flexure. No other abnormality was demonstrated...Please note that small rectal lesions cannot be entirely excluded on this single contrast study. Further evaluation of the polyp in the descending colon by endoscopy and biopsy is recommended. The G.I. resident has been informed of this finding.

See EXHIBIT 3 TO MORROW DECLARATION.

There is no issue that the Barium Enema Report found another separate and distinct mass that was identified as a polyp located in Mr. Stephenson's descending colon. The report also states:

> Further evaluation of the polyp in the descending colon by endoscopy and biopsy is recommended. The G.I. resident has been informed of this finding.

See EXHIBIT 3 TO MORROW DECLARATION.

Inexplicably, and for the second time, the VA's health care providers failed to follow through with a second identified abnormal mass, this time in Kyle Stephenson's descending colon. Following the identification of the second abnormal mass, no VA health care provider ever notified Kyle

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Stephenson or took any steps to carry out any further evaluation by endoscopy and/or biopsy of the polyp in the descending colon, even after the health care providers stated on the barium enema report that, "The G.I. resident has been informed of this finding." (EXHIBIT 3 TO MORROW DECLARATION; DECLARATION OF DR. WINAWER AT PG. 26, LN. 7-11.)

The VA and its health care providers departed from reasonably prudent care by failing to carry out the basic task of following through with its patient after identifying abnormal masses. Evaluation by endoscopy and biopsy of the polyp found in Kyle Stephenson's descending colon was mandatory. At this time, Mr. Stephenson had demonstrated on two different occasions, in two parts of his colorectal anatomy, his proclivity for developing polyps. In addition, Mr. Stephenson's rectal bleeding, a potential sign of cancer, which was known to the VA's health care providers, had not been evaluated and the source of his rectal bleeding was unknown. Reasonably prudent medical care required that the entire length of Kyle Stephenson's colon and rectum be visualized and evaluated by colonoscopy. Any polyps identified during colonoscopy would need removal and histological evaluation, followed by counseling, education, and management of the patient with ongoing surveillance for identification and removal of any future polyps. (*See* DECLARATIONS OF DR. WINAWER, DR. BIGGERS, DR. SHARMA, DR. DAVIS, DR. HOLLENBECK, AND DR. KONIKOW.)

A VA document dated September 10, 2001 states:

> ...The CAPRI record, and the information available on the C&P exam report do not show that Mr. Stephenson was scheduled for the recommended GI consult or notified that an abnormality was found.

See EXHIBIT 19 TO MORROW DECLARATION.

Both of Mr. Stephenson's identified masses were pre-cancerous polyps.

Kyle Stephenson was never informed that he had two abnormal masses in his colorectal tract or given any information regarding the potential significance of these masses. He was repeatedly told

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that his ongoing rectal problems were due to hemorrhoids. (*See* EXHIBITS 1, 5, 6 AND 8 TO MORROW DECLARATION; AND DECLARATION OF KYLE W. STEPHENSON.)

3. On May 15, 1987, the VA issued a rating decision denying Mr. Stephenson disability benefits for hemorrhoids and failed to notice or alert anyone, including Mr. Stephenson of his prior abnormal findings and of the studies that were ordered and not carried out.

The May 15, 1987 rating decision was a third opportunity for the VA and its agents, to rectify its negligent conduct when it reviewed Mr. Stephenson's medical chart. (*See* EXHIBIT 4 TO MORROW DECLARATION) Mr. Stephenson's medical chart required reviewing on this occasion in order to determine whether or not he had hemorrhoids that could be considered to cause him any disability. In reviewing the patient's chart, the VA examiners failed to notify Kyle Stephenson or his VA health care providers that two abnormal masses were previously identified on two different visits, as documented in Kyle Stephenson's chart, along with the studies that were ordered and not carried out.

Again, had the defendant's agents acted in a reasonably prudent manner on this occasion, Mr. Stephenson would have been alerted to his potentially serious medical condition. Reasonably prudent medical care would have been delivered and Mr. Stephenson would have received proper treatment, education, and ongoing monitoring so that his pre-cancerous polyps would not have progressed over six years and transformed into cancer (*See* DECLARATION OF DR. WINAWER, PG. 27, LNS. 9-20).

4. On May 25, 1989, the defendant failed to obtain and review Kyle Stephenson's medical chart and failed to exercise reasonably prudent medical care for Kyle Stephenson

In May of 1989, a fourth opportunity arose for the VA and its health care providers to diagnose, treat, and prevent Kyle Stephenson from developing cancer. Kyle Stephenson once again contacted the VA Medical Center with ongoing complaints of hemorrhoids, with increased bleeding.

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(*See* EXHIBIT 5 TO MORROW DECLARATION.)

On May 25, 1989, Kyle Stephenson presented to the General Surgery Department at the VA where he was seen and treated by a third year medical student (*see* EXHIBIT 6 TO MORROW DECLARATION). As discussed in Kyle Stephenson's Declaration, Dr. Radke's signature appears after the medical student's signature on the medical chart note prepared by the medical student. Dr. Radke did not "personally examine" Kyle Stephenson that day, nor was he present at any time during the examination, despite Dr. Radke's incorrect statement contained in his Declaration that he "personally examined" Kyle Stephenson that day. (*See* DECLARATION OF KYLE W. STEPHENSON.) Dr. Radke makes this claim without any recollection of the events in an effort to avoid the fact that a young, inexperienced medical student examined Kyle Stephenson and attributed a large rectal mass as a "large internal hemorrhoid" instead of the pre-cancerous adenoma, which was in the same location where the malignant rectal mass was found in 1993.

Kyle Stephenson has a clear memory that the man who performed the examination was very young and inexperienced. Kyle remembers this young male to be in his late twenties or early thirties. Dr. Radke was born November 5, 1930, making him almost 73 years old. Fourteen (14) years earlier, in 1989, Dr. Radke would have been approaching sixty years old. No one that age ever saw or examined Kyle Stephenson that day. (*See* DECLARATION OF KYLE W. STEPHENSON.)

Kyle Stephenson also remembers the occasion well because he left that visit very frustrated with the superficial care he received. Kyle went that day to the VA expecting that the health care provider would do something definitive for his longstanding hemorrhoids. Instead, a young male health care provider briefly saw Kyle and prescribed the usual hemorrhoid treatment, consisting of soaking in a bathtub, keeping hydrated, avoiding spices, and applying a salve or a balm. No other person was present in the examining room that day. (*See* DECLARATION OF KYLE W. STEPHENSON.)

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On this occasion, Kyle Stephenson presented as a 46-year-old male with a long history of ongoing rectal bleeding that had been increasing. Based on this history and without the benefit of the critical data contained in Kyle Stephenson's medical chart, the mandatory work-up required a colonoscopy and the cancer would have been prevented. (*See* DECLARATIONS OF DR. WINAWER, DR. BIGGERS, DR. DAVIS, DR. HOLLENBECK, DR. KONIKOW, AND DR. SHARMA.)

The medical record states:

> PROBLEM LIST UPDATED? [ ] YES [X] NO
>
> S: 46 y.o. male in excellent health presents via PEC referral for int. hemorrhoids. Had long history of hemorrhoids treated with tucks, sitzs baths, now worsening since Jan. 89. Increased bleeding with BM, also now protrusion requiring manual reduction. Inquiring about treatment.
>
> O: No ext. tags. Spastic sphincter tone. 1 large int. hemorrhoid at 4 o'clock, some excoriation of anal mucosa by anoscopy. Swollen crypts.
>
> A: 46 year-old male in excellent health with 1 internal hemorrhoids and cryptitis.
>
> P: Metamucil increase stool bulk, hydration, decrease strain, avoid spices, sitz baths.
> RTC 1 month.
>
> H. Miller- UWIII [University of Washington – third year medical student]
> HM Radke

See EXHIBIT 6 TO MORROW DECLARATION.

a. <u>The defendant failed to obtain and review Mr. Stephenson's medical chart and to inform him of his documented colorectal masses.</u>

A basic concept in medicine is for a doctor to obtain and read the patient's medical chart when a patient presents for treatment in order to properly care for the patient. The chart contains the patient's medical history, the patient's pertinent medical conditions, documentation of past medical conditions, medical abnormalities, and medical procedures. Reviewing a patient's chart prior to diagnosing and treating a patient allows the current physician to gain the benefit of the patient's

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critical history and provide continuity of medical care. (*See* DECLARATIONS OF DR. WINAWER, DR. BIGGERS, AND DR. SHARMA.)

If Mr. Stephenson's chart had been obtained and reviewed by the defendant's health care provider on this date, regardless of all prior failures, Mr. Stephenson's rectal cancer would have in all probability, been avoided. In August 2000, when Kyle Stephenson's chart was reviewed by Barbara Williams, a vocational rehabilitation counselor, it was obvious to her that Kyle Stephenson had been diagnosed with an abnormal mass in 1987 that "appeared suspiciously related to his later diagnosis of colon cancer." (*See* EXHIBIT 16 TO MORROW DECLARATION.)

Contained in Mr. Stephenson's chart was Dr. Nevitt's examination of January 23, 1987, which identified the first abnormal rectal mass along with her orders for Kyle Stephenson to have a GI consult and a flexible sigmoidoscopy. Also contained in his chart was the Barium Enema Report, identifying the second "ABNORMAL NEW FINDING", which was the polyp in the descending colon along with Mr. Stephenson's physicians' recommendation for further evaluation by endoscopy and biopsy. All of this information would have been readily available to Mr. Stephenson's health care provider, had he obtained, reviewed and discussed the documented medical conditions with Mr. Stephenson.

May 25, 1989, was four years and three months before Kyle Stephenson was diagnosed with colorectal cancer. If Kyle Stephenson had undergone the required endoscopy, the polyps would have been identified and removed. Following the removal of the polyps, tissue specimens would have been sent to pathology for microscopic evaluation. Most important, once all polyps were removed and pathologically evaluated, Kyle Stephenson would have been given the vital information relative to the significance of the polyps and then appropriately followed in the future with timely colonoscopies. (*See* DECLARATIONS OF DR. WINAWER, DR. BIGGERS, DR. SHARMA, AND DR.

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DAVIS.)

Colonoscopies are the standard screening examination for a person such as Kyle Stephenson who was at high-risk for colorectal cancer because of his pre-cancerous polyps. Had such action been taken, Mr. Stephenson would not have developed the cancer he was diagnosed with six years later in 1993. Mr. Stephenson would have avoided his colostomy, his debilitating peristomal hernia, and his permanent impotency, which resulted from the extensive surgery. He would have also avoided the crippling emotional suffering that he lives with every day of his life. (*See* DECLARATIONS OF DR. WINAWER, DR. BIGGERS, DR. SHARMA, DR. DAVIS, AND DR. DLIN PREVIOUSLY FILED WITH THE COURT.)

Instead of responding appropriately to the history obtained, which was ongoing, increased rectal bleeding and requesting a colonoscopy in order to visualize Mr. Stephenson's colorectal tract, the third year medical student looked at Mr. Stephenson's anal canal with a short instrument called an anoscope. The anoscope, which is a short speculum with limited capabilities, is not an adequate diagnostic scope for evaluating the rectum or colon. (*See* DECLARATION OF DR. WINAWER, PG. 32, LNS. 8-15.)

In looking through the anoscope, the medical student saw a large rectal mass and diagnosed Mr. Stephenson again with a large internal hemorrhoid. Mr. Stephenson was again told of the usual hemorrhoid treatment. He was told to go home, take sitz baths, keep hydrated, take Metamucil, and avoid spices.

Furthermore, the description charted as to the location of the rectal mass "at 4 o'clock" is consistent with an inexperienced medical student. One of the most authoritative textbooks on Gastroenterology is Gastrointestinal Disease by Sleisenger, 14th ed. (1989). On page 1573, under the heading "EXAMINATION OF THE ANORECTUM" the following is stated,

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> The location of anal lesions around the circumference should be described anatomically; reference to the face of a clock is confusing because it depends on the patient's position.

Another authoritative Gastroenterology textbook is The Textbook of Gastroenterology by Yamada, 2nd ed. (1995). On page 2027, the following is stated under the heading "ANORECTAL EXAMINATION",

> Lesions should be described with regard to their anatomic location. Clockface descriptions are confusing unless patient position and orientation are specified.

The history that Kyle Stephenson provided as contained in the medical record of May 25, 1989 corroborates Kyle Stephenson's lack of awareness that VA health care providers had identified two abnormal masses and ordered critical studies in 1987. From the beginning of his interaction at the VA Medical Center on January 23, 1987, with Dr. Nevitt, until his last health care visit on May 25, 1989, Mr. Stephenson's medical records demonstrate that he was repeatedly told that his ongoing rectal problem was due to hemorrhoids.

At every step of the way, the defendant's health care providers failed Kyle Stephenson. Despite identifying two abnormal masses, and ordering critical tests to work up and treat Kyle Stephenson, the defendant's health care providers repeatedly let Kyle Stephenson fall through the cracks. On each occasion where Kyle Stephenson presented to the VA Medical Center, the defendant's health care providers had the ability to remedy their prior carelessness and prevent the tragedy from occurring. Not only did the defendant's health care providers commit repeated careless errors, they also failed to supply Kyle Stephenson with the critical information relative to their findings so that he could have taken matters into his own hands to prevent the tragic transformation of a benign rectal polyp into a malignant rectal tumor.

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b. **Rectal bleeding is presumed cancer in a 46-year-old male until ruled out with appropriate studies.**

The Textbook of Gastroenterology by Yamada, 2nd ed. (1995), states at pg. 1920:

> **Rectal bleeding, especially in patients older than 40 years of age or those with other risk factors, should never be ascribed solely to co-existing hemorrhoids without a thorough evaluation of the colorectum.**

As was the case on January 23, 1987, once again, Kyle Stephenson presented to the VA Medical Center on May 25, 1989 with an ongoing history of rectal bleeding. Kyle Stephenson's rectal bleeding was due to benign bleeding polyps, which over time, grew, transformed into cancer, and became ulcerated. (*See* DECLARATION OF DR. WINAWER, PG. 30, LN. 20 TO PG. 31, LN. 4; AND EXHIBIT 21 TO MORROW DECLARATION.)

On this occasion, Mr. Stephenson presented to the Surgery Department where the health care provider obtained the history of ongoing, increased rectal bleeding.

Reasonably prudent medical care required that a colonoscopy be carried out on this patient with his clinical picture in order to adequately visualize the colon and rectum. The rule for rectal bleeding is that it is to be considered cancer until ruled out by appropriate studies. (*See* DECLARATIONS OF DR. WINAWER, DR. BIGGERS, DR. SHARMA, AND DR. DAVIS.)

The etiology of rectal bleeding cannot be determined to be secondary to hemorrhoids based on an anoscopy and/or a digital rectal examination, (*See* DECLARATIONS OF DR. BIGGERS, DR. WINAWER, DR. DAVIS, DR. KONIKOW, DR. HOLLENBECK, AND DR. SHARMA). Yamada's The Textbook of Gastroenterology, 2nd ed. (1995), pg. 2030, also states,

> However, hemorrhoids should not be considered the source of hematochezia until other potential bleeding sources in the colon and rectum have been investigated...a flexible sigmoidoscopy or, if clinically appropriate, a full colonoscopy should be performed. Occult bleeding should not be attributed to hemorrhoids. Occult blood in the stool deserves a complete evaluation regardless of the presence of hemorrhoids.

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In addition, an anoscopy is inadequate for visualizing colorectal lesions or masses. A colonoscopy has been the gold standard since the 1970's for properly visualizing the rectum, the sigmoid and the remainder of the colon. The colonoscopy is the procedure necessary to look for a source of rectal bleeding, and to remove any identified colorectal polyps or lesions. (*See* DECLARATION OF DR. WINAWER, PG. 31, LN. 14-17.)

The "large internal hemorrhoid at four o'clock" visualized by the medical student, was to a high degree of medical probability, the same mass palpated by Dr. Nevitt in January of 1987, and was the rectal cancer found in 1993. (*See* DECLARATIONS OF DR. SHARMA, DR. WINAWER, DR. DAVIS, AND DR. BIGGERS.)

Hypothetically, had a "large internal hemorrhoid at four o'clock" existed in May of 1989, the diagnosis of a hemorrhoid would fail to provide the requisite information to the health care provider as to whether or not Mr. Stephenson also had a possible cancer or pre-cancerous polyps in other parts of his rectum and/or colon. Mr. Stephenson had at least two polyps as of May 25, 1989.

The defendant's multiple attempts to claim that the **rectal mass** palpated by Dr. Nevitt in 1987 was the "large internal hemorrhoid" noted by the medical student and not the rectal mass that was diagnosed as rectal cancer in 1993, omits one very important fact. The barium enema in February of 1987 found another pre-cancerous polyp in Mr. Stephenson's colon. No VA health care provider told Kyle Stephenson about the abnormality that was stamped in red, bold, capital letters "ABNORMAL NEW FINDING", and no VA health care provider followed through by removing this pre-cancerous polyp. Had this occurred, Mr. Stephenson would have been followed with timely colonoscopies to visualize his entire colon and remove any polyps. Had the defendant exercised reasonably prudent care with respect to the identified and documented pre-existing colon polyp, Mr. Stephenson would have avoided the transformation of his other pre-cancerous rectal polyp into rectal

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cancer. With timely colonoscopies, Kyle Stephenson would not have gone six years while a pre-cancerous rectal polyp transformed into a large 5 cm rectal cancer.

5. <u>On June 29, 1989, the defendant again reviewed Kyle Stephenson's medical chart and again failed to notify Kyle Stephenson of his documented abnormal colorectal masses</u>

On June 29, 1989, Kyle Stephenson's medical record states, "Chart Review", "Hemorrhoids under Rx", "Failed to Report", and "Reschedule." The medical record was signed by HM Radke – Chief of Surgery (*see* EXHIBIT 8 TO MORROW DECLARATION).

Even though the June 29, 1989 medical chart note states Kyle Stephenson's chart was reviewed by the Chief of Surgery, Dr. Radke, no VA health care provider, including Dr. Radke, notified Kyle Stephenson about the two documented abnormal colorectal masses found by the VA in 1987, which were the basis for ordering the multiple tests, studies, and gastrointestinal consultation.

Dr. Radke's "Chart Review" as the Chief of Surgery was the eleventh (11) time the defendant failed to act as a reasonably prudent health care provider going back to January of 1987. Dr. Radke completely missed the documented abnormal colorectal masses and the multiple healthcare failures in his review of Kyle Stephenson's medical chart.

The defendant has now come forward in the litigation and taken the position that Kyle Stephenson's missed clinic visit on this one occasion prevented the VA health care providers from notifying Kyle Stephenson of his two abnormal colorectal masses, and prevented the VA health care providers from removing the pre-cancerous rectal polyp before it transformed into rectal cancer. The defendant has not only blamed Mr. Stephenson for the preventable tragedy, the defendant has also made inflammatory comments regarding Dr. Joe Jack Davis, plaintiff's treating colorectal surgeon.

Defense expert, Dr. David A. White, stated in his two-page report,

> It is true that the discovery of multiple villous adenomas in 1987 (or 1989) would likely have prevented the progression to rectal cancer and

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> subsequent colostomy…I find missed opportunities in seeking care and actions that were irresponsible by the veteran. The content of the 9/27/00 consultation report by Joe Jack Davis, MD is disturbing as I find it irresponsible on his part and clearly incendiary…I find his consultation rather worthless medically and inappropriate for its content and opinion.

See EXHIBIT 34, AT PG. 6, TO MORROW DECLARATION.

The defendant and its experts have now come forward, lashing out and making unprofessional comments regarding Kyle Stephenson and his treating physician, after the defendant's health care providers committed approximately a dozen repeated departures from the standard of care over a period of several years. The defendant makes these assertions after Dr. A.J. Thompson, the reviewing physician who was retained by the defendant to evaluate the defendant's care of Kyle Stephenson, unequivocally and honestly told the defendant that the VA failed to timely diagnose and treat Kyle Stephenson, which caused the progression of his pre-cancerous rectal polyp into rectal cancer. The defendant makes these assertions after previously admitting in a VA document that Mr. Stephenson was not notified of his colorectal abnormalities. The defendant makes the assertion with respect to the June 29, 1989 missed appointment despite this last blown opportunity by Dr. Radke who claimed he reviewed Mr. Stephenson's medical chart, but completely failed to pick up the documented, critical information and notify Kyle Stephenson. The defendant also makes this assertion despite Dr. Radke's failure to "Reschedule" Kyle Stephenson for another appointment for his "Hemorrhoids under Rx", a diagnosis Kyle had been carrying for years and which the VA health care providers repeatedly told Kyle was the sole basis for Mr. Stephenson's chronic ano-rectal problems.

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C. **The VA medical center and its health care providers' repeated departures from reasonably prudent medical care, more likely than not, was the cause of the progression of Kyle Stephenson's pre-cancerous polyp into cancer**

1. The 1 cm. mass palpated by Dr. Nevitt in January of 1987, to a high degree of medical probability, was a pre-cancerous polyp that slowly grew and transformed into the 5 cm. cancerous mass that was diagnosed in August of 1993.

The pathology report dated September 3, 1993 confirms that the 5 cm cancer came from a pre-existing polyp or adenoma, stating the following:

> Tumor arises in pre-existing villous adenoma.

See EXHIBIT 13, AT PG. 2, TO MORROW DECLARATION.

The pathology report confirms that Mr. Stephenson's cancer began as a polyp before it transformed into a malignant tumor. It is well known and medically understood that not all polyps develop into cancer. In fact, most polyps do not eventually develop into cancer. However, most, if not all, colorectal cancers begin as pre-cancerous polyps or benign adenomas. This is called the adenoma-carcinoma sequence. (*See* DECLARATION OF DR. WINAWER, PG. 33, LN. 3-7.)

The time frame for a polyp to develop and grow large enough to transform into cancer is 10-12 years. (*See* DECLARATION OF DR. WINAWER AT PG. 33, LN. 16-17, Principal Investigator of the National Polyp Study.) Given the 6-year time frame from 1987 to 1993, it is highly probable and consistent with the natural history of colorectal cancer, that the rectal mass palpated by Dr. Nevitt in 1987 was the rectal polyp or adenoma that subsequently transformed into the large 5 cm rectal cancer that was diagnosed in 1993. Not only was the rectal polyp present in 1987 when Dr. Nevitt palpated the rectal polyp during her examination, it would have been present for years prior to 1987. (*See* DECLARATION OF DR. WINAWER AT PG. 33, LN. 16-21.)

For the defendant to assert that there was no rectal polyp in 1987 and that the large rectal mass felt in 1989 was a "large internal hemorrhoid" and therefore no rectal polyp was present in Mr.

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Stephenson's rectum, defies basic principles of medicine, and the established, understood, and accepted medical knowledge regarding the length of time it takes for a benign polyp to transform into cancer. The following description is apt:

> Pathological estimates, plus observations from the U.S. National Polyp Study, indicate that it takes a relatively long time, 10-12 years on average, for a polyp to develop, grow to a clinically significant size, and degenerate into a gross cancer. Therefore, there is ample opportunity for screening and surveillance methods to detect the developing neoplasm while it is still clinically benign and easily treated...The chance to interfere with or interrupt the adenoma-carcinoma sequence is called 'secondary prevention', and is an opportunity that is somewhat unique among the major malignancies. This clinical opportunity adds a major component of urgency to screening and surveillance strategies.

European Journal of Cancer (1995) (*See* DECLARATION OF DR. WINAWER AT PG. 34.)

Once Mr. Stephenson's polyps were removed, he would have then undergone regular monitoring for future polyps by timely colonoscopy. Had these reasonably prudent steps occurred as they should have occurred, Mr. Stephenson would not have developed cancer and his subsequent colostomy, impotence, and hernia would have been avoided. (*See* DECLARATIONS OF DR. WINAWER, DR. SHARMA, DR. BIGGERS, DR. DAVIS, DR. KONIKOW, DR. HOLLENBECK, AND DR. DLIN, PREVIOUSLY FILED WITH THE COURT.)

D. <u>The Defendant failed to timely disclose the identity of its expert witnesses as required under FRCP 26(a)(1) and FRCP 26(2)(A)</u>

Disregard of a court order without reasonable excuse or justification is deemed willful. Allied Financial Servs. v. Mangum, 72 Wn. App. 164, 168, 864 P.2d 1, 871 P.2d 1075 (1993) (*citing* Lampard v. Roth, 38 Wn. App. 198, 202, 684 P.2d 1353 (1984)). Nondisclosure of a witness is deemed willful absent a reasonable excuse. Falk v. Keene Corp., 53 Wn. App. 238, 251 (1989). The trial court does not abuse its discretion by excluding the testimony of witnesses a party has willfully (without reasonable excuse or failing to supply any reason for noncompliance) failed to disclose as

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required by court rule or court order. No showing of prejudice to the opposing party is required in order for the sanction to be imposed. Allied Financial Servs., *supra*, at 168, 169. Violation of an explicit court order without reasonable excuse must be deemed willful Anderson v. Muhundro, 24 Wn. App. 569, 574 (1979), Taylor v. Cessna Aircraft, 39 Wn. App. 828, 836 (1985). The trial court does not abuse its discretion in deciding to exclude a witness who was not timely disclosed as required by the case schedule when the failure to disclose was willful Dempere v. Nelson, 76 Wn. App. 403, 407 (1994).

Fed. R. Civ. P. 26(1)(a) is the federal rule requiring mandatory initial disclosures of "the name and, if known, the address and telephone number of each individual likely to have discoverable information that the disclosing party may use to support its claims or defenses..."

Fed. R. Civ. P. 26(2)(A) states,

> *Disclosure of Expert Testimony:*
> In addition to the disclosures required by paragraph (1), a party shall disclose to other parties the identity of any person who may be used at trial to present evidence under Rules 702, 703, or 705 of the Federal Rules of Evidence.

In the instant case, the Court's Order Regarding Initial Disclosures required disclosure on April 25, 2003 (*see* EXHIBIT 27 TO MORROW DECLARATION). The plaintiffs disclosed the identities of all witnesses, including the identities of expert witnesses to the defendant pursuant to the Court's Order and the Federal Rules (*see* EXHIBIT 28 TO MORROW DECLARATION). The defendant failed to list a single expert witness (*see* EXHIBIT 29 TO MORROW DECLARATION).

On June 2, 2003, plaintiff's counsel wrote to defense counsel notifying him that the defendant did not disclose the identity of any expert witnesses pursuant to the Court's Order and the Federal Rules, and requested that the defendant disclose its expert witnesses. (*See* EXHIBIT 30 TO MORROW DECLARATION).

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On June 11, 2003, defense counsel responded by letter stating:

> In response to your first question regarding the disclosure of experts, please be advised that the United States has to date, not secured experts, and therefore, is not in a position to disclose expert testimony or identity.

See EXHIBIT 31 TO MORROW DECLARATION.

Plaintiff's counsel responded by letter dated June 12, 2003 requesting to confer under Fed. R. Civ. P. 37 regarding Defendant's failure to disclose the identity of any expert witness. (*See* EXHIBIT 32 TO MORROW DECLARATION). On June 17, 2003, the parties conferred pursuant to Fed. R. Civ. P. 37 and Local Rule 37 W.D. Wash. Defense counsel again stated he had not secured any expert witness to date, he would furnish plaintiff's counsel with the identity of any expert witnesses when he retained expert witnesses, and that he did not have a requirement to disclose the identity of expert witnesses.

The defendant disclosed its experts six months past the Court's April 25, 2003 deadline for disclosing the identity of expert witnesses.

Plaintiff respectfully requests that the defendant's disclosure of expert witnesses at this stage of the litigation be stricken as untimely and defendant's expert witnesses be excluded.

E. <u>The Defendant failed to submit an expert report for Dr. Billingham as required by the Court's scheduling deadline</u>

The Court's Order Setting Trial Date & Related Dates listed October 22, 2003 as the deadline for expert reports.

On October 22, 2003 plaintiffs filed with the Court and served defendant with copies of nine signed and dated expert witness reports.

On October 23, 2003 plaintiffs received a document from the defendant entitled "United States' Disclosure of Expert Witnesses." The defendant disclosed the identity of the following three expert witnesses: 1. Dr. David A. White – Oncologist; 2. Laura Vadman, C.E.T.N. – Enterostomal

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Therapist; 3. Dr. Richard P. Billingham – Colon and Rectal Surgeon.

Dr. White submitted a signed report. Ms. Vadman submitted a signed report. The defendant failed to submit any report for Dr. Billingham.

The defendant has had almost a year to obtain signed expert reports, including a signed expert report from Dr. Billingham. Plaintiffs' counsel has written several times to defense counsel and convened a rule 37 conference requesting the defendant disclose its expert witnesses when the defendant refused to comply in April 2003. For six months, defense counsel ignored plaintiffs' requests stating the defendant would be submitting expert reports as required by the due date of October 22, 2003 pursuant to the Court's Order. The defendant then failed to furnish plaintiffs with the required signed expert report of Dr. Billingham without any reasonable excuse, an act deemed willful under Washington law. Plaintiffs respectfully request that the defendant be precluded from using Dr. Billingham as an expert witness.

F. Plaintiffs have supported its position with respect to the defendant's negligence with statements made by Dr. A.J. Thompson, a Board Certified Gastroenterologist, hired by the defendant to evaluate the defendant's care of Kyle Stephenson; Dr. Thompson's statements underline the defendant's lack of candor in its defense of the case

In response to Plaintiffs' Interrogatory No. 14 which requested the name, job title, and address of the person who conducted the February 20, 2002 examination and opinion with respect to the care Kyle Stephenson received at the Seattle VA, the defendant Answered in part:

> Defendant objects to the premise which is implicit in the question; namely, that an opinion was issued "with respect to the care Kyle Stephenson received at the Seattle VAC." On the contrary, the VA records examination report dated February 20, 2002, was not directed to the question of fact, which is at issue in the present litigation.

See EXHIBIT 25 TO MORROW DECLARATION, *emphasis added.*

On a document dated September 10, 2001, the defendant specifically asked Dr. Thompson to answer the precise question that is at issue in the present litigation by stating:

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> Veteran is claiming compensation based on VA failure to furnish proper medical care following VA Comp and Pen exam in January 1987 and barium enema done in February 1987, which found soft, movable, rectal mass and guaiac positive stool. No record of GI consult found on CAPRI. Veteran underwent abdominoperineal resection for carcinoma in 1993.
>
> **Please provide your medical opinion, with reasoning, on a more likely as not basis, as to whether or not VA failed to timely diagnose and properly treat the rectal mass in 1987, and that this caused the continuance or natural progression of Mr. Stephenson's rectal cancer.**

See EXHIBIT 19 TO MORROW DECLARATION, *emphasis added.*

In response to the precise question that is at issue in this litigation, Dr. Thompson made the following statement:

> We are asked to determine if the VA failed to timely diagnosis and properly treat the rectal mass found in 1987, and if this caused the continuance and natural progression of Mr. Stephenson's rectal cancer.
>
> **Yes, the VA failed to timely diagnosis and properly treat the rectal mass found on rectal examination in 1987, which progressed to rectal cancer, requiring abdomino perineal resection of the rectum.**

See EXHIBIT 20 TO MORROW DECLARATION, *emphasis added.*

Dr. Thompson also stated on February 20, 2002 the following:

> On a more probable than not basis the recurrent rectal bleeding noted in the service in 1970 was due to benign bleeding polyps, which subsequently became larger, became ulcerated, and underwent malignant transformation...

See EXHIBIT 21 TO MORROW DECLARATION.

In response to Plaintiffs' Requests for Admissions, the defendant subsequently denied that Dr. Thompson correctly stated on a more probable than not basis that Kyle Stephenson's benign polyps became larger, ulcerated, and underwent malignant transformation. (*See* EXHIBIT 26 TO MORROW DECLARATION, REQUEST FOR ADMISSION NO. 66 & NO. 67). This particular denial is

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difficult to understand when the surgical pathology report dated September 3, 1993 unequivocally states, "Tumor arises in pre-existing villous adenoma." (*See* EXHIBIT 13 TO MORROW DECLARATION.)

G. The defendant's reliance on Littlejohn v. United States of America is misplaced

As a means to avoid the statements made by Dr. A.J. Thompson, the defendant also cited Littlejohn v. United States of America, 321 F.3d 915; 2003 U.S. App. LEXIS 3890 (9th Cir. 2003) stating:

> The United States admits that the file review cited in Request for Admission No. 64 was done and an opinion was issued. However, the United States objects to the use of such opinion as evidence in litigation under the Federal Tort Claims Act. See: Littlejohn v. United States of America, F.3d 915; 2003 U.S. App. LEXIS 3890 (9th Cir. 2003).

See EXHIBIT 26, AT PG. 16, LN. 15-19, TO MORROW DECLARATION.

Attached for the Court's convenience is a copy of Littlejohn, *supra* (*see* EXHIBIT 36 to MORROW DECLARATION). Defendant's reliance on Littlejohn is misplaced and incorrect. In Littlejohn, the plaintiff incorrectly attempted to assert claim and issue preclusion against the defendant in a subsequent FTCA claim based on the defendant's prior award of disability benefits by the VA. The Court held that the rating decision and the prior award of disability benefits given to the veteran by the VA did not bar the litigation of liability issues under the doctrines of claim and issue preclusion in a subsequent FTCA action because claim and issue preclusion are incompatible with the statutory purposes underlying the veteran's disability and FTCA statutory schemes, different burdens of proof are required, and the VA was unable to raise its causation defense.

Plaintiff agrees with the holding in Littlejohn, *supra*. However, plaintiff is not asserting claim or issue preclusion in this case based on the VA's prior rating decision or award of disability benefits. Furthermore, Littlejohn's holding, contrary to defendant's statement above, did not state

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that an expert retained by the defendant to answer the exact question at issue in the subsequent FTCA litigation, and whose opinion as to liability and causation was based on a "more probable than not" or "a more likely than not basis", was inadmissible as evidence.

To the contrary, while the Littlejohn court denied plaintiff's theories of claim and issue preclusion, the VA rating decision was before the court and admitted into evidence. (*Please see* DECLARATION OF ADAM MORROW WITH RESPECT TO PRIOR CONVERSATION WITH LITTLEJOHN'S COUNSEL.) The prior VA rating decision was the central piece of evidence the court looked at in deciding findings of fact.

While plaintiffs agree with the Littlejohn holding that the VA rating decision should not act as a bar to the subsequent FTCA litigation, the defendant is incorrect as to its interpretation of the court's holding. Dr. Thompson's liability and causation opinions, which relate to the precise question at issue in this case, and which are based on the same required burden of proof, are pieces of important, relevant evidence. The fact that the defendant refuses to acknowledge and give credence to Dr. Thompson's prior statements relative to the same question at issue in the present litigation also demonstrates the defendant's lack of candor as to matters that cannot reasonably be disputed.

VII. CONCLUSION

Plaintiffs respectfully request the Court grant Plaintiffs' Motion for Summary Judgment against the Defendant because there are no genuine issues of material fact regarding the Defendant's repeated, ongoing failures over several years, to carry out the required gastrointestinal consultation, flexible sigmoidoscopy, air contrast barium enema, endoscopy, and biopsy as ordered by the defendant in order to appropriately evaluate, treat, and monitor Kyle Stephenson's pre-cancerous rectal and colon polyps in a reasonably prudent manner, which would have prevented the

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development of cancer from a pre-cancerous rectal polyp, and to inform and warn Kyle Stephenson of his pre-cancerous condition identified by the defendant so that he could make necessary and critical decisions, which he had an absolute right to know about, in order to prevent the progression of his pre-cancerous rectal polyp from developing into rectal cancer.

RESPECTFULLY SUBMITTED this 6 day of November 2003.

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