Doc 69

IN THE CIRCUIT COURT OF RUTHERFORD COUNTY
MURFREESBORO, TENNESSEE

NANCY GORMAN and Husband, GERALD GORMAN, Plaintiffs,	)	
vs.	)	NO. 31218
ELIZABETH LAROCHE, M D., Defendant.	)	

The Deposition of: DR. JAMES L. BOERNER
August 30, 1994

RESHA * BLACK
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The deposition of DR. JAMES L. BOERNER was taken by consent at 2095 Lascassas Pike, Murfreesboro, Tennessee, beginning at 1:30 p.m., on August 30, 1994.

All formalities as to notice, caption, and certificate are waived. All objections, except as to the form of the questions, are reserved to the hearing.

A P P E A R A N C E S:

For the Plaintiffs:

Mr. Douglas S. Johnston
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217 Second Avenue, North
Nashville, Tennessee 37201

For the Defendant:

Mr. Thomas Lawrence
Attorney at Law
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200 Fourth Avenue, North
Nashville, Tennessee 37219

DR. JAMES L. BOERNER,

called as a witness, having first been duly sworn, was deposed as follows:

EXAMINATION BY MR. JOHNSTON:

Q. Dr. Boerner, my name is Doug Johnston. I represent the plaintiffs in this matter that's been brought against Dr. LaRoche. Let me first ask you if I'm pronouncing your name correctly.

A. It's Boerner, just like a gas burner.

Q. And that's B-o-e-r-n-e-r?

A. Yes.

Q. Would you, for the record, tell us the address of where we are, please, sir.

A. It's 2095 Lascassas Pike.

Q. And this is your home?

A. Yes.

Q. Doctor, do you have a current CV?

A. No, I don't.

Q. Do you have a CV at all?

A. No.

Q. What I'm going to do this afternoon, Dr. Boerner, is to ask you a few questions about the testimony which it is proposed that you are going to provide in this matter, I want to be sure

that before you answer any question that I ask you, that you understand exactly what it is that I'm asking you, and if you don't, please stop me and I'll attempt to put that in a form that you do understand.

Let me also say -- turn that around and tell you that if you answer me in a way that I don't understand, I'm going to ask you to put that more into layman's terms. I'm not a medical doctor, I have not studied medicine, and I, in many cases, do not understand medical terms. And while I'm going to try as best I can to understand your answers, I want to be sure that I do and I don't want to just guess.

A. Sure.

Q. Let me start by asking you, sir, how long have you known Dr. LaRoche?

A. I've known her as long as she's been in town, however long that's been, when she moved here, which probably would have been about '85 or '86, I'm guessing. But it's when she started the practice of medicine at Middle Tennessee Medical Center.

Q. At that time were you associated with Middle Tennessee Medical Center?

A. Yes, I was.

Q. Are you now?

A. Yes.

Q. So you are a colleague of hers; is that correct?

A. We practice at the same hospital. Yes, I would assume that. We're not associated, but yes, we practice in the same specialty.

Q. Is this professional relationship that you've had with Dr. LaRoche the only kind of relationship that you've ever had with her?

A. Yes. I mean, we live in the same town, we'll see each other at what we call these group parties where you find 500 of your most intimate friends, but as far as have I been in any civic clubs with her or anything like that, no. I don't attend the same church, just, you know, I'll see her at the hospital and that's basically it.

Q. You all don't have any sort of a relationship outside of the work environment?

A. No.

Q. Okay. Prior to this afternoon, have you ever provided expert testimony in a medical negligence case?

A. Yes, I have.

Q. On how many occasions have you provided testimony in medical negligence cases?

A. As an expert witness?

Q. Yes.

A. One that I can remember.

Q. And when was that?

A. That was a long time ago, six, seven years ago. It was a case involving a woman in Manchester or Shelbyville that ate a McDonald's hamburger that had a roach on it and had some medical problems associated with that and wanted to know how much really could be related to her ingesting a roach and how much was psychosomatic from the trauma of it.

Q. And were you asked to testify as an expert for the plaintiff or the defendant in that case?

A. The defendant.

Q. McDonald's, I guess?

A. Yes. I gave a deposition. That's as far as it went.

Q. In any other kind of a case, any case at all, have you been asked to testify as an expert?

A. No.

Q. Have you ever provided deposition testimony, other than in this McDonald's case?

A. In medical malpractice, once I've been involved in -- well, no, there's been a couple. It was a case in '82 or '83 where one of the professors where I did my training was involved in a malpractice suit. I could never really find out whether I was still involved in it or not. I had to go testify. The case was settled in favor of the professor.

Q. What do you mean when you say you've been involved in this?

A. Well, they called me a week before it went to trial and said that I was one of the defendants in it. I had never been served any papers, never any depositions, they just called up and said the case is going to court and you're one of the people at fault. So I called my carrier and talked to them about it and they thought it seemed sort of fishy, and I never did get a straight answer. I went up and testified and we won the case, but reading between the lines, I think I was involved because he was Egyptian and didn't speak real well and couldn't convey what was going on, and they wanted someone who could communicate. So

I went up, they paid for my plane ticket. I didn't understand it either.

Q. Where was this?

A. Cleveland, Ohio.

MR. JOHNSTON: They do things a little differently in Cleveland than here.

MR. LAWRENCE: Off the record.

(Discussion held.off the record.)

Q. Other than that case, have you provided deposition testimony in any situation?

A. Yes. I've been involved in two malpractice cases of my own that I've had to give depositions for, and testimony.

Q. You mean involved as a defendant?

A. Yes.

Q. What was the most -- what was the first of those, sir?

A. First was a rectovaginal fistula.

Q. Can you spell that, please?

A. R-e-c-t-o-v-a-g-i-n-a-1 f-i-s-t-u-1-a. And the first was a hung jury and the second one their expert witness got sick, and then the third time we tried it we won..

Second was a lost sponge where the nurse had counted that they were all there and they

weren't. And I was held 20 percent responsible on that.

Q. Is that a recent case?

A. Three years ago -- two years ago.

Q. Do you know who the plaintiff's lawyer was on that last case?

A. No, I sure don't.

Q. Where was it tried?

A. It was tried here.

Q. What was --

A. Murfreesboro.

Q. What was the patient's name that brought the suit?

A. Dyer, Peggy Dyer.

Q. Who were the other defendants?

A. The nurses involved, and there were three, and then Middle Tennessee Medical Center.

Q. Do you remember who the first named defendant was?

A. Sure can't.

Q. Do you remember the plaintiff's lawyer in the first malpractice case, the one that you tried three times?

A. Oh, that was Tom Parsons in Manchester, and Walter Bussart.

Q. In either of those cases, do you recall who any of the experts were for the plaintiff?

A. He was an osteopath in Manchester, but he left -- in fact, he even left before it went to trial and I can't remember what his name was.

Q. Other than these two cases in which you've been a defendant and those that you've told me about already, have you ever provided deposition testimony in anything else?

A. No. A traffic accident once, that's it.

Q. Dr. Boerner, do you have a file that you've created on this case for this case?

A. No.

Q. Do you have documents that you've been provided or that --

A. Yes.

Q. -- or that you have created?

A. No documents that I've created, and the only documents I have are the depositions that Mr. Lawrence has given me.

Q. Tell me which depositions you've been provided.

A. LaRoche's, Gorman's, Nancy Gorman's

and her husband's, and Howard Cohen's, and then the office files of all the stuff involved, LaRoche's, Westmoreland's, Wertz's, Corlew's.

Q. Anybody else? Any other doctors that you have files from?

A. No.

Q. Just those four?

A. Yes.

MR. LAWRENCE: Let me just make a statement for the record. I know that I have sent Dr. Boerner some pleadings and maybe the complaint and answer, and also the Rule 26 that summarized the testimony of the plaintiffs' experts, and he does not have those with him here.

Q. Who was the first person to contact you about any aspect at all of this case?

A. Mr. Lawrence.

Q. When was that?

A. I really don't have a recollection. I would say -- I would say maybe six, eight weeks ago. I can't give you a specific date.

Q. That's fine. Prior to this first contact with Mr. Lawrence, had Dr. LaRoche discussed the matter with you at all?

A. No.

Q. She hadn't asked you if you would consider doing this?

A. No. I didn't even know she had a malpractice case pending.

Q. And when Mr. Lawrence contacted you on this first occasion, what were you told about what the circumstances were?

A. Basically that Dr. LaRoche had a malpractice case pending against her and would I be willing to review the chart and possibly give a deposition, review the notes and give my opinion of whether her care was reasonable standard care.

Q. And then 1 assume you did those things?

A. Yes.

Q. Between the time of your first contact with Mr. Lawrence and the time that you rendered your opinion, I assume you were provided some or all of the materials that you've got here in front of you and that we've already talked about.

A. Yes.

Q. And when those materials were provided to you did you receive any other information from any source whatsoever about any

aspect of this case?

A. No.

Q. So at the time that you rendered your opinion to Mr. Lawrence, the sole sources of your information came from the depositions and the medical charts that you've described and the first. conversation that you had with Mr. Lawrence?

A. I believe at that time it was the medical -- the medical records and the information that Mr. Lawrence gave me, I really at that point had not reviewed any of the depositions. In fact, the depositions I think I received maybe 10 days ago.

Q. Okay. After you had already told him what you had thought?

A. Yes.

Q. Did the material in any of those depositions in any way change any of the opinions that you originally provided to Mr. Lawrence?

A. No.

Q. Do you believe or is it your opinion that the material in those depositions supported the opinions that you provided?

A. There was some agreement and some disagreement.

Q. Are you able to point out to me the areas of disagreement that you're making reference to?

A. Well, there were several. I guess I could start with specifically the -- as to some of the -- I guess the biggest disagreement would be with Dr. Cohen and how he felt things should be approached and specifically what he feels is standard care and what I feel is.

Q. Well, that part I can understand and I'm going to get to that in a little bit, but --

A. I figured you would.

Q. What I really, I guess, am looking for is whether or not you found areas of disagreement with any of Dr. LaRoche's testimony.

A. No.

Q. All right. Have you been provided from any source whatsoever any information about this case that is not in your, I'm going to refer to it as your file, but I understand what you're saying about that --

A. Sure, yes.

Q. -- and which you've not already told me about, or which Mr. Lawrence has not stated on the record?

A. What I have are the medical records. There were some answers -- I don't have the proper term for all this stuff because I certainly don't understand the legal aspect of all of this, but some of my answers -- there's a doctor in Nashville, OB/GYN, I saw his -- some of his answers, comments, after I had reviewed things, but most of it's just the depositions,

MR. LAWRENCE: May I make another comment?

MR. JOHNSTON: Sure.

MR. LAWRENCE: Well, the only other thing that occurred to me when he said that is that he has also seen the pleading supplemental response to interrogatories that we filed in which we summarized his and our other expert.

Q. Okay. As long as we're bringing that up, let me just hand this to you. What I've got in my hand is a copy of the interrogatory response in which you are named as an expert --

A. Yes.

Q. -- in this case, along with two other doctors, one of whom I'm guessing is the person you're making reference to in your last answer to me. And if I'm correct, please let me know.

A. Yes, yes, yes.

Q. Okay. And when you were making your statement that you had received some comments about this other doctor, is this the document or a copy of the document that you were making reference to?

A. Yes, I believe so. Yes.

MR. JOHNSTON: Let's make his response Exhibit Number 1.

(Interrogatory response marked as Exhibit Number 1 and filed as a part of this deposition.)

Q. Other than those contacts that we've discussed with Mr. Lawrence, have you had any contacts whatsoever in regard to any aspect of this case with Dr. LaRoche?

A. No, none.

Q. Have you had any contacts with any of the other doctors named in what we've designated as Exhibit Number 1?

A. No, no, no. In fact, I've never talked to either one of these ever,

Q. Do you know either one of them?

A. No.

Q. Have you had any conversations or any contacts with any other person relative to any

aspect of this case?

A. No.

Q. At any time have you informally discussed any aspect of this case, whether or not you indicated that you were involved in it, with any colleague, just to seek an opinion or to bounce off an idea or anything of that type?

A. No.

Q. I'm not attempting to be repetitive in my questions but I do want to make sure that I've taken care of everything that I can think of on this point. Let me just ask you point-blank, have you discussed the case with anyone who has indicated to you that Dr. LaRoche was negligent in any way?

A. No.

Q. What is your financial arrangement with Mr. Lawrence or whoever in providing your expert testimony in this case?

A. Specifically how much an hour?

$150.

Q. For anything and everything?

A. Yep.

Q. And can you estimate approximately how many hours you have put into this case so far

A. I'd have to look at some calendars.

Q. Are we talking about an hour or two or are we talking about something longer than that?

A. Certainly more than five, less than 10.

Q. Have you ever provided expert evaluation, whether or not it ever went to testimony of any kind, for Mr. Lawrence or his firm?

A. No.

Q. Have you ever provided expert evaluation for any lawyer or law firm prior to --

A. Other than the ones I described earlier.

Q. Okay. Have you submitted a bill to Mr. Lawrence for payment of anything to date?

A. No.

Q. So you've not received any payment?

A. No, I have not.

Q. Do you know who Dr. LaRoche's malpractice insurance carrier is?

A. Yes.

Q. Is that the same malpractice insurance carrier that you have?

A. Yes. I think it's the same one tha

80 percent of the doctors in this state are insured with.

MR. LAWRENCE: I assume we have a standard caption,

MR. JOHNSTON: Sure. Oh, yes. I understand.

Q. Let me get back to Exhibit Number 1 for just a moment. This exhibit names three doctors as potential experts for Dr. LaRoche, yourself included. A substantial part of this several-page response deals with these other doctors. Let me ask you about that which deals with your proposed testimony, if I could.

A. Okay.

Q. Who prepared the language that is included there regarding your proposed testimony?

A. Mr. Lawrence and I did.

Q. You and Mr. Lawrence?

A. Yes. We discussed it and -- group effort.

Q. Did you prepare something in writing that you provided to him?

A. No. We just discussed this,

Q. Over the phone and then --

A. And in the office several times.

Q. In person?

A. Yes.

Q. Okay. And then subsequent to those discussions, Mr. Lawrence or someone on his behalf provided you a copy of this proposed language and you had an opportunity to review it?

A. Yes.

Q. Is that correct?'

A. Yes.

Q. And when you were first provided a written copy of your proposed testimony, did you make any changes in it?

A. I can't really remember. We discussed several of the paragraphs.

Q. So you don't know whether you made changes or not before it was finalized?

A. I would say there were -- it's hard. Certainly I want to give the best answer I can. 'We had a copy that was provided to me. We discussed this and came up with this, okay. So exactly what was changed, I can't remember, because I certainly didn't take any notes when we -- with the first one.

Q. In formulating any opinions that you may hold in this case, did you make reference to

any medical texts?

A. No.

Q. Whether or not you made reference to any medical texts, when you rendered your opinions in this case or formulated your opinions in this case, did you rely on your knowledge of any particular medical text?

A. Not any particular text. Testimony coming from 17 years of practice in being an obstetrician/gynecologist. We read.several magazines, several publications, but to name one specifically, no.

Q. What are some of the magazines that you regularly read as a part of your professional development?

A. Something that's called "The Green Journal," which is obstetrics and gynecology. There is also "Contemporary OB/GYN." There's a publication, I'm not sure exactly what the -- it's published by the American Cancer Society. Its publication comes out several times a year on different topics, different types of cancer, how they're approached. But I'm hot sure of the specific title of that journal.

Q. I believe you indicated that in

addition to several magazines that you regularly read as part of your professional development, there may also be other professional publications that you would also review on a more or less regular basis.

A. Those are the journals I review on a regular basis.

Q. All right. Let me go back just a minute since we're talking about professional development and that sort of thing and ask you some other questions about your background since I neglected to do that on the front end. You indicated just a moment ago that you've been in practice for 17 years?

A. Let's see, I've been -- including my training -- I graduated from medical school in '77, so 17 -- yeah, 17 years.

Q. Where did you go to medical school?

A. University of Louisville, Louisville, Kentucky.

Q. That was in '77?

A. Yes.

Q. And where did you do an internship -- internships?

A. Well, the program was at Case Western

in Cleveland, Ohio, and it was a combined residency program of four years. We had -- it wasn't a formal internship but we had six months general surgery, internal medicine, high risk pediatrics all sort of rolled into six months of that six months of OB/GYN, and then second, third and fourth year was straight OB/GYN.

Q. When you completed that residency program at Case Western, where did you go?

A. I came here to Murfreesboro.

Q. What is it that led you to Murfreesboro?

A. I wanted a somewhat large town, which it wasn't, but I didn't find that out till I got here, outside a big city. I grew up in Owensburg, Kentucky, and liked the flavor of the town and stumbled onto Murfreesboro about six months before Nissan came, and it's been nice ever since.

Q. This would have been --

A. '81.

Q. '81?

A. Yeah.

Q. Have you either authored or helped to author any articles published anywhere which deal with the diagnosis or treatment of breast cancer?

A. No. No, I have not,

Q. Let me jump back now to where we were before I got off onto this background material. We were talking about various texts and I was asking you about texts that you may have either referred to or relied upon in formulating your opinions in this case, and I think you've indicated to me that there are no specific texts that you either referred to or relied on, Am I accurate about what I just said?

A. Yes.

Q. Okay. Regardless of what you may or may not have referred to or relied upon, are there any medical texts which you can tell me about which would support any of the opinions which you have formulated in this case?

A. I would have to say most of the information would come out of the journal articles, the journal articles being more recent and more up to date than the published textbooks.

Q. I understand what you're saying and I'm not -- I don't want to argue with you about that but I don't think that really answers the question that I asked you. I'm not suggesting that there's something there that you've specifically

referred to or relied on in formulating the opinions that you hold in this case, What I'm asking you is are you familiar with any particular text which you believe supports the opinions that you have formulated or that you hold in this case?

A. I can't specifically give you a name' of a book that's going to support -- support my opinions.

Q. Okay. So at the trial of this case, then, you have no intention as of right now of making any reference to a specific text or saying --

A. No.

Q. -- here's the standard of care or here's this or here's that and this supports my opinion. You're not going to do that?

A. No.

MR. LAWRENCE: Well, I guess I'll have to say something here. The way you first asked that question, you said he has no intention at the present time of doing that, and I don't have any objection to that statement, Whether or not we make a decision at this point to utilize references to texts would be a trial decision, and so I'm going to object to the form of the question to that

extent.

MR. JOHNSTON: Well, I understand that.

Q. I guess what I'm trying to do here -- I mean, this is my only opportunity to ask you any questions, and if you can think of a particular text out there that at some later point you might recommend to Mr. Lawrence as being something that would support your opinions, then I need to know about that now. I mean, anything at all that might be supportive is really what I'm asking you, if you're generally familiar with such texts.

A. Okay. Well, certainly, you know, texts in my training. You have Williams Obstetrics. Let's see, there's a Schwartz book on surgery I used to read a lot. Sabiston. I think that's it.

Q. Okay. Are you generally familiar with any medical texts which would support the proposition that Dr. LaRoche was negligent in some aspect of her care and treatment of Mrs. Gorman?

A. Do I know of a specific text that -- no, I don't.

Q. Are you familiar with a work by Drs. Donovan and Spratt entitled "Cancer of the

Breast"?

A. I vaguely -- that was brought up because that came out in some of the depositions, and I'd have to go back and look. I think Spratt was at one time at the University of Louisville when I was there, but I don't know that for a fact.

Q. During the course of these proceedings, have you gone to review any of the -- any portion of that work?

Q. If I characterized the Donovan and Spratt work as being authoritative, would you agree or disagree with my characterization of that work?

A. I think it's a pretty good textbook, okay. But whether it's the end authority, I'm not sure I'd characterize it that way.

Q. Can you tell me why not?

case is that -- that is the evaluation and recognition -- recognition, evaluation and early treatment of problems with breasts, specifically breast lumps, breast masses, breast cysts, however you want to characterize them, and without knowing specifically -- it's hard to -- without having read the book to know exactly what I'm going to agree and what I'm going to disagree with.

Q. Okay. I want to make a statement to you and I'm going to ask you if you agree or disagree with that statement.

A. Okay.

Q. The statement is, breast cancer survival rates could be increased if cancers were diagnosed at an early stage. Do you agree or disagree with that statement?

A. I think that the best knowledge we have today I would agree that the earliest the diagnosis -- and this is non-specific instances taking several thousands of patients. If you factor -- pick a number, 10,000 patients, the sooner you make the diagnosis in those 10,000 patients, statistically your chances of survival or cure are probably improved.

Q. All right. Let me try to

recharacterize your answer.

A. Okay.

Q. That's what I'm doing, I'm telling you up front, and if you disagree with my recharacterization then just say so because what I'm really trying to do is not put words in your mouth but try to understand what you said. In response to the specific question did you agree or disagree with the statement, would it be fair for me to say that you generally agree but that there might be specific instances where that would not be true?

A. What I'm saying is if you take 10,000 patients and look at their -- the time of diagnosis, the time of treatment, the type of therapy, that the sooner the diagnosis is made the more likely of improved treatment, improved survival. I guess what I'm trying to get away from is that I think there's a time between diagnosis and treatment that weeks, days, may not be critical. So I think if you're taking a large mass of people, that yes, statistically your chances are going to be improved.

Q. Let me give you another statement and you tell me if you disagree with this one.

A. Okay.

Q. A mass in the breast of a woman of any age is suspect until its nature can be established.

A. I think any mass found in the breast is suspect until it can completely be evaluated and a final diagnosis is made,

MR. JOHNSTON: Can you read his answer back, please?

(Requested portion of record read.)

Q. Following up on that answer, if an OB/GYN in Murfreesboro, Tennessee, failed to take the steps to evaluate and properly diagnose any given breast mass, would that failure deviate from your understanding of the recognized standard of accepted professional practice for OB/GYNs?

THE WITNESS: Can you read that back?

(Requested portion of record read,)

A. I feel there's certainly different steps, different modalities for evaluating breast lumps, breast masses, but I fee that for someone who doesn't completely evaluate a breast lump, breast cyst, yes, would deviate from the standard of care.

Q. Okay. Where a pa ient presents to an

OB/GYN in Murfreesboro, Tennessee, with a palpable breast mass, does the recognized standard of acceptable professional practice for OB/GYNs in Murfreesboro require that OB/GYN to take steps. which would rule out the existence of cancer?

MR. LAWRENCE: Object to the form.

A. I think with standard of care that a doctor in Murfreesboro needs to evaluate that breast lump or lumps, and there certainly are several ways to do that. Specifically it is not necessarily something that needs to be -- needs to have a final conclusion that day but certainly to where there are steps that need to be taken that needs to come to a final diagnosis.

Q. All right. Let me -- I think I know what your answer is to my question, but I'm not certain. Let me ask you to do this, and I'm not -- I don't want to attempt in any way, shape, or form to limit your testimony. Maybe in response to that question if you can tell me yes or no and then explain it.

(Brief interruption.)

Q. Let me back up just a minute and make a clarification. I think I heard in your answer a reference to possible time periods and all of that,

and specifically my question did not include time. I'm not trying to restrict my question or your answer to any particular time period. I'm simply asking you if the recognized standard of acceptable professional practice requires an OB/GYN who has a patient who's presented with a 'palpable breast mass to take steps over some period of time which would ultimately rule out the existence of cancer.

A. Yes.

Q. Okay. Now, then the second part of that question then is does the recognized standard of acceptable professional practice for OB/GYNs in Murfreesboro, Tennessee, require such steps to be taken in a timely manner?

A. Yes.

Q. Okay. And in responding to that question specifically, what would your definition of the word "timely" be?

A. Well, that's varied, It depends on your clinical judgment, when you do the exam. I think to say that a patient's going to present herself and either she feels the lump or you feel the lump and that the meter starts running and you're going to make a diagnosis within three mont , I don't think you can really say that, I

think you have to tailor your standard of care to the situation. So certainly I think there's a timely -- there is a definite time factor that needs to be addressed, but I don't think you can -- I don't think that's hard and fast in every situation.

Q. Okay.

A. I mean, it's not. It's just not.

Q. I want to come back to that in just a minute, but let me ask you, we've been using the term, or I've been using it in my questions and I assume you've been using it in your answers to those questions, the term, the recognized standard of acceptable professional practice, and specifically I've been making reference to that recognized standard in Murfreesboro, Tennessee, but as we are discussing timely steps towards a diagnosis of breast cancer or not, would the accepted -- would the standard of care be different in Murfreesboro, Tennessee, as opposed to Nashville or Atlanta or New York or anywhere?

A. Not having practiced in those areas, I really can't make any comment as to the standard of care in any other situation than basically Middle Tennessee. I would not think that the

standard of care between here and Nashville would be that much different versus even possibly -- I could go as far as Nashville, because kno doctors there, I've gone up to conferences there and I have a pretty good idea as to how they practice., but to make a judgment as to the standard of care in Washington, D.C., or San Francisco or Cleveland or -- well, Cleveland, I could -- Atlanta, that would not be a fair call.

Q. Why would there be such a difference, if there is one?

A. Well, I don't know if there is. For me to say that -- I would hope that they would approach things the same way, but that's a different locale and different training and whether they're going to order a mammogram first or do CBC first or however, they possibly might have a different way of approaching things.

Q. Okay. I understand that part and I'm not -- I'm really not trying to be as specific as that just yet. I'm really trying to stay -- I think the series of questions we've gone through have been very general. We haven't really nailed down specifics, what a person should do first or second or third, and there may be disagreements as

to that sort of thing. What I'm really asking about is this standard of care that we've defined which is simply that where a patient presents to an OB/GYN with a palpable breast mass, and we've already established that where that occurs, the OB/GYN is required to take some timely steps towards an ultimate diagnosis, ruling in or ruling out the existence of breast cancer.

A. Okay.

Q. Okay. And just that general standard that we've talked about without plugging in the specifics where there may be some disagreement, as a general proposition, would you expect to find any difference in that standard?

A. I would not expect to find any difference, but again, for me to testify on the standard of care in a place I've never practiced, I'm not sure how fair that is. But I would assume that things would generally be the same.

Q. In your experience, they are basically the same here in Middle Tennessee and they would be the same in Cleveland, Ohio?

A. Yes.

Q. Okay. Let's talk about some of the specifics that might be required. In your opinion

as an OB/GYN practicing in Murfreesboro, Tennessee, where a patient presents with a palpable breast lump, what are the steps that are required of you?

A. Well, the requirement for the breast lump is to make a timely diagnosis, and even taking it to the final step that you need to rule out malignancy.

Q. Would you agree that the one and only way to determine absolutely if a suspicious mass is or is not cancer is through histological exam?

A, Yes.

Q. Under what circumstances would histological exam not be required when a patient presents with a palpable, suspicious breast mass?

A. Well, I think the real crux of the answer to your question is that how suspicious, how alarmed the physician is when they examine, discuss the symptoms with the patient, and evaluate the problem. To answer -- to get to the meat of the question, though, histological diagnosis is going to be the only way -- if you have a palpable mass that in a timely fashion is being evaluated and is still present, then the only way you're going to make a definite diagnosis is to do a biopsy, histological diagnosis,

Q. I think you may have answered this question in that answer, but just to be sure, let me follow up and ask it directly. What are the indications for biopsy?

A. My indications for biopsy is a breast lump that is either highly suspicious in shape, consistency, basically physical exam, possibly would warrant biopsy. One, a mass that has undergone evaluation through a mammogram or an ultrasound that is suspicious for malignancy, or finally, in a timely fashion a breast mass that no matter what the following, the mammogram, the ultrasound findings were, if a mass is still present, in a timely fashion then it needs to be biopsied, needs to undergo histological evaluation.

Q. Okay. I want to ask you a whole lot of things about what you just told me. Let me -- let me start with one of the first things that you said in that answer, and that was one of the indications for you for biopsy would be a situation in which a breast lump was, I think your words were highly suspicious as a result, of the physical examination.

A. Yes.

Q. Shape, consistency, that sort of thing. Can you be a little bit more specific and tell me what are some of the things that you would look to to determine if in your mind a breast lump was, as you said, highly suspicious?

A. Shape, consistency, mobility, basically -- size doesn't have a lot to do with it. But I guess it can. You know, I hate to get into really concrete, but certainly size, shape. Is it irregular, is it smooth, are the --

Q. Smooth meaning --

A. Smooth edges. Does it have the consistency, spongy, is it rock hard, is it fixed, non-mobile to where you can't move it? These all would be things that would enter into how suspicious things are.

Q. Okay. In regard to the shape, would you say that where a breast mass is more regular in shape as opposed to irregular, that is more indicative of the possibility of cancer or less?

A. Less. When it's very irregular I'd be more concerned about cancer. And the irregularity is usually pretty marked, it's spindle-shaped projections and this sort of thing. Usually a smooth mass is not going to be as

suspicious.

Q. One with smooth borders is generally not as suspicious as one where borders are not completely smooth, correct?

A. The smooth borders certainly would be more reassuring.

Q. And in regard to mobility, the more fixed it is, the more suspicious it is?

A. Yes.

Q. You also indicated consistency. How would you -- what do you mean by that?

A. How they're going to feel through the layers of tissue. Good example, if you put a grape and a rock under three or four layers of towels, they're going to feel different. One's going to feel more cystic, the other one's going to feel hard, granular. Even how you could move those shapes or consistencies under two or three, you know, layers of towels. If you put two or three towels down over a rock, you'd be able to -- or over a grape, you could move it around a lot easier than you could trying to push a rock, piece of gravel.

Q. To any extent at all, were any of the indications that you have just described to me

present when Mrs. Gorman presented to Dr. LaRoche on February the 20th of 1991?

A. Let me review that just to make sure. The one that -- the office visit where she presented to Dr. LaRoche and Kim Baker saw her, no. From reading the notes, I did not feel that that would have -- certainly would warrant thorough workup, but nothing in that note would tell me that I ought to walk this patient down to a surgeon to be evaluated. So the answer, no.

Q. Okay. She indicates here that the borders are not completely smooth. That means that it could be suspicious, correct?

A. Well, as I said, my answer, certainly things need to be followed up and they need to be evaluated. And like with any lump, it's something that I'm not going to be completely relaxed until A, it's either gone away, or it's been biopsied. But nothing in that note would make me think that that day when she came in she had cancer.

Q. And that really isn't my question.

A. Okay.

Q. My question is, where she indicates here the borders are not completely smooth, that would be something that could raise a suspicion in

a reasonable OB/GYN that possibly this is cancer, not necessarily that *you* have **to** rush down for anything, but that could raise a red flag, couldn't it?

A. That flag wouldn't be any different than her walking through saying I've got a lump in my breast.

Q. Well, in fact, that's what she did. She says I have a lump in my breast and that lump has borders that are not completely smooth --

A. Yep.

Q. -- and it's not completely mobile.

A. Yeah.

Q. Correct?

A. Yes.

Q. So all of these things taken together, it could be that this is a suspicious mass, correct?

A. Well, it's suspicious when she walked through the door. Does this make it any more suspicious? To me, no. In a thin individual that -- and again, I wasn't there. All I can do is sort of read between the lines on this, and I really feel that what **she** was describing, Kim Baker, when she examined -- what she's describing

again doesn't put at the head of'the list that she's got cancer.

Q. It certainly doesn't indicate that she does not have cancer, does it?

A. No, it doesn't.

Q. And we've already established, haven't we, that where we have a situation such as this one where Mrs. Gorman appeared at that office on February the 20th of 1991, it was incumbent upon Dr. LaRoche to take steps to rule out the existence of cancer.

A. Yes.

Q. Okay. And obviously as a result of this initial examination, the physical examination on February the 20th, that could not be done, could it?

A. No.

Q. All right. Where a biopsy is indicated, either -- for any of the reasons that you have provided to me, when should it be done?

A. I feel a biopsy ought to be done after doing an evaluation and after timely observation that the mass in question can only be diagnosed as either being malignant or nonmalignant by doing the biopsy. So I guess what I'm saying is

there are certainly certain steps that can be taken to try and reassure both the patient and the physician that either this may be nonmalignant, may be malignant, and after those steps have been taken, that if the mass is still there, it needs to be biopsied.

Q. All right. And over what period of time are we talking about as a general proposition that these steps need to be taken?

A. I think it all starts with a physical exam. I think if you do a physical exam and are highly suspicious and you feel a rock hard, fixed nodule in a breast in someone who has a strong family history and you're very concerned that that patient possibly has malignancy, she needs to have it biopsied soon. Soon, I would think that's something that ought to be arranged within a week, 10 days, okay. I think if you do a physical exam -- and I think a lot of good information can be gleaned from a physical exam, and if someone who does a lot of breast exams, feels comfortable with their exams and is not highly suspicious for a malignancy, that still other tests need to be done to back this up. And probably the most common test would be to do a mammogram. And that would need to

be arranged in a timely fashion.

Q. What is the purpose of mammography once a patient has presented with a palpable breast mass?

A. In my judgment, the mammogram is going to give you information that either is going to somewhat reassure you or somewhat concern you. Specifically doing a mammogram, if you do a -- you've done a physical exam, which is somewhat reassuring but again it's not -- I mean, you're feeling a lump that's there. So right off the bat you know that you need a diagnosis, but certainly doing a mammogram they're looking for calcium, looking for distorted architecture, looking for things that are going to make you more suspicious to possibly proceed a little quicker to a biopsy, or is going to be reassuring to the point that one could say that the physical exam -- the lump's there, it's not very suspicious, the mammogram's reassuring, let's let this patient cycle through her hormones and see if this is possibly a cyst that's going to go away on its own.

Q. Okay. Let's talk about that for just a second. As you've just indicated, it might be appropriate for a patient who presents with such a

mass to cycle through her hormones to see if the mass either decreases in size or disappears, correct?

A. Yes.

Q. And when *you* say cycle through her hormones,. basically what you're talking about is going through a menstrual cycle.

A. Yes.

Q. A complete menstrual cycle, correct?

A. Yes, that's true. Basically from the menstrual period all the way through the different phases to where it would go through a complete cycle.

Q. So what period of time then are we talking about there?

A. Well, it certainly varies from woman to woman ranging anywhere from, I'd say probably 26, 28, up to -- some people that are overweight or underweight will have periods -- you know, it's not unusual, I probably see one a day that is in excess of 32, 36 days, between the start of her period to another start of her period.

Q. Okay. Let's say then that after 35 days, just to provide as wide a possibility as we could, from the date that a person first presents

to the OB/GYN with a palpable breast lump, that that 35-day period passes and the breast lump is still there. Where does that put you?

A. I think at that point that, given enough time to cycle, that the patient needs to reevaluate her mass, whether it's still there, the symptoms, and basically if it's still there, which is what you're asking, then it needs to be reevaluated.

Q. And in reevaluated, what do you mean? What do you do?

A. Would be to have the patient come back and to reexamine the breast and see if, in fact, the patient really is feeling the same lump, has it decreased, has it gotten bigger, and then making a decision how to proceed with the evaluation.

Q. All right. Well, let's just say -- I'm just throwing this out as a proposition. Let's say that in this particular case a patient presents with a breast lump, the office determines that in fact there is a lump, that there are some suspicious aspects to that lump but not'such that would require immediate biopsy, but there are some, that they allow that to cycle through a full

period, and then 35 days later that lump is still there but it's not gotten any larger, where does that put you?

A. I think that patient needs to be seen back for evaluation.

Q. How long?

A. You know, I guess what you're asking for is how long a period between the time you feel the lump and the time that that patient ought to undergo a biopsy, and, you know, with someone who's had a hysterectomy, it's a little more difficult to know -- recent hysterectomy -- can probably follow their cycle pretty closely, but someone who's had one several years ago isn't going to have the menstrual flow to remind them what's going on and that's going to be a little more difficult. I would think even with a negative mammogram, that six to eight weeks from the time of examining the breast lump, they need to consider doing a biopsy.

Q. Okay. And that would be true, would it not, sir, even if in the interim, a mammogram was done that was negative?

A. Yeah. I think if from the time of the diagnosis that -- you know, eight weeks down the road, if it's still there, if it can be felt

either by the patient or the doctor, that mass needs a histological diagnosis.

Q. At various places in these proceedings, the mass that was in Nancy Gorman's breast when she presented on February the 20th of 1991, has been described as a dominant mass. What' is your understanding and definition of the phrase "dominant mass"?

A. It's a -- it gets down to fibrocystic disease, which is going to feel sort of lumpy and cystic to begin with, but a dominant mass is one that possibly is a little more prominent, a mass that has been picked up by the patient, diagnosed -- not really diagnosed, but has been noticed by the patient. You know, 65, 70 percent of all the breast lumps are found by the patient, and it's a mass that is sort of set apart from the rest of the breast.

Q. Okay. So it would be an accurate designation to say that Mrs. Gorman presented on February the 20th, 1991, with a dominant mass?

A. I don't -- you know, I -- I guess I would rephrase it. That she has a palpable mass. The mass that's there -- I'm not trying to confuse things, but I don't use that terminology, okay. A

mass is a mass and it's there and you identify it the best way you can, you describe it the best way you can, and, you know, size and shape and consistency means a whole lot more to me than a dominant mass. I mean, you know, to me it doesn't give me much information so why put it in the record.

Q. It's just a different way of saying the same thing?

A. Confusing things, yeah.

Q. In conducting an examination of a patient, whether she presents with a breast mass or not, is it important -- excuse me, not important, let me scratch that word -- is it helpful for the doctor to have done prior examinations on this particular patient? Obviously that can't happen when you have a new patient, but certainly in subsequent and follow-up appointments that can be done. Is that something that's helpful?

A. Yes and no. I think it comes down to more nuts and bolts of this because, you know, a patient comes in and she feels a mass and shows it to the doctor. In fact, you know, it's a whole lot easier to say just instead of examining the breast, show me what you feel. And they'll show you what

they feel and then you can examine the breast. And it's certainly somewhat helpful but I don't think, end result, the therapy's going to be different, because a mass is a mass is a mass. And if you've got a mass, you know, you're going to do the mammogram, you're going to give it a timely period, you know, depending on how suspicious things are, you know, and I guess the thing about it, too, is -- I'd like to back up a little bit.. On the six to eight weeks thing, I think that's still a general point, or a general time frame, but depending on what you find from all your tests determines how quickly you're going to jump into things. But the end result is still going to be if the mass is there, you're going to have to have a histological diagnosis. So whether you've examined them six or eight times or for the first time, a lump is a lump.

Q. What I want to ask you in this next series of questions, Doctor, is not necessarily your opinion about what anybody else could have done or should have done or anything. What I want to ask you is what you would do under the set of circumstances that I'm going to lay out in my question, and specifically what I'm going to try to

do is make it as close to the circumstances that I know about in this case as I can.

A. Okay.

Q. Let's assume that Mrs. Gorman had been your patient since 1986 and that in 1991, after basically two, maybe three yearly appointments with you in which you had conducted breast exams, given her specific instructions on what to do and pretty much followed the routine that was followed by Dr. LaRoche and Mrs. Gorman, according to her chart.

A. Yeah, according to her chart she was seen twice a year.

Q. I understand. When she presented in February of 1991, would you have had a nurse practitioner perform the exam or would you have done that yourself?

A. Well, I don't have a nurse practitioner that works for me, so that wouldn't be an option. But, you know, throughout I think nurse practitioners are qualified, they do a good job. I hate to say it but I think it's the wave of the future --

Q. I'm not suggesting that's not the case, I'm really not. All I'm -- if I'm

understanding these records correctly, on February the 20th of 1991, that was the first and only time that Kim Baker ever performed any such exam on Mrs. Gorman.

A. Yes.

Q. And this was also the first and only time that Mrs. Gorman made an appointment prior to her next scheduled appointment because of the finding of a new breast mass. And I guess my question is, would -- I guess if you don't have a nurse practitioner you wouldn't have used her at all. Let me change that question just a bit and ask you, was that an appropriate thing to do given that set of circumstances, or not?

A. I think it was appropriate.

Q. Would it have been a better practice for Dr. LaRoche to have done the examination herself, given that set of circumstances?

MR. LAWRENCE: Before he answers, let me -- I'm going to object to the form of the question, particularly to the use of the term "appropriate," but you can answer it.

A. Well, you know -- let me -- a couple of things. One thing, too, is -- and then I'll answer the question, too, is that she really didn't

come just for the breast lump. She had some other things; vaginal discharge, which was even the first -- because I was on the wrong page, but in February of '91, she came to see LaRoche, Baker, whoever, for a vaginal irritation, which when it comes to vaginal irritation, urinary tract infections, a lot of things, and I won't call them basic or simple or anything like that, but a pretty common complaint of -- and, you know, the question is, you know, which did she really come to -- in fact, she says comes in with, you know, a couple of complaints and even, you know, addresses the first one as the vaginal discharge.

So I can't even tell you -- I don't know whether anybody can -- she came to the office with a vaginal discharge, oh, by the way I've had this lump in my breast. So to say should LaRoche have done it, would that have been a better approach, I don't think so. I think the way it was handled and the way that Baker was doing the exam, I don't have any problem with it. You know, I've done some precepting, you know, whatever, when I first came to town. I've worked with nurse practitioners in the health department and still have some dealings with them now because they don't

have a physician there all the time and they're constantly calling for questions and evaluations and that kind of thing. So, you know, I think in certain circumstances, and I think this is one, that it's an acceptable practice.

Q. Let's move to the referral for mammogram, Would you agree that you, as an OB/GYN, cannot rely on a mammogram to rule out the presence of cancer?

A. No, you cannot. I think they're very helpful, but certainly the only one going to tell you when you've got cancer is a pathologist.

Q. Sure. And, in fact, there is a recognized false-negative rate in mammography, is there not?

A. Yes.

Q. Do you know what that false-negative rate is?

A. Well, there's different -- the one that I really adhere to is 10 to 15 percent -- 15 percent.

Q. And that's really for all women, isn't it?

A. Yeah. Just like you can take -- you'll find breast cancer in one out of every nine

women -- well, that's between 13, and, you know, 85. So again, you get back to these statistics and --

Q. Do you know whether or not that false-negative rate may be higher for women under 403

A. Some people think it is, but not everybody adheres to that. So I'm a little skeptical of that. But I know that these are some people that do feel that it is.

Q. There are studies that have indicated such things?

A. Yes.

Q. Where a patient presents with a palpable breast mass, the reliance on mammography to rule out cancer would deviate from the recognized standard of acceptable professional practice for OB/GYNs in Murfreesboro, Tennessee,' wouldn't it?

A. To make the diagnosis of cancer, I guess you could say you could make a diagnosis of cancer moving towards a biopsy, throw it up, say boy, that really looks bad and we need 'to do a biopsy, but to look at a mammogram and say I can tell you it's not cancer, you can't do that.

Q. And to do that, to rely on that so as to rule out cancer would deviate from the recognized standard of acceptable professional practice?

A. Yes.

Q. And in fact -- well, I don't want to be unfair to you. I was going to say that wouldn't matter to you whether you were in Murfreesboro or anywhere else. You don't know of anyplace anywhere in this country where to --

A. Nobody is going to make a diagnosis of cancer without a histological diagnosis. I mean, that's -- and I think it's fair to say that you could find that anywhere.

Q. Okay. Let's go back to Exhibit Number 1. And if you want to refer to them, please do so. It may have been a while since you actually read them over. Let me ask you, first of all, are all of the opinions that you hold in this case about with which you expect to testify included in this interrogatory response?

A. I would guess so. I mean, I can't tell you what kind of questions I'm going to be asked, whether, you know --

Q. Well, let me just ask you if you'll

take a minute to read through that, and if there's some opinion that you've developed --

A. Of the opinions in here, no, I feel pretty comfortable with this.

Q. Well, let me make sure that we're addressing the same issue here.

A. Okay.

Q. If there is an opinion that you have formulated in the course of this lawsuit and which you think you are going to testify or which you expect to testify but which is not included in there, please tell me what it is.

A. I couldn't think of anything.

Q. Okay. As we sit here today, everything you expect to testify to is included in that interrogatory response?

MR. LAWRENCE: Doug, I'm going to have to object to the form of the question, because when you use the term everything you expect to testify to --

MR. JOHNSTON: Well, every opinion --

MR. LAWRENCE: That would require me to go back and help Dr. Boerner redraft a more detailed and very lengthy document. You see what I'm saying --

MR. JOHNSTON: I understand. Every opinion. There may be details about opinions that, you know, don't have to be included in the response, obviously. That's up to me to ferret out.

Q. What I'm looking for is a specific opinion that you've formulated in this case and that you reasonably expect to testify to at the trial. Is there something that meets that but that is not included in that interrogatory response?

A. (Witness shakes head.)

Q. You're shaking your head. Is that a no?

A. No, I don't think there's any other opinion than what is in here that I'm going to testify to.

Q. Okay. The first sentence under your portion up there indicates that it is your opinion that there was no deviation from the recognized standard of acceptable professional practice on the part of Dr. LaRoche and her care and treatment of Mrs. Gorman during this period of 1991, from February 20th onward at all. Am I correct?

A. Yes.

Q. No deviation whatsoever?

A. No.

Q. Now, you've already indicated to us earlier that in your opinion a six- to eight-week period following the presentation with a palpable breast lump is the reasonable period of time in which biopsy should be ordered. Have I stated that correctly?

A. Yeah, and I made that statement and I've thought about it a little bit and it's hard to put, you know, this timely fashion, okay, and -- and using -- I guess when I made that comment I was using general circumstances, you know. Certainly there will be times that you can go in and examine a breast lump that you might even go a little longer than that, and certainly there's going to be times you're going to be more suspicious and do less than that. So for me to put a specific time on -- it would be a general time and I think a good number might be eight weeks. But yet if it was done sooner or done later, I still think that's within the standard of care. Would I let it go three months? Probably not.

Q. All right. Let's talk about that. Tell me what the circumstances would be in which you would feel comfortable letting a palpable

breast mass go without biopsy for longer than six weeks.

A. I would feel comfortable with -- with a negative mammogram, a somewhat reassuring physical examination, someone who doesn't have a strong, strong family history of breast cancer. A lady comes in and says well, my mother died at 55 of breast cancer and I've got a sister that six months ago was diagnosed with breast cancer, and that patient came in that day and said I feel a lump, yeah, I would be very concerned about that. But to have someone who comes in without a real strong family history, with a relatively reassuring physical exam and a reassuring negative mammogram -- really not reassuring but a negative mammogram, I'd want to give her enough time to cycle to see if this is going to go away,

Q. But we've already established that a full cycle would really be 35 days. Why would you need to go through longer than one full cycle?

A. Well, because not everybody ovulates every single month. You know, 35 was your number. You know, trying to be realistic -- you know, again, it's your level of suspicion. And to have someone very heavy, very thin, who does not ovulate

every single month, may go two months without ovulating.

Q. Of course Mrs. Gorman didn't ovulate at all, correct? Is that correct?

A. I'd have to look.

Q. Let's assume, just assume for a moment. Let's just take the general situation in which a patient has presented and is postmenopausal.

A. Okay.

Q. What's the purpose of delaying for longer than three or four weeks even?

A. Well, again, postmenopausal is someone who is -- usually referring to someone who's past the magic number of 50, one that is having no hormonal cycle. But of course the other flip side is you're dealing with someone who's older and as people get older they're more likely to develop any type of cancer. Certainly a5 you get older your immune system breaks down to where you're going to be more prone to having cancer.

Q. Does it make any difference in this case whether or not Nancy Gorman went through menstrual cycles or not?

A. As far as using that as a Landmark to

know whether she's cycled and is going to have the hormonal changes during her period.

Q. All right. And if she does not, then what would be the purpose in her case of going beyond a physical examination?

MR. LAWRENCE: I object to the f rm of the question. It presumes a fact that's not in evidence.

A. I didn't know whether they ever took her: ovaries or not, which I presume at her age they did not, so she would still be ovulating, still having hormonal cycles and still being prone -- I mean, still undergoing the cyclic ovarian function that anybody would have whether they had a hysterectomy or not. And people are going to cycle -- people ovulate up to the time they're 85.

Q. When you were discussing this earlier just a few minutes ago, I was asking you the circumstances where it might be appropriate to delay histological examination beyond six weeks, and one of the things that you said was a somewhat reassuring physical examination. Would you describe the physical examination of Mrs. Gorman on February the 20th, 1991, as somewhat reassuring?

A. From the description, yes, I would

find that reassuring.

Q. Why is it that you say that?

A. That dealing with the smooth borders, mobile -- I realize she talks about somewhat smooth and somewhat mobile, but --

Q. Well, no, that's not what she says.

A. Okay, let's flip and we'll find out exactly what she says. Has had a moderately mobile mass, approximately one and a half -- the patient has a moderately mobile mass which is approximately one and a half centimeters in diameter, the borders are not completely smooth --

Q. Let's just take those two things right there, sir.

A. Sure.

Q. I think we've already established that if the mass was completely mobile, then that would probably be something that you could consider to be reassuring, at least at that early stage. Would it not? Completely mobile.

A. Well, that would certainly be reassuring, but the fact that it's not hard and fixed, the fact that it is mobile to me is reassuring.

Q. Okay. I'm getting to that but I want

to take this one stage at a time.

A. Okay.

Q. If this had been recorded as being completely mobile, that would be something that could be reassuring, could it not?

A. Well, yeah. That would be reassuring, yes.

Q. All right. And that's because as a general proposition, a cancerous tumor is going to be less mobile than a noncancerous tumor, just as a general proposition.

A. Yes.

Q. And so if on the other extreme it were completely immobile, that would be scary?

A. Yes.

Q. My word, not a scientific word.

A. That describes it pretty well.

Q. This one is somewhere in the middle?

A. Yes.

Q. All right. We've already established, have we not, that any breast mass should be considered cancerous until it is ruled otherwise. Did we not do that early on?

MR. LAWRENCE: I object to the form.

Q. Did you not agree with that statement

early in your testimony, sir?

A. I think that the final diagnosis on any breast mass is histological.

Q. Okay. And that any breast mass should be considered suspicious unless and until it is -- the presence of cancer is ruled out.

A. The fact that a breast lump is there necessitates the fact that it needs to be evaluated before it's ignored.

Q. Sure. Okay. Okay, moving on to the second part of that. The borders are not completely smooth. Now, if she had said in this note that the borders were completely smooth, that also would be something that would be somewhat reassuring, would it not?

A. Yes.

Q. Okay. The fact that she said here that they are not completely smooth appears to me as a layperson to be evidence that should make one suspicious of this lump. Would you agree or disagree with that?

A. Yes. What's in the note is, to me, means that yes, this needs to be evaluated and it needs to be watched and it needs to go away.

Q. Okay. You would agree, then,

wouldn't you, sir, that this mass on February 20th, 1991, was a suspicious mass.

A. Any mass in a breast is suspicious. So it's no different -- on this day was no different than any other mass that's felt in a breast.

Q. Okay. You also indicated that one of the circumstances that you might take into consideration in making a determination that observation of this mass might go beyond six weeks without histological exam would be where a patient presents with no significant -- excuse me, I think your words were strong family history of breast cancer.

A. Yes.

Q. What is it that you take to be strong family history of breast cancer?

A. What concerns me the most is breast cancer that happens on a family -- familial basis at an early age being recurrent. My other example was, you know, a mother who's in her 50s, late 40s that has breast cancer, and then her daughters come along and start having problems not with cysts, not with lumps, but with diagnosed cancer. That concerns me.

Q. Okay. Anything other than that that you would consider to be a strong familial history?

A. That would be the worst. Certainly the most significant is the family history on the maternal side, the mother's side and not the father's side.

Q. All right. I understand most significant. What I'm asking you really about is what do you mean when you say strong family history. In this case, for example., Mrs. Gorman, I think, had three paternal aunts who had contracted and died of breast cancer.

A. Yes.

Q. Is it your position that the occurrence of breast cancer on the paternal side is of no importance?

A. No, it's just not as significant.

Q. Not as significant as that on the maternal side.

A. Yeah. And I think significantly less significant on the father's side than the mother's side.

Q. Okay. But the fact remains that has more importance than a situation in which there is absolutely no family history of breast cancer,

would you agree with that?

A. I think that's fair to say.

Q. Okay. So in this situation then you have a situation where the patient is presenting with a somewhat suspicious lump and that there is some family history of breast cancer. Have I stated that accurately?

A. Oh, I think the most accurate way is the patient presents with a lump, okay. And the patient has a family history.

Q. Okay.

A. Now, whether it's suspicious -- it's certainly suspicious in the fact that it's there, but is that going to send up red flags? No.

Q. All right. So in the first six to eight weeks after Mrs. Gorman presented, then the only particular circumstance that Dr. LaRoche had that would be really positive would be the negative mammogram, correct?

A. No. Well, she's got the negative mammogram and, again, I don't feel the exam was overly suspicious. So I think she's got the exam and she has, you know, the mammogram. Certainly, there's a lot of things that would have been nice -- I mean, it would have been nice to know

that both -- you know, Mrs. Gorman knew the lump was getting bigger. The husband had felt it and knew it was getting bigger. But unfortunately Dr. LaRoche didn't have access to that.

Q. Looking to Dr. LaRoche's notes following February the 20th of 1991, is there any indications in any of these notes which specifically tells the patient that she is to return to Dr. LaRoche for a follow-up exam on any given day?

A. It's sort of confusing here that they recommend the follow-up --

Q Excuse me. Tell me where it is you're looking.

A. Middle of the phone call on 3/5/91. That she describes the mammogram and then recommends follow-up in four to six months. I guess there's some things we can assume. I don't know whether they're talking about a follow-up exam, follow-up mammogram, they're just talking about her left breast needs to be evaluated four to six months from now. So it really doesn't specify that -- if you're asking in this note, is it being recommended that she has a follow-up, yes, it does.

Q. A follow-up mammogram.

A. Well, it doesn't say that. It says follow-up. I guess you can -- I don't know. It says follow-up in four to six months. So, yeah.

Q. Under what circumstances would it be appropriate for an OB/GYN to allow a breast mass not to be examined for a period of four to six months following a two- to three-week period -- excuse me, a 15-day period, after she had first presented with this lump?

A. I think four to six month's is too long.

Q. All right. Other than this indication that she should follow up in some way in four to six months, what other indication is there that Dr. LaRoche told Mrs. Gorman that she should return for a physical examination in any of these notes?

A. Well, in any of the notes she, since 1987, has been coming into her office twice month -- or twice a year, and, you know, I think certainly this patient is at high risk to have -- not at high risk, but she's certainly at risk to have recurrence of her -- of her cervical cancer and has been, you know, having pap smears done twice a year. And certainly there's been a

pattern established that, you know, she's been seeing Dr. LaRoche or coming to her office twice a year. So I think from her office notes that she's been evaluated twice a year.

Q. That doesn't really answer the question that I asked you, sir.

A. Okay.

Q. I'm asking you to tell me where in these notes it shows that Dr. LaRoche told Mrs. Gorman that she should return for a follow-up physical examination.

A. There's nothing after that note to indicate that she specifically -- other than the pattern they had set up previously, they did not discuss deviating from that.

Q. Let's talk about that for just a moment then,

A. Okay.

Q. Well, before I do that, let me ask you another question related to what we're talking about right now. If we assume -- I'm not asking you to concede anything, I'm just asking you to assume something. If we assume that the notes reflect what Dr. LaRoche actually did or said, and that the lack of a note reflects that Dr. LaRoche

did not tell Mrs. Gorman that she should come back for a follow-up physical examination, would that failure on the part of Dr. LaRoche constitute a deviation from the recognized standard of acceptable professional practice for OB/GYNs in Murfreesboro?

A. No.

Q. Why not?

A. I think with standard of care that the patient needs to be -- you're asking if it's written down --

Q. No, I'm not asking that at all. That's not my question.

A. Okay.

Q. I'm saying that if she did not tell her, regardless of what the notes say -- put aside the note for a moment. We haven't been able to find anything in the notes to indicate that she did, and I'm asking you to assume that Dr. LaRoche never told Nancy Gorman that she needed to come back in for a follow-up physical examination. If you assume that, is that failure on the part of Dr. LaRoche a deviation from the recognized standard of acceptable professional practice for OB/GYNs in Murfreesboro, Tennessee?

MR. LAWRENCE: Object to the form.

A. See, I have problems with that question. 1 think that -- because I don't think it's relating to this at all. I think the standard of care is follow-up, and 1 'think that Dr. LaRoche had set out -- and in Dr. LaRoche's mind, you know, this patient was being seen -- God, I mean, it had been going on for four or five years that she would come in twice a year to be seen, had an appointment scheduled, and -- which would have been in what I feel is an acceptable time frame for all the information we have, so I think it was within the standard of care.

Q. Not to say anything at all?

A. Well, you're asking me to guess at something. I think --

Q. No, I'm asking you to make an assumption.

MR. LAWRENCE: He's already answered that question. I object to the question on the grounds of asked and answered.

Q. Let me make sure that I'm understanding what your answer is then.

A. Okay.

Q. You're stating that because there was

a pattern or a practice established between Dr. LaRoche and Nancy Gorman, that any failure on the part of Dr. LaRoche to specifically tell Mrs. Gorman that she should return for a follow-up physical examination did not deviate from the recognized standard of acceptable professional practice; is that correct?

A. What I'm saying is the fact that this patient had been seen twice a year and had faithfully kept those, I think as far as the doctor/patient relationship, had complied with that and come in to be seen, that Elizabeth had been taking care of this patient for quite a long time and from reflecting her notes had a pretty good idea of this patient's health status and what she needed and for her to know that she's coming in on her next scheduled appointment, which is, you know, two or three months from now, I feel was within the standard of care.

Q. All right. Regardless of anything that you think is within or without the standard of care on this, had this been your patient following up after February the 20th, 1991, would you have specifically told her she needed to come in for a follow-up physical examination?

MR. LAWRENCE: I'm going to object to the form of that question. I don't know that this doctor can assess and properly answer that question without knowing everything that Dr. LaRoche knew.

MR. JOHNSTON: Well, you have her records and you've reviewed her records and you've used those records to formulate your other opinions about this case, have you not, sir?

A. Well, I guess if I can make assumptions, I feel that -- yeah, okay, if I can make assumptions and guess at what I believe and what I know, okay, from reviewing these notes, is that, you know, I think Elizabeth is a thorough doctor and takes good care of her patients, and -- is it deviating from the standard of care --

Q. I'm just -- aside from that. I'm just asking you if you would have done that.

A. Yes, I would have.

Q. You go on -- excuse me, Mr. Lawrence goes on in this response describing your expected and proposed testimony and your opinions to state that the follow-up care provided by Dr. LaRoche was appropriate considering a number of things and I want to go through these one by one. First of all, the fact that the patient had a well established

history of fibrocystic breast disease. Why is that of importance in determining the appropriateness or lack thereof of Dr. LaRoche's follow-up care of Mrs. Gorman after February 20th, 1991?

A. Well, certainly there's going to be -- the breasts are going to be, with fibrocystic disease across the board, examining people with fibrosis disease they're going have more lumps and bumps than someone who doesn't have fibrocystic disease. So to feel a lump, again, needs to be evaluated, it needs to be followed up, but just because she has fibrocystic disease and we examined her doesn't mean that she has to have a biopsy that day.

Q. The existence or not of past fibrocystic disease, or changes, doesn't in any way alter the standard of care when a person presents with a palpable breast lump, does it?

A. No.

Q. Specifically on that point about fibrocystic changes, do you recall in your review of Dr. LaRoche's notes that in 1987 Dr. LaRoche referred Mrs. Gorman to a surgeon because of a breast cyst; do you recall that?

A. I don't think -- well, it was -- they

felt a lump and, yeah, she ended up going to --

Q. Dr. Westmoreland.

A. Yeah, Westmoreland for the biopsy.

Q. Uh-huh. Considering that in 1987 Dr. LaRoche felt that regardless of the existence of fibrocystic changes, or a history of fibrocystic changes, that it was important to refer Mrs. Gorman to a surgeon, is there any indication in her notes that would tell us why that would not have been the case in 1991?

A. Well, let me ask you this. Are you asking me, is there a difference in the way she approached things in '87 versus '91? No, I don't think so.

Q. Why do you say that?

A. Well, I mean, basically she examined her, you know, felt a cyst, a centimeter across, couple weeks later she said it was getting smaller, less tender and they were going to continue to follow things. She was going to see her back in four months. So I think generally speaking her approach in '87 was the same as it was in '91, basically. You know, a lump's here, granted she didn't do a mammogram, that's true, but was a little more reassured by the physical exam. It was

a little more mobile, little more -- get her exact words -- it was very mobile, tender, approximately a centimeter across. She felt it was a cyst.

Q. And you're talking about in 1987?

A. Yes.

Q. So if it was less suspicious in 1987 and she did not refer her to a mammogram but did refer her to a surgeon, I'm sorry, I don't understand why that's not a substantial difference from what she did in 1991.

A. That's what I'm saying. There's not a substantial difference. I'm confused now. What I'm saying is -- okay, go ahead.

Q. Why is that not a substantial difference?

A. Well, basically they examined her, okay. Two weeks later they had some things that were not -- a little reassuring, by the patient was a little smaller, less tender. It's like well, let's watch things a little bit. Okay. Same thing in '91. They examined her, weren't real concerned, still the lump was there. The mammogram, it was reassuring. It was like well, jeez, you've got an appointment here for your biannual -- or your six month exam, let's see what it looks like. So I

don't see a lot of difference with that.

Q. Now, that last part you just indicated in your answer, that's all an assumption on your part, isn't it?

A. Well, assuming that after she's done it for three, almost four years, that she's going to continue this in someone who's had significant -- well, cancer of the cervix and had to undergo a major procedure --

Q. We're going to get to that in just a minute. But what you've just said is an assumption on your part, isn't it?

A. Well, no, it's in the record. She had an appointment scheduled.

Q. I understand. But you don't have any idea what was going through Dr. LaRoche's mind or Nancy Gorman's mind or anybody else's mind because you haven't talked to any of them about any of this --

A. Oh, no.

Q. All you've done is refer to the records, correct?

A. Again, I thought we were making assumptions here. Okay.

Q. So that's my question, you were

making an assumption of what was going through their minds when you said well, gee, we can follow this up and --

A. No. What I'm saying is 'yes, we had this pattern here in '87, we have this pattern here in '91, and, you know, we have office visits every six months, and then we have an appointment scheduled here for the patient to be seen in May, I mean, I don't think that's an assumption, I mean, that's --

Q. Okay. The next thing that you list here that is a consideration of the appropriateness of Dr. LaRoche's follow-up care is that she underwent a new mammogram, negative for any sign of carcinoma.

A. Yes.

Q. And we've already discussed that. Whether or not that is reassuring, that is not anything that can or should be used by any OB/GYN to rule out the existence of cancer, is it?

A. What, the repeat mammogram?

Q. Any mammogram.

A. Yeah, She's got a mass in her breast. Yeah, it needs to be biopsied.

Q. And the last thing there is that she

was scheduled to return for an office visit in early May of 1991. Correct?

A. Yes.

Q. How do you know that?

A. Well -- well, from the records, it's right here and it's -- did not keep appointment.

Q. Okay. Specifically you're making reference to a portion of Dr. LaRoche's chart with that May date and the initials that indicate that she did not keep the appointment, correct?

A. Yeah. And basically, yeah, that she was here for a recheck -- well, here in '90, it's got she's coming back for a pap smear. So they had written down that she was here for a recheck, not for a pap smear. So she was coming back to have her breast rechecked.

Q. Okay. Now, have you read Dr. LaRoche's deposition in which she describes her office procedure for these follow-up and subsequent appointments?

A. Not all of it, no.

Q. Do you recall anything about her procedure?

A. Not specifically.

Q. Okay. In looking solely at the notes

from Dr. LaRoche regarding Mrs. Gorman, and in going back to when she first, Mrs. Gorman, became Dr. LaRoche's patient, let me ask you if you would point out to me any instance at all, any instance in which Mrs. Gorman did not follow precisely what Dr. LaRoche told her to do. Can you do that?

A. No.

Q. Is that because there isn't any such indication?

A. Yeah. I don't see any of these here where she did not follow Dr. LaRoche's instructions, except the time she chose to go to Vanderbilt to have her surgery.

Q. In fact, in each case going back to 1986, Dr. LaRoche first of all provided her specific instructions about what she should do, and number two, Nancy Gorman followed those instructions to the letter in every single instance, didn't she?

A. Run that by me again now.

Q. Two things happened.

A. Okay.

Q. In every instance Dr. LaRoche provided specific, precise instructions as to what Mrs. Gorman was supposed to do, what was expected

of her.

A. Yes.

Q. And the indications are in these notes that Mrs. Gorman followed each and every instruction explicitly every time, isn't it?

A. Yeah. Yes.

Q. Let's go back to 6/87. Beginning in 6/87, and continuing for virtually every scheduled appointment after that, Dr. LaRoche prepared or had prepared a typed note of her contact with Mrs. Gorman and specifically provided not only an assessment but a plan that she laid out step-by-step, correct?

A, Yes.

Q. All right. In 6/87, the plan includes several things. The third one is this, and let me read it word for word.

A. Okay.

Q. She, meaning Mrs. Gorman, will return in four months for a repeat pap smear or earlier if she should have any problems.

A. Yes.

Q. Now, 1 don't know how the medical profession would read that, but let me just say, if I read that, I see that as an either/or situation,

I have two options. I've got a scheduled appointment out here in four months, or a standing, basically, order to come back to me -- back to the doctor if something occurs prior to that time. Is that a reasonable way to read that?

MR. LAWRENCE: Are you -- I'm going to object to the form of the question. Are you asking him to evaluate this statement based on how a patient would evaluate it, or do you want his opinion as a physician on what he thinks about another doctor's notes?

MR. JOHNSTON: However you think you can answer that question, Doctor. I mean, it's pretty plain English.

A. I'll tell you what I tell people and I'll tell you how I interpret this, because certainly the doctor/patient relationship is a two-way street. I think we have a responsibility, I think the patient has a responsibility. And we can certainly give a lot of our expertise for a lot of different things if we have the option to do it. Similarly they can give us a lot of information if they'll give it to us. And so I think it's a two-way street. I think everybody has a responsibility and basically what I do, and I

probably dictate on 99 percent of my -- on my returning on a patient, it's like well, we'll see you in a year, or, you know, if you have any problems, call. I tell people when th'ey leave, if you've got problems communicate, tell us what's going on, you know, anything. Call me, call my nurse, just talk to somebody so we'll know what's going on. And that's how I interpret this.

Q. You basically do the same thing then that's being done here, and that is you provide your patient an either/or situation, correct?

A. Well, no, I read this differently. What I say is okay, I want to see you -- it's like a postop problem. When I'm sending somebody home from the office, I say well, we'll see you on Monday at 9:00 o'clock and the nurse will take your staples out and then we'll see you back in a month and if you have any problems, any question, call me. I tell 100 percent of my patients that when they leave the hospital, meaning we're going to see you in a month, or if you're having problems, anything that concerns **you**, **you** need to call me and let me decide whether **you** need to come in sooner or whether I'm going to see **you** in a month. That's what I get from this. I don't think it's either.

I'm not going to give the patient the option of deciding the time frame of what's going to go on. And, you know, there's a lot of things that enter into it. I'll see patients that will 'just decide that they want things done differently, they want things done sooner, they want things done later, whatever, but certainly I'm going to set down the time frame that I want them to adhere to.

Q. And if they have a problem prior to that time, that's related to that or not, they are certainly free to --

A. To call, yeah.

Q. -- call or come in if they need to?

A. Discuss it, whatever it takes to solve the problem.

Q. In any event, however that may be interpreted, it is clear that she has prepared this specific instruction for Mrs. Gorman?

A. Yep.

Q. And then according to Dr. LaRoche's office plan, what happens at this point, and I'll just sort of refresh your memory about this, is that she writes this -- Dr. LaRoche writes out this plan or this idea on a ticket, Mrs. Gorman takes the ticket to the front office, the receptionist

takes that ticket and puts it on the book as close to whenever Dr. LaRoche has indicated she needs to see her, and then gives Mrs. Gorman a card indicating the date and the time that'the appointment has been set. Do you recall reading that in the deposition?

A. Vaguely, yes.

Q. And Dr. LaRoche testified that that's what she did in each and every one of these situations.

A. Okay.

Q. And if you will look through these records, on every occasion where Mrs. Gorman appeared following this procedure on the regularly scheduled appointment, that same plan was given to her again.

A. Okay.

Q. Correct?

A. Okay.

Q. Am I correct about that?

A. Well --

MR. LAWRENCE: I object to the form.

A. Yeah, I mean, that -- I guess if that's what she's testified to, that's what appears in the notes, but I mean, I've never been in

LaRoche's office. I don't know. I don't know how she does that, But it certainly would be that, you know, there's a pattern here as to how she wants to follow this patient.

Q. Exactly. And on each occasion that she saw Mrs. Gorman, despite the fact that they had established a pattern or anything else, she gave Mrs. Gorman a specific instruction as to what she was to do, didn't she? That's indicated in the notes, isn't it?

A. Yes.

Q. Okay. And that goes all the way through the note on 11/90, does it not, sir?

A. Okay, yeah.

Q. All right. And then tell me whether or not you can find following the pattern that Dr. LaRoche herself has established over this roughly four-year, little over four-year period, show me where it is that Dr. LaRoche specifically and expressly, following her own plan, tells Mrs. Gorman that she is to return in May of 1991.

A. Well, you know, a couple things. One is that this is what Kim Baker wrote, okay. And basically it comes down to this phone call. And I know how I do it and how most physicians do it, is

that, you know, the mammogram comes back and LaRoche, you know, has her chart, because I mean, she dictated on it, and it is sitting there and it's like well, okay, here's Nancy Gorman and she's got a problem with carcinoma situ and breast disease and all these other problems and calls her up and discussea a mammogram with her. And it takes no math at all to realize well, jeez, we saw her back in November, we're going to see her in May, and we're going to evaluate things, And she, well, I mean --

Q. That's not responsive at all to my question.

A. Oh, I know, but what --

Q. I'm asking you, Dr. Boerner, to show me specifically in these notes where there is an indication that Dr. LaRoche followed her normal and usual pattern that she had established with Mrs. Gorman for over a period of more than four years, specifically telling her that she was to return in May.

MR. LAWRENCE: He's already answered that question. He said the six months between November of '90 and May of '91. I object to the form of the question. It's been asked and

answered.

A. Well, and, you know, I guess the thing about this, too, is that -- that in most of her notes is dealing with her pap smears, and discussing every single time that -- and I guess what you're asking for is on every single note if she needs to back up and comment on every single problem she has.

Q. No, I'm not asking anything like that at all. Nothing at all. We've been through these notes.

A. Yes.

Q. And it's clearly unequivocally established by the notes themselves that on each and every occasion in which Mrs. Gorman presented to Dr. LaRoche's office, Dr. LaRoche provided her a specific instruction as to when she was to return. Every time. Every time for more than four years. Now, what I'm asking you is from February the 20th of 1991, please show me any note that indicates that Dr. LaRoche followed her established pattern for more than four years.

A. Okay. But you're confusing apples with oranges. On every single -- on every single -- on every note she's being seen she's seen

for the pap smear, okay, and has established a pattern for being seen every six months. And for me to look at all these notes and say that she deviated from her pattern or deviated from her approach, I can't say that.

Q. Show me where she said specifically Nancy Gorman is supposed to show up on May the 7th of 1991 following the February the 20th --

A. Is it written anywhere other than the fact that every six months for three years --

Q. No, I'm asking you to tell me, to show me where in the notes there is a specific instruction after February the 20th Dr. LaRoche gave to Mrs. Gorman that she should show up on May the 7th, 1991. Show me where it says that.

MR. LAWRENCE: You're limiting it now to only notes after February 20th, 1991.

MR. JOHNSTON: That was my question.

MR. LAWRENCE: Originally you didn't restrict it that way which is why I objected to the question.

A. Yeah, after February of '91, no, there's nothing where she -- it was written down, although implied, that she should come back in the beginning of May.

Q. Where is it implied?
A. The notes. I mean, for three years --
Q. Show me where it's implied in any note.
A. Well, the fact that she -- well --
Q. Did Mrs. Gorman have access to'these notes?
A. Sure.
Q. And so she could have come in any time and said let me see these notes, I want to know what the implications are here?
A. Absolutely. I mean, y'all know that. She could have had these records anytime she wanted to.
Q. There are specific instructions given by Dr. LaRoche to Mrs. Gorman subsequent to February the 20th about things that she should do and when she should do them, aren't there?
A. Yes.
Q. And none of those things include returning in May of 1991, do they?
A. Yeah, it says right here (indicating).
Q. Where are you pointing?

A. November of '90. I mean, it's written down she's coming back in six months.

Q. And specifically what does it say, exactly, word for word?

A. She will return in six months time for a repeat pap smear unless she has any problem.

Q. Unless she has any problems.

A. Yes.

Q. And obviously she did have a problem and she took advantage of that phrase and came back earlier, didn't she?

A. Yes.

Q. And then subsequent to that point Dr. LaRoche did give her specific instructions about what she should do and when she should do it, didn't she?

A. On the --

Q. After February the 20th.

A. Yeah, I'm sure she did.

Q. Well, I mean, it's in the notes. You can see that she did.

A. Which one are you referring to?

Q. Well, any of them. Look at 3/5. And basically if you read Dr. LaRoche's own testimony, she indicates that she asked Mrs. Gorman to go by

Dr. Hays' office and get the mammogram films and --

A. Yes.

Q. -- and Nancy Gorman did all of those things that she was asked to do, didn't she?

A. Yes.

Q. She was given specific instructions about what she was supposed to do and when she was supposed to do it and she did them.

A. Yes.

Q. Okay. You would agree that as of May of 1991, in this particular case the existence of cancer had not been ruled out, wouldn't you?

A. In May of '91?

Q. Yes.

A. Yes. It had not.

Q. Now, assuming that in fact there really was supposed to be an appointment on May the 7th of 1991, would that appointment have been important in properly diagnosing this unexplained mass?

assume -- I mean, it was certainly written down and it was documented in LaRoche's appointment book that the appointment was there. So to assume that, I don't understand that.

Q. The question is, would that -- whether it's there or it's not there, or whether you assume it or don't assume it, would this appointment have been important in appropriate and proper diagnosis of this unexplained mass?

A. Absolutely.

Q. Okay. All right. Let me ask you how you would have handled this specific situation. You have a patient who has presented with a breast mass who has been your patient for some four and a half years, or thereabouts. The patient misses, unexplained absence from a scheduled appointment, To the best of your knowledge, that mass may still be there or not there, you don't know. Would you take it upon yourself to either call that patient or would you instruct someone in your office to call that patient to inquire as to why they missed the appointment?

A. No. No, we don't have a process set up for that, Certainly there's a lot of assumptions that would go on that either, you know, the appointment comes and goes, she has decided that she doesn't want to wait,, she wants to go to another doctor, the cyst has gone away. You know, I would assume that in a patient that's educated

and understanding -- I mean, she had been through this once before, had gone through the scenario, a breast lump, and that if she's not going to show up for her appointment, either it's gone away, she's gone somewhere else, or the patient doesn't -- it's either gone way or she's gone somewhere else.

Q. You don't know of your personal knowledge, either through conversations with anyone or any other way, that prior to May the 7th, 1991, anyone -- you need a break?

A. Yes.

(Brief recess.)

(Requested portion of record read.)

Q. Anyone expected or assumed that Mrs. Gorman would show up on May the 7th of 1991, do you?

A. Run that by me again. I mean, was she going to show up for an office visit? Yeah, I think that -- or do I know that?

Q. Yes, do you know that?

A. Only the fact that she had done it for three years previously, but, I mean, that's an assumption. No, I can't testify as to what she's going to do or how she's going to feel or whether she was happy with the care she was getting or

anything.

Q. And you can't really say that Dr. LaRoche herself prior to May of 1991 expected Mrs. Gorman to make this appearance, can you? I mean, that, too, would be an assumption.

A. Yeah, I guess so. But I mean, she had no reason to suspect she wouldn't.

Q. I understand that. I'm not trying to argue with you on that. I'm just trying to establish that you don't have any personal knowledge that would tell you anything other --

A. No. I've got 40 people scheduled tomorrow and I can't tell you that half of them will show up.

Q. Right. You may have an opinion about whether or not someone expected this, but you don't know of your personal knowledge that anyone did.

A. No.

Q. Okay. I think you probably answered this, at least in part, but I need to ask you this directly so that it's clear. Is it your opinion that any failure, if that's what occurred, on the part of Dr. LaRoche to follow up on the alleged missed appointment of May the 7th, 1991, deviated from the recognized standard of acceptable

professional practice for OB/GYNs in Murfreesboro, Tennessee?

A. These questions keep getting longer and longer, trying to follow -- do I think Elizabeth had a responsibility, either herself or her office staff, to contact Nancy Gorman after she missed her appointment? No. And I think that's within the standard of care. I think the standard of care is you don't have to pick up the phone every missed appointment. I see probably two or three a day that decide they're not going to come in. They may reschedule, they may go elsewhere. We're not going to intrude -- if they've decided they found some person they would rather go see, that's their decision.

Q. Okay. Is there anything, any indication that you are aware of that Mrs. Gorman had made some decision as of May of 1991 that she no longer wanted to see Dr. LaRoche?

A. No.

Q. Okay. Continuing on with Exhibit 1 and what is included here as to your expected testimony, it states that you're expected to testify that -- I'm paraphrasing this -- doctors can expect patients to be compliant and responsible

in order to give physicians the opportunity to render appropriate care. And my question is, could you show me in the records -- let's put aside the note on 5/7/91, indicating that she didn't keep this appointment. Let's put that one aside for the moment. Other than that, is there any indication in any of Dr. LaRoche's chart that Mrs. Gorman was not compliant and not responsible?

A. Yes, in the fact that -- and it's -- when Nancy Gorman had her abnormal pap smear and ended up going to see Steven Dudley in Nashville to have that performed -- well, in fact, I'll tell you, all physicians -- in fact, I was really surprised when I saw this. If I have a patient in my office that I can perform a procedure and I feel I'm as competent and trained to do that procedure, if someone goes somewhere else for their surgery, I won't see them back.

Q. Well, what does that have to do with being compliant or responsible?

A. I think it -- that in the back of my mind, I always wonder whether the patient really completely trusts me as a physician. And again, this is my feeling. I mean, that's -- I don't know of anybody in town that doesn't feel the same way.

Q. I understand what you're saying, I'm just not sure I understand how that's related to being compliant or responsible.

A. Oh, compliant and responsible, I guess maybe that's why if -- that when this happened in May, that, you know, I would have wondered whether she had found somebody else to go see, somebody up in Nashville. She certainly had doctors who could have evaluated this, you know, gone back to see Dudley, gone to see Westmoreland. So I think there's -- whether that's implied in the records, at least that's how I handle it in my practice,

Q. We're -- I think one of us isn't communicating well and it may well be me. So let me try to go at this a different way. My interpretation of the word compliant as it appears here in this statement indicating your expected testimony is that when you as a physician give a patient an instruction, you should reasonably expect that that patient's going to carry that out, That's part, I think, of what you were talking about earlier in terms of responsibilities on both sides,

A. Yeah, okay.

Q. And if the patient doesn't do that, then, you know, they've violated their own responsibility in that regard.

A. Yes.

Q. That's what I'm assuming that you've meant by using the term compliant and responsible, the phrase compliant and responsible. Now, is that -- am I on solid ground there or am I missing the importance of this phrase?

A. Yes. Maybe I'm not communicating really well on --

Q. Well, let me change the question just a little bit, okay?

A. Okay.

Q. So I can follow it in my mind and make sure I'm okay. All right. Let's go back to what I was asking you and let me ask you specifically, is it your opinion that other than this May 7th, 1991, thing, putting that aside, other than that, is it your opinion that Nancy Gorman was in some way not compliant with the reasonable instructions given to her by Dr. LaRoche?

A. Now, I'll agree with that.

Q. Okay. She did -- the records

indicate that she basically did what Dr. LaRoche told her to do?

A. Yes.

Q. With the exception of this thing, we'll have differing interpretations of that, but if you put that aside, she was compliant and responsible?

A. Yes.

Q. All right. Let me switch gears and ask you about some other things. If the mass with which Mrs. Gorman presented in February of 1991 had been diagnosed however, but had been properly diagnosed as cancerous in either February or March of 1991, just if that had happened, would lumpectomy have been an alternative she could have considered?

A. I think anywhere along the line, lumpectomy could have been something she could have considered.

Q. Including right up to December and January of -- December of '91, January of '92?

A. I think there certainly have been people that have adamantly not wanted radical mastectomies that have opted for that, certainly none in my practice, but I don't think that -- in

my opinion, I don't think lumpectomy's a -- well, let me phrase it this way. If that was presented -- these circumstances were presented to me as my wife, I would want her to have a radical mastectomy, modified radical mastectomy. But to answer your question, certainly that would be an option, but even from day one whenever this would have been diagnosed, that's not what I would have felt would have been the best treatment for her. But again, I'm not an oncologist, and certainly past diagnosing, evaluating, then it goes to a surgeon and then decisions are made from there.

Q. All right. Are you generally familiar with the stages of breast cancers?

A. Generally, yes.

Q. You understand the four stages and -- I don't guess I could give you precise measurements and ask you if that was a Stage --

A. Sure, generally, sure.

Q. Okay. To the best of your knowledge, is there any evidence anywhere that in February of 1991 the mass in Mrs. Gorman's right breast was anything other than a Stage I?

A. Certainly there's nothing to indicate it's any worse, but there's no way to indicate that

it's anything less than -- I mean, it's -- from the -- breast cancer staging is done surgically and not by physical exam and not by mammography. So to answer your question, that's not a fair answer. But I mean, it's an assumption. You want an assumption?

Q. No. I understand what you're saying --

A. You can measure the lump and from that statistically look at how many people -- if you take 100 women, how many people are going to have lymph node involvement and how many aren't, and statistically look at survival in that kind of way. But just looking at one individual case, it's impossible to be able to know it's Stage I just from the exam in February.

Q. Okay. I want to follow up on some of what you said in your answer but let me kind of follow this along. It may not be logical to you but it is to me. If I'm understanding your earlier testimony correctly, I think you've told us that a first step in proper and appropriate diagnosis of a suspicious breast mass would be physical examination by the doctor or someone --

A. By the caregiver.

Q. By the caregiver from the physical exam.

A. Physical exam.

Q. Do you know whether or not it is generally true that as a cancerous tumor advances through the various stages it becomes less susceptible to treatment?

A. No, it doesn't become less susceptible to treatment.

Q. Do you know whether it is generally true that as a cancerous tumor advances through the various stages it becomes more life-threatening?

A. Yes.

Q. Are there circumstances in which a cancerous breast mass would not worsen over time?

MR. LAWRENCE: And you're not putting any limitations on the time?

MR. JOHNSTON: I'm not putting any. limitations on the time.

A. Are there instances where you could wait six months and the prognosis would be the same? Sure.

Q. All right. Can you give me circumstances where that would be the case?

A. Basically the type of cancer, as to

how the patient's immune system can fight it off, the time it's detected and the size.

Q. A few moments ago in part of your answer you -- well, you indicated something to me. I don't want to put words in your mouth so I'll just turn this around and ask a question about it. Do you know whether or not there is any relation between the size of a malignant tumor and the incidence of positive axillary node involvement?

A. I can't give you any numbers but I do know as a lump gets bigger the likelihood of having masses -- having lymph node involvement increases.

Q. So there is a statistical relationship between those two things?

A. Yes.

Q. If there is axillary node involvement, are there things which could evidence that fact at a physical examination?

A. There could be. I mean, depending on the involvement, depending on the size,

Q. I know. I understand that. It may or may not be -- excuse me. Axillary node involvement may or may not be something that would be -- discernible may be too strong a word, but indicated at physical examination, but I guess my

question to you really is that -- that it would not be completely impossible --

A. No, that's true. But I think that's where we're getting to, okay. I mean, I've never felt positive axillary lymph node in all the years, but --

Q. It could be, that is something --

A. I'm sure somebody has, yeah. Not very likely.

Q. In the physical examination could you describe for me what it is that you would expect to feel if you did find what you suspected was axillary node involvement?

A. Well, swollen, tender. But even flipping that, though, is that if you examine the lymph nodes, there would be no way to tell that those were malignant lymph nodes without a biopsy. Could be from a cold, could be from a sore throat. It's just -- you know, in Nancy Gorman, if that had been felt, we wouldn't know where it's coming from.

Q. I understand that. I'm not trying to suggest that there's any positive way to do it. I'm just saying that if there is, it is possible that that might be indicated in physical

examination and where it is indicated in physical examination, I'm just trying to get you to describe what you might find. I mean, that's all.

A. You know, might, but like I said, I've never --

Q. I understand. But if it were -- we know that it is possible, and I think what you've said is that what you could find is swollen tissue, it could be tender to the touch. You would not necessarily know that that was a result of positive axillary node involvement. You wouldn't know that, But that is something, looking back on it, that you could say was consistent with that ultimate finding,

A. I'd have to say, best medical knowledge, from what we got out of this, the size, when it was examined, I don't think it would be possible to be able to feel lymph nodes in her.

Q. Why do you say that?

A. Just because of the size of the mass in the breast, when it was first diagnosed, to think that you'd be able to feel that, I guess we're talking about in May, in March, whenever, February, that that would not be possible.

Q. Okay. And in fact, there isn't any

evidence at all --

A. No. I'd want to see --

MR. LAWRENCE: Wait. Hold on a second. Let me see what he's asking you.

MR. JOHNSTON: That is important.

Q. In this chart, there is no evidence at all that there is any axillary node involvement as of February the 20th, 1991, correct?

A. Let me look. No, there isn't.

Q. I asked you this question earlier relative to May of 1991. Let me extend the time period just a little bit and ask you the same thing. Are you aware of any evidence which would indicate that Mrs. Gorman had lost confidence in Dr. LaRoche as of the end of July of 1991, and just to put it in an appropriate time reference, that's when she returned for her follow-up mammogram, returned to the radiologist.

A. No.

Q. Are you aware of any evidence at any time up through December of 1991 that Mrs. Gorman had lost confidence in Dr. LaRoche?

A. Nope.

Q. Do you have any opinion as to whether or not it was incumbent upon Dr. LaRoche to

specifically request that the follow-up mammogram be done bilaterally as opposed to only on the left breast?

A. Let me look at this. Let me see the report. I don't know where the report is, of the mammogram. It's my opinion that -- yeah, I think that she asked to repeat on the left breast was acceptable. I think the fact that if they did it on the right breast and didn't see anything at all, that -- I wouldn't have ordered one. That's not what I would have wanted to have seen. It gets back to the same old -- you know, if a lump's there, it's -- needs to go away or it's going to go away, they've got to take it out. So I wouldn't have ordered to repeat.

Q. Regardless, again, of whether or not you believe there's been any deviation from any standard of care, is there anything about Dr. LaRoche's treatment of Mrs. Gorman that you would have done differently given the benefit of hindsight?

A. No. Well, I brought this up before. The thing that really stood out and it stood out more than anything about the whole deal is the fact that Elizabeth could have done a vaginal

hysterectomy and didn't, and if she had been in my practice, you know, if she had found another doctor she had been comfortable with, I wouldn't have seen her back. You know. And, you know, I had a hard time understanding that when I first started practicing, but every single doctor in town, that's the way they approach it. In fact, that's how the new guy in town gets most of his patients, is by people coming that had seen another doctor or had been going to another doctor had gone somewhere else for their procedures and then wouldn't come back. And so it's -- and it's interesting because that's -- it's the first time I've come across this where it hasn't been this way, because all the other doctors do that. So, maybe I commend Elizabeth for doing that, but on the other hand --

Q. Is it your opinion that Mrs. Gorman was in some way negligent in looking out for her own best interests in this matter?

A. Yes, I do,

Q. And in what way was Mrs. Gorman negligent?

A. I think that, at least running through her notes, her deposition, Elizabeth's notes, everything I can put together -- and again

these are just assumptions -- I think that she was a relatively well-educated person who understood the -- you know, she's not somebody who worked in a factory. She was educated, was a secr'etary, and one would assume had a pretty good understanding about things. And that certainly things come up where she could have missed an appointment, wanted to reschedule, whatever, but to me it doesn't make a lot of sense because, you know, for years it had been one way and then all of a sudden boom, it quits.

You know, putting the breast lump aside, you know, she didn't come back for a pap smear. You know, could have postponed it, you know, come back in the middle of the summer when the kids are out of school, could have called anybody up, could have called Westmoreland up, could have called anybody up. To me, in these days and time, you can't pick up a magazine, a woman's magazine, okay, and not have some article about breast cancer, breast self exams, the importance of not letting things go by. And it just -- something doesn't fit here. And I think that certainly, you know, could have picked up the phone.

I mean, to wait until -- and even in

her husband, to be realizing walking on the beach, knowing her breast lump is getting bigger, and to just ignore that -- you know, on a lot of other things she would call back and discuss things with the nurse or Dr. LaRoche. To just completely ignore things, I have trouble putting all of that together.

Q. Let me ask you to make an assumption, and I want to somewhat repeat that question. If you assume that Mrs. Gorman was attempting to do exactly what she had been asked to do, going to this initial mammogram when she already had another one scheduled, getting the films and bringing them to the radiologist, getting the scheduled follow-up mammogram in July, showing up for that, basically doing what she thought. If you make the assumption that she was following what she thought were the instructions of her doctors, do you still see negligence on her part?

A. Well, I guess I look at how -- answering the question, like doing the mammogram, if they had done the mammogram on the other breast, do I think it would have made a difference? No. Referring back to the office note where, you know, come back in four months or sooner if you have a

problem, or call if you have a problem anywhere along the line if she had followed up on any of the instructions she had been given in the past, whether it's having a pap smear every six months, whether it's having a dialogue with her physician that supposedly she felt comfortable -- I really don't have anything to suggest that she's not, you know. If anything -- any of those had transpired, she would have come back -- or she would have been seen, the lump still would have been there and it would have been biopsied.

I mean, if I'm assuming things, I don't think she could have set foot in that medical clinic and seen any doctor after -- I don't know, pick a number, two, three, four months, and she goes, you know, I've still got this lump If she had gone in for a sinus infection and brought up I still have this lump, she would have had the biopsy the next day.

Q. Isn't the radiology office in that medical complex, I mean, isn't that all part of the single medical complex?

A. Well, that's true. And I guess -- you know, I don't know what transpired there as far as if it had, you know -- and I guess it's this

communication and dialogue. I think, like I said, there's this patient/doctor relationship where, you know, if things are communicated it's a lot easier to treat them. You know, I think if she had mentioned, you know, hey, jeez, will you do my right breast, you know, it's still sore. I still have this lump.

Q. Are you familiar at all with the proposed testimony of Dr. Clay Newsome, I mean have you looked at that part of this --

A. No. Is that the Exhibit 1?

Q. Yes.

A. I didn't really review it.

Q. Is there anything that you can see that Dr. Newsome is supposed to testify to that you disagree with?

A. No.

MR. JOHNSTON: I think that's all the questions I have.

FURTHER THIS DEPONENT SAITH NOT.

STATE OF TENNESSEE)
)
COUNTY OF DAVIDSON)

I, Cindi C. Resha, Notary Public in and for the State of Tennessee at Larg'e,

DO HEREBY CERTIFY that the foregoing deposition was taken at the time and place set forth in the caption thereof; that the witness therein was duly sworn on oath to testify the truth; that the proceedings were reported by me in shorthand; and that the foregoing pages constitute a true and correct transcription of said proceedings to the best of my ability.

I FURTHER CERTIFY that I am not a relative or employee or attorney or counsel of any of the parties hereto; nor a relative or employee of such attorney or counsel, nor do I have any interest in the outcome or events of this action.

'IN WITNESS WHEREOF, I have hereunto affixed my official signature and seal of office this 16th day of September, 1994, at Nashville, Davidson County, Tennessee.

Cindi C. Resha
Notary at Large
State of Tennessee

My Commission Expires: April 14, 1998

IN THE CIRCUIT COURT RUTHERFORD COUNTY, TENNESSEE
AT MURFREESBORO

NANCY GORMAN and husband, GERALD GORMAN,

Plaintiffs,

v. NO. 31218

ELIZABETH LaROCHE, M.D.,

Defendant.

SUPPLEMENTAL ANSWERS TO PLAINTIFF'S FIRST SET OF INTERROGATORIES BY DEFENDANT ELIZABETH LAROCHE, M.D.

The Defendant, Elizabeth LaRoche, M.D., hereby supplements her previous answers to Plaintiffs' First Interrogatories, pursuant to Rule 26, Tennessee Rules of Civil Procedure:

4. With respect to each person you anticipate calling as an expert witness at trial, please state:

(a) the name, current business and residential address and telephone numbers;

(b) the subject matter of said expert witness testimony;

(c) the substance of the facts and opinions to which the expert is expected to testify; and

(d) a summary of the grounds for each opinion.

RESPONSE:

(a) (i) Dr. Clay Newsome
222 22nd Avenue North
Nashville, Tennessee 37203
Telephone (615) 284-2500

(ii) Dr. James Boerner
507 Highland Terrace
Murfreesboro, Tennessee 37130
Telephone (615) 890-2442

(iii) Dr. John Hainsworth
Sarah Cannon Cancer Center
250 25th Avenue, North
Suite 412
Nashville, Tennessee 37203
Telephone (615) 320-5090

(b) Dr. Newsome and Dr. Boerner, as board-certified OB/GYNs, are expected to testify regarding the recognized standard of acceptable professional practice applicable to Dr. LaRoche in this case, as well as issues of causation, pursuant to T.C.A. § 29-26-

EXHIBIT
1 Boerner 8-30-94

115. Dr. Hainsworth is expected to testify regarding medical oncology issues in this case.

(c) The opinions of these experts are based upon review of relevant portions of numerous medical records and other discovery documents in this case, including but not limited to the office records of various physicians who have treated Nancy Gorman, including Dr. Elizabeth LaRoche, Dr. Wayne Westmoreland, Dr. Kenneth Wurtz, Dr. Charles Penley, Dr. Jeanne Ballinger, Dr. Lois Wagstrom, and Dr. Stephen Dudley; the hospital records regarding both of Ms. Gorman's admissions for breast surgery and follow-up care; the depositions of both Plaintiffs and of Dr. LaRoche; and the testimony summaries of the Plaintiffs' proposed expert witnesses.

(1) Dr. Newsome and is expected to testify that, in his opinion, Dr. Elizabeth LaRoche did not deviate from the recognized standard of acceptable practice in treating the patient, Nancy Gorman. In coming to this conclusion, Dr. Newsome is of the opinion that, in view of the patient's well-established fibrocystic breast disease, the followup care provided by Dr. LaRoche following the patient's visit with a lump in her right breast on February 20, 1991, was appropriate. It was appropriate for Dr. LaRoche to order a mammogram of the patient, and after learning of the negative findings from the mammogram and comparing the results with an earlier study, to follow-up at the patient's next regularly-scheduled office appointment on May 7, 1991, to re-evaluate any changes in the right breast. Due to her long-standing fibrocystic breast disease, Ms. Gorman had developed numerous breast masses of a cystic nature in the past and in such patients, it is appropriate to monitor the fluctuation in size of new lumps for a reasonable period of time. Dr. Newsome is expected to testify that the fact that this patient had a family history of breast cancer in paternal aunts did not make her more susceptible to breast cancer, since this history did not appear on the patient's maternal side.

Further, Dr. Newsome is expected to testify that physicians are entitled to rely upon the duty of patients to be reasonably

responsible for their own health and well-being; that the standard of care did not hold Dr. LaRoche nor any other physician responsible for a patient missing an appointment and/or failing to contact either Dr. LaRoche or some other physician or other health care provider for a period of ten months to inform them of her continuing concern, that the mass continued to be present in her right breast, and/or that the mass was enlarging.

In addition, Dr. Newsome is expected to testify that any alleged delay in diagnosing the right breast mass as carcinoma could not be construed to be the cause of her right modified radical mastectomy and resulting chemotherapy, nor of the resulting cancer, surgery and chemotherapy regarding the left breast.

(2) Dr. Boerner is also expected to testify that Dr. Elizabeth LaRoche did not deviate from the recognized standard of acceptable practice in treating Nancy Gorman. Dr. Boerner is of the opinion that the followup care provided by Dr. LaRoche following the patient's visit with a lump in her right breast on February 20, 1991, was appropriate, considering the fact that the patient had a well-established history of fibrocystic breast disease, underwent a new mammogram which was negative for any sign of carcinoma in the right breast, and that she was scheduled to return for an office visit in early May, 1991.

Further, Dr. Boerner is expected to testify that the standard of care applicable to physicians practicing OB/GYN medicine in Murfreesboro permits them to expect patients to be compliant and responsible in order to give physicians the opportunity to render appropriate care. This is particularly true for a physician in this case, where the Dr. LaRoche knew that the patient was well-educated regarding the presence of breast masses due to her long-standing fibrocystic breast disease, and that the patient knew the importance of breast lumps which did nor change in size or lumps which increased in size. The standard of care did not hold Dr. LaRoche responsible for a patient missing an appointment and/or failing to contact either Dr. LaRoche or any other physician for a

period of ten months while, in accordance with deposition testimony, the lump in her right breast continued to enlarge.

In addition, Dr. Boerner is expected to testify that any alleged delay in diagnosing the right breast mass as carcinoma could not be construed to be the cause of her right modified radical mastectomy and resulting chemotherapy, or of the resulting cancer, surgery and chemotherapy regarding the left breast.

(3) Dr. John Hainsworth is expected to testify that, considering this patient's age, estrogen level, pre-menopausal status, and other factors, it is his opinion that had this patient been diagnosed with cancer as early as February, 1991, the treatment would have been essentially the same as that which she received in December of 1991. It is impossible to say whether Ms. Gorman's lymph nodes were involved in February of 1991. Since the staging of breast cancer is dependant upon knowing whether the lymph nodes were involved or when they became involved, it is not possible to say that her ten-year survivability rate was adversely affected by the alleged ten month delay in diagnosis. Further, it is Dr. Hainsworth's opinion that the cancer contracted by this patient in the left breast in 1993 was a new, primary lesion which was not caused by, nor exacerbated by, the alleged delay in diagnosing the cancer of the right breast.

In addition, pursuant to Alessio v. Crook, 663 S.W.2d 770, 779 (Tenn.App. 1982), Defendant reserves to right to call any of the Plaintiff Nancy Gorman's physicians who provided care, treatment or consultation to her related to the matters set forth in the Complaint in this cause of action.

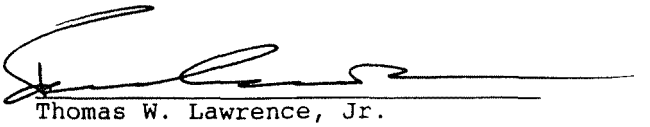
Respectfully submitted,

PARKER, LAWRENCE, CANTRELL & DEAN

Thomas W. Lawrence, Jr. - 3611
200 Fourth Avenue, North
5th Floor, Noel Place
Nashville, Tennessee 37219
(615) 255-7500

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing document was mailed to Douglas S. Johnston, Jr., Esq., 217 Second Avenue, North, Nashville, Tennessee 37201 on this 10th day of June, 1994.



Thomas W. Lawrence, Jr.