

TRANSCRIPT OF PROCEEDINGS

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IN THE CIRCUIT COURT
OF RUTHERFORD COUNTY
MURFREESBORO, TENNESSEE

DOC 110

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:
NANCY GORMAN and Husband, :
GERALD GORMAN, :
:
Plaintiffs, : Case Number
:
v. : 31218
:
ELIZABETH LaROCHE, M.D., :
Defendant. :
:
----- -x

DEPOSITION OF HOWARD LEWIS COHN, M.D.

Sterling, Virginia

Tuesday, July 26, 1994

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Defendant. :

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REPORTED BY:
JANE W. BEACH

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Deposition of HOWARD LEWIS COHN, M.D., called
for examination pursuant to notice of deposition, on
Tuesday, July 26, 1994, in Sterling, Virginia at the
offices of Dr. Cohn, 207 East Holly Avenue, at 1:40 p.m.
before JANE W. BEACH, a Notary Public within and for the
Commonwealth of Virginia, when were present on behalf of
the respective parties:

DOUGLAS S. JOHNSTON, JR., ESQ.
Attorney at Law
217 Second Avenue North
Nashville, Tennessee 37201
On behalf of Plaintiffs.

THOMAS W. LAWRENCE, JR., ESQ.
Parker, Lawrence, Cantrell & Dean
200 Fourth Avenue North
Fifth Floor
Nashville, Tennessee 37219
On behalf of Defendant.

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P R O C E E D I N G S

Whereupon,

HOWARD COHN, M.D.

was called as a witness in the above-entitled matter and,
having first been duly sworn, was examined and testified as
follows:

EXAMINATION

BY MR. LAWRENCE:

Q Would you state your full name for the record,
please?

A Sir, my name is Howard--H-o-w-a-r-d--Lewis--
L-e-w-i-s--Cohn--C-o-h-n, M.D.

Q What is your business address, Dr. Cohn?

A Sir, I have got two professional offices.
The one at which we are presently at is at 207
East Holly--H-o-l-l-y--Avenue, Suite 215, Sterling--
S-t-e-r-l-i-n-g--Virginia 20164.

I maintain another professional office at 106
Irving--I-r-v-i-n-g--Street, Northwest, Suite 408,
Washington, D.C. 20010.

Q Do you have an office in Maryland as well?

A No, sir, I do not.

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1 Q Have you ever had an office in Maryland?

2 A No, sir.

3 Q The two offices which you mentioned, on Sterling
4 and on Irving Street, are those both medical practice
5 offices?

6 A Yes, sir.

7 Q Are you a solo practitioner?

8 A Yes, sir.

9 Q If that's a correct word.

10 A That's correct, sir.

11 Q And you are an Ob/Gyn?

12 A That's correct.

13 Q Board-certified?

14 A Yes, sir.

15 Q Both as an obstetrician and a gynecologist, or is
16 that combined?

17 A It's a combined certification, sir.

18 Q Okay.

19 How much time do you spend between the two
20 offices, Dr. Cohn?

21 A I'd say these days I spend about 90 or 95 percent
22 of my time seeing patients in the Virginia office and only

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1 about five to ten percent of my time seeing patients in the
2 D.C. office.

3 Q When were you first contacted to review anything
4 in this case or give any opinions in this case?

5 A Sir, it's my recollection that I was first
6 contacted in the spring or summer of 1993.

7 Q By whom?

8 A By Attorney Johnston.

9 Q And do you know how Mr. Johnston got your name as
10 a potential expert in this case?

11 A Not exactly, no, sir.

12 Q When you say "not exactly," do you have a theory
13 or a guess?

14 A Well, I seem to recollect that when the first
15 contact was made, Attorney Johnston told me he got my name
16 either from a doctor or from another attorney, but I don't
17 recall the exact details.

18 Q Okay.

19 Have you ever worked with Mr. Johnston before?

20 A No, sir.

21 Q Have you ever worked with any other Tennessee
22 attorneys in medical malpractice cases before this one?

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1 A Yes, sir, I have.

2 Q Okay.

3 How many?

4 A I have worked with David Randolph Smith out of
5 Nashville.

6 I have worked with Randall Kinnard out of
7 Nashville.

8 I have worked with a Walter Bussart--
9 B-u-s-s-a-r-t--out of Nashville; and with a Deborah
10 Godwin--D-e-b-o-r-a-h G-o-d-w-i-n--from Memphis.

11 Q Did any of those cases involve issues similar to
12 the ones that are involved in this case?

13 A Not to my recollection, no, sir.

14 Q Do you currently have any active cases in
15 Tennessee with any of the four counselors you just
16 mentioned?

17 A I have done, I believe, two cases with David
18 Randolph Smith, both of which had discovery depositions.

19 It's my understanding that one case tabled or
20 placed on hold, and the other case may have already been
21 settled, so I don't know whether that's active or not.

22 But I think I have one active case with Attorney

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1 Bussart, one with Attorney Kinard--K-i-n-a-r-d.

2 Q Two n's.

3 A Two n's. K-i-n-n-a-r-d.

4 And one with Attorney Godwin--G-o-d-w-i-n.

5 So it's my understanding that I believe I have
6 three other active cases.

7 Q I take it that some of those cases are located in
8 Davidson County, Tennessee, in Nashville, in the court
9 there?

10 (Pause.)

11 If you don't recall, that's okay.

12 A I don't recall.

13 Q Do you recall the names of any of the defense
14 lawyers involved in the cases with either Mr. Kinnard or
15 Mr. Smith?

16 A I don't think I know who the defense attorneys
17 are with Attorney Kinnard or Attorney Bussart.

18 And David Randolph Smith, it's in the deposition
19 transcript, I just don't happen to recall who it is offhand.

20 Q Do you recall the styles of the cases, the names
21 of the patient/plaintiff in any of those cases?

22 A If you give me a few minutes, I probably can come

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1 up with one of the defendant/doctor's name.

2 Did you ask for plaintiff?

3 Q Either the patient/plaintiff or the
4 defendant/physician; either one.

5 Why don't you think about that, and if it comes
6 to you, then we will get that.

7 A Okay.

8 Q Do you keep files on your medical malpractice
9 cases that you act as a consultant in?

10 A I'm not sure what you mean by "keep files."

11 Q Well, if you are asked to consult in a medical
12 malpractice case and give your opinions and therefore review
13 records, do you make a file for that case?

14 A I try to maintain together the records that
15 pertain to that case, yes.

16 Q Okay. And do you place them in a file and keep
17 them all together?

18 A They're placed at various places around my
19 offices or home. I don't know--I don't have an organized
20 system whereby I can go right to any specific case
21 immediately.

22 Q Okay.

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1 And after a case closes, what do you do with the
2 materials and the files and so forth that you had
3 developed?

4 A I discard it.

5 Q Okay. So you don't keep anything beyond if a
6 case is settled or if a case is tried or if a case is
7 dismissed, then--

8 A That's correct.

9 Q --you throw everything away?

10 A That's correct.

11 Q Okay.

12 You do maintain a file in this case, I take
13 it?

14 A Yes, sir.

15 Q All right.

16 And what does that file contain?

17 A Sir, the file contains the materials I have now
18 in front of me. And it contains the original mailing that I
19 got from Attorney Johnston in the summer of 1993, and that
20 consists of the following:

21 No. 1, an opinion letter by Dr. Peter

22 A. Schwartz--S-c-h-w-a-r-t-z;

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1 No. 2, the records for Nancy Gorman in the office
2 of Dr. Elizabeth LaRoche--L-a-R-o-c-h-e; and also with other
3 doctors involved in the Murfreesboro Medical Clinic;

4 No. 3, a discharge summary from the Middle
5 Tennessee Medical Center in Murfreesboro, Tennessee,
6 addressing the admission under the supervision of Dr.
7 Westmoreland--W-e-s-t-m-o-r-e-l-a-n-d, admission date
8 1/17/92, for a breast biopsy and a modified radical
9 mastectomy; and

10 No. 4, responses of Dr. Elizabeth LaRoche to
11 plaintiff's first set of interrogatories.

12 Subsequent mailings that were added to my file
13 included: the plaintiff's supplemental responses to
14 defendant's first set of interrogatories, and supplemental
15 answers to plaintiff's first set of interrogatories by
16 defendant Elizabeth LaRoche, M.D.

17 Q Okay. Now let me just ask you one quick
18 question.

19 One of those documents, the first one that you
20 just mentioned, the ones that you have in your hand, is that
21 a document that summarizes what your expected testimony was
22 to be?

1 A I believe, among other things, it did summarize
2 what my expected testimony was, yes, sir.

3 Q Okay. All right.

4 A And lastly, added to the materials that would
5 consist of a file, I guess, would be depositions of
6 Mr. Gorman and Mrs. Nancy Gorman, and the deposition of
7 Dr. Elizabeth LaRoche.

8 Q Okay.

9 Have you spoken with the plaintiff or her
10 husband?

11 A No, sir.

12 Q Actually, they're both plaintiffs. So I should
13 ask you if you have talked with either Nancy or Butch
14 Gorman?

15 A No, sir.

16 Q Okay.

17 Therefore, I take it, you have never examined
18 Mrs. Gorman?

19 A That's correct.

20 Q Can you estimate how many hours you have
21 spent so far in reviewing this case and formulating your
22 opinions?

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1 going to send me back either the original or a copy so I can
2 maintain a complete file.

3 Would you do that?

4 MR. LAWRENCE: We would be glad to handle it any
5 way you want to. If you want him to have his originals
6 back, we can attach copies to the deposition. That would be
7 fine with me.

8 MR. JOHNSTON: Yes, I think that's what we want
9 to do.

10 MR. LAWRENCE: This is really as much for
11 identification purposes as anything.

12 And I would like you to hold on to that, please,
13 Doctor.

14 THE WITNESS: Yes, sir.

15 MR. LAWRENCE: So we can talk about it later in
16 the deposition.

17 BY MR. LAWRENCE: (Resuming)

18 Q Now, I take it you have, in addition to receiving
19 those three depositions that you listed earlier, you have
20 also read those.

21 Is that correct?

22 A Yes, sir.

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1 Q Have you made any notes on those pages?

2 A I believe I have underlined and made some
3 marginal notes, and also I have color highlighted in those
4 depositions.

5 Q Did you read or consult with any articles or
6 other literature in preparing your opinions?

7 A It's my recollection that to substantiate my
8 original opinions in summer of 1993, that when I gave
9 my report to Attorney Johnston, I read him various
10 passages in a textbook entitled "Cancer of the Breast,"
11 published in 1988; the exact reference should lie in the
12 Exhibit No. 1.

13 Q Okay. That's the Donevan and Spratt text.

14 Is that correct?

15 A Yes, sir.

16 Q Do you keep that in your library here at your
17 office?

18 A No, sir, I do not.

19 Q Okay. Do you feel that that is a particularly
20 substantive text as far as the issues that are involved in
21 this case is concerned?

22 A I think it's a representative text. I don't

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1 think I would call it particularly substantive.

2 Q Okay. So it's representative.

3 A That's correct.

4 Q Can you name other representative texts that
5 cover the standard of care and causation issues that are
6 involved in this case?

7 A I would think any of the major textbooks of
8 gynecology.

9 Q Okay. Of gynecology?

10 A Yes, sir.

11 Q Would you consider the text "Cancer of the
12 Breast" to be a gynecological textbook?

13 A Well, since it's written by two surgeons, I would
14 believe that it more falls into the category of a surgical
15 textbook, but it has oncological and gynecological
16 importance.

17 Q Okay. Okay.

18 So you, as I understand what you have told me,
19 you have at some point in time, perhaps back in the spring
20 of 1993, referred to the Donevan and Spratt treatise in
21 formulating your opinions, to some extent?

22 A No, sir.

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1 My opinions were already formulated prior to
2 looking at that textbook on the basis of my general
3 gynecological reading and my general knowledge, training,
4 and experience.

5 I thought it would be beneficial and helpful to
6 supplement that with some passages of a general surgery
7 textbook that addresses breast cancer to give the benefit of
8 that confirmatory information to Attorney Johnston.

9 Q And when you read that text, did it change any of
10 your preconceived or previously formulated opinions?

11 A No, sir.

12 It solidified what my opinions were based upon
13 previous gynecological reading, knowledge, training, and
14 experience.

15 Q All right.

16 Who is Dr. Peter Schwartz?

17 A Dr. Peter Schwartz is director of gynecology at
18 the Reading Hospital in Reading, Pennsylvania, and I believe
19 he is an associate of Jeannette Finkel--F-i-n-k-e-l--the
20 sister of Nancy Gorman.

21 And Jeannette Finkel is, in addition, to my
22 knowledge, a registered nurse.

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1 Q Do you know Ms. Finkel?

2 A No, sir.

3 Q Have you ever spoken with her?

4 A No, sir.

5 Q Have you ever spoken with Dr. Schwartz?

6 A No, sir.

7 Q Do you know him at all?

8 A No, sir.

9 Q Okay.

10 So you only know about these identities of those
11 two persons through reading the materials that are in front
12 of you on the desk today?

13 A That's correct, sir.

14 Q When you read--I think you indicated you had read
15 a report that had been submitted to you written by
16 Dr. Schwartz.

17 Is that correct?

18 A That's correct.

19 Q Did you agree with his assessment set forth in
20 that letter?

21 A I agreed with ultimate opinion in terms of
22 agreeing with, if by assessment you mean every single thing

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1 that he says in the report, then I would have to read the
2 report and see if I agree with every single passage.

3 Q All right.

4 Let's don't do that right now because I haven't
5 read it either. So what I would like to do is read that and
6 then perhaps we can talk about it later in the deposition.

7 A Yes, sir.

8 Q Now, you indicated that you had spent
9 approximately six hours getting ready for today's
10 deposition, if I understood you correctly.

11 A That's correct.

12 Q And I assume that would include meeting with
13 Mr. Johnston?

14 A No, I believe I spent an additional hour today
15 meeting with Attorney Johnston.

16 Q And then my next question is: How many hours in
17 addition to your work today on this file have you expended
18 reviewing and formulating your opinions?

19 A Well, my work today consisted of one hour. My
20 work over the last--

21 Q I am speaking of prior to today. Prior to your
22 getting ready, your actual preparation for this deposition.

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1 A Okay.

2 Q The six hours plus one hour with Mr. Johnston.

3 A Okay. Okay.

4 I don't recall how many hours I spent in the
5 spring and summer of 1993 in reading over the originally
6 submitted materials and rendering a communication to
7 Attorney Johnston.

8 Neither do I recall how long it took me to read
9 the plaintiff's supplemental responses to defendant's first
10 set of interrogatories nor the supplemental answers to
11 plaintiff's interrogatories by defendant, nor the
12 depositions involved.

13 Q Okay. How much do you charge for consultation of
14 this kind to a plaintiff?

15 A My usual charge to an attorney, whether it's a
16 plaintiff or a defense attorney, is \$175 per hour.

17 Q Okay. And that is for reviewing materials,
18 meeting with attorneys, that kind of thing?

19 A Yes, sir.

20 Q Okay. But then you charge \$250 an hour for
21 depositions?

22 Is that correct?

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1 A Well, I charge \$750 for a deposition, and in the
2 event that the deposition goes more than three hours, the
3 additional hours are billed at \$250 per hour.

4 Q Okay.

5 Have you billed Mrs. Gorman or her counsel to
6 date for your work on this case?

7 A I don't recall whether I actually sent bills or
8 told Mr. Johnston during telephone conversations what my
9 expected charge would be.

10 Q Well, what I am trying to find out is how much
11 you have charged the plaintiff so far in this case.

12 Do you know the answer to that question?

13 A I don't have the records that would address that
14 issue. But if the checks were all issued by your office or
15 by Attorney Johnston's office, then it should be easy to
16 determine what the charge would be.

17 Q Well, my question is, one of my questions was
18 have you billed the plaintiff to date for any of the time
19 you have spent on this case?

20 A Well, I have received remuneration. I don't
21 recall whether the remuneration is a check issued by the
22 plaintiff or plaintiff's counsel.

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1 I suspect the check was issued by plaintiff's
2 counsel. But I don't recall the exact amount, nor do I
3 recall whether I physically sent a pretyped-up bill or
4 whether communication with Attorney Johnston I told him what
5 my expected reimbursement would be for the particular
6 assignment.

7 Q Okay. So at some place in your office or at your
8 home--do you have an office at your home as well?

9 A No, sir.

10 Q At some place, at home or in your office, you
11 would keep records of how much income you received from this
12 project.

13 Is that correct?

14 A Well, I would deposit any check I received from
15 Attorney Johnston along with any other reimbursements for my
16 clinical work over the course to that date. I would deposit
17 that in the bank that day or the following day.

18 Q Right.

19 But in your file here on this case, you do not
20 keep any records of how much you have billed out to date or
21 what your income from your association in this case as an
22 expert witness would be?

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1 A Well, it's my usual policy to either write down
 2 or to keep track by memory of whatever expected remuneration
 3 is forthcoming for a particular assignment, and once that
 4 remuneration is received, then I no longer keep the record
 5 since I no longer need to.

6 Q So what you are telling me today is you have no
 7 way of telling me how much money you have received to date
 8 or how much money you have billed Mrs. Gorman or her
 9 representatives for time spent on this case.

10 Is that right?

11 A No, sir. No, sir, that's not what I said.

12 Q Well, answer that question.

13 Do you have any way of doing that?

14 A Yes, sir, I do.

15 Q And what method would that be?

16 A I would determine, if necessary, the amount of
 17 money that your office has sent me, the amount of money that
 18 Attorney Johnston's office has sent me, and add the two
 19 together.

20 Q Okay. Well, I know how much I have sent you. I
 21 have sent you a check for \$750.

22 A Okay.

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1 Q Which is your minimum required fee.

2 A Correct.

3 Q Is that correct?

4 A That's correct.

5 Q Okay. Now what I want to know is how much
6 Mr. Johnston's office has paid you so far.

7 A Okay. I don't have that information.

8 I guess you would have to ask Mr. Johnston's
9 office. I don't keep records.

10 Q That was my question.

11 Do you have any way of determining how much money
12 Mr. Johnston's office or Mrs. Gorman have paid to you for
13 your work on this case?

14 A Well, keeping in mind that after a payment is
15 received, then I either no longer keep in mind how much I
16 requested a payment for nor if I put a script of paper down
17 reminding me how much I requested for a particular
18 assignment, once that check is received, then it no longer
19 concerns me that payment has been requested, and I no longer
20 keep track of what my original request was nor whether that
21 request was met in full or partially once the bill is paid
22 in full.

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1 Q So the answer is "no"?

2 A Keeping in mind that I did say that there was a
3 way to find out, the answer is at this point, with my own
4 records, no.

5 Q Dr. Cohn, have you agreed to travel to Nashville
6 to testify in this case at the trial or actually the
7 Nashville area if this trial will be in Murfreesboro,
8 Tennessee?

9 Have you agreed to do so?

10 A I have not been requested to travel to Tennessee,
11 sir.

12 Q If requested, would you do so?

13 A Presuming that it doesn't interfere with any
14 clinical or familial responsibilities, yes, sir.

15 Q Have you ever been to middle Tennessee?

16 A No, sir.

17 Q Is that a "no"?

18 A I said, "No, sir."

19 Q Okay.

20 Have you ever given a deposition for evidence
21 that was to be utilized in a trial in Tennessee?

22 A I believe I said earlier in the proceedings that

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1 I had given two depositions for Attorney David Randolph
2 Smith.

3 Q Were those for evidence to be utilized at
4 trial?

5 A I am not sure what you mean by--I gave two
6 discovery depositions. I don't know if that is the same as
7 for evidence to be--

8 Q It's not.
9 It's a little bit different.

10 A Okay.

11 Q Today's proceeding is a discovery deposition.
12 And I don't know whether or not you have had a discussion of
13 that with Mr. Johnston.

14 It would also be possible for Mr. Johnston to
15 take your deposition to be used at the trial of the case.

16 So my question is: Did Mr. Smith, Mr. Kinnard,
17 Mr. Bussart, or Ms. Godwin, whatever his name was, did they
18 take your deposition for the purpose of utilizing that
19 transcript at a trial in Tennessee?

20 A I think what you are asking me is have I ever
21 done a videotaped trial deposition?

22 Is that it?

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1 Q Not necessarily videotaped. It could be
2 videotape but it also could be just like we're doing today,
3 just an oral deposition.

4 A I have not been aware that in either of the
5 depositions that I gave for David Randolph Smith, whether he
6 in addition intended them to be used as evidence at trial.

7 Q Have you ever traveled to any portion of
8 Tennessee, Dr. Cohn?

9 A No, sir.

10 Q Can you estimate for me how many cases you have
11 participated in as an expert in medical malpractice
12 litigation?

13 A By "participating," I assume that is an
14 all-encompassing term?

15 Q It is, yes.

16 And I mean from reviewing files and also giving
17 depositions and possibly also being a live witness at a
18 trial.

19 A Okay. Is it limited to those assignments, or is
20 it all-encompassing under any circumstance in which I was
21 asked to give an opinion, including opinions traveling
22 through a corridor of a hospital or a phone call asking for

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1 a preliminary idea?

2 Is it restricted to the incidents in which you
3 mentioned, or is it more encompassing than that?

4 Q It's restricted to the request for a formal
5 opinion by an attorney involved in a filed lawsuit involving
6 medical malpractice.

7 A Okay.

8 I would say approximately 100 times.

9 Q Okay. Since when?

10 A Since late 1987 or early 1988.

11 Q How many active cases do you have at the present
12 time?

13 A I need to know what you mean by "active."

14 Q Well, as distinguished from a case that has
15 already been tried, a case that has been dismissed, a case
16 that has been settled and therefore you are no longer
17 working on it and you don't have to keep the file and you
18 throw the file away.

19 A That's a difficult question to answer because not
20 every attorney is courteous enough to let me know when a
21 case has been dropped or settled or dismissed or transferred
22 to another law firm or just progressed on and another expert

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1 was hired because the original attorney didn't like my
2 opinion.

3 I also don't know whether if I have rendered a
4 formal opinion to an attorney who was considering filing a
5 lawsuit whether he actually filed that or not.

6 And so my answer is obligatorily restricted by
7 the fact that I don't know what happens to most of my cases.
8 But as a gross estimation, keeping that in mind, I would say
9 approximately 20.

10 Q How much time would you estimate those, you know,
11 your work with medical legal matters, consume in
12 relationship to your normal practice as an Ob/Gyn?

13 A I would say it consumes approximately 10, no
14 higher than 15 percent of my professional time.

15 Q In ny of those approximately 100 cases that you
16 estimated that you had worked on formally since, I think you
17 said, and I have forgotten the date, but at any rate--

18 A Late 1987 or early 1988.

19 Q Okay. Have any of those dealt with issues
20 similar to the ones we are dealing with here; that is,
21 delayed diagnosis of breast cancer?

22 A I don't recall specifically any specific case in

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1 which there was a delayed diagnosis of breast cancer.

2 There may have been, at most, one, but I can't
3 recall, but certainly no more than one.

4 Q You think there is one, or there might be
5 one?

6 A I think there might be one, but I don't recall
7 specifically any case that dealt with delayed diagnosis of
8 breast cancer. And keeping in mind that my memory is not
9 infallible, I believe at most there could be one, but I
10 can't recall for certain, and I am rather confident that
11 this is the first and only one.

12 Q Okay.

13 Now, what is the Forensic Medical Advisory
14 Service, Dr. Cohn?

15 A The Forensic Medical Advisory Service is a peer
16 review organization that utilizes me from time to time in a
17 number of its various missions.

18 Q Is it a private enterprise?

19 A I am not knowledgeable about the specific
20 business organization. But if you mean private as opposed
21 to public, meaning federally funded, if that's what you're
22 asking, then it is private.

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1 Q Well, is it associated with a hospital or a
2 medical group here in the D.C. area?

3 A Okay. To my knowledge, it's an organization that
4 has two offices, one in Rockville, Maryland, and the other
5 in Plymouth Meeting, Pennsylvania, and I am not aware of it
6 being part of a hospital or medical facility in the
7 Washington area.

8 Q Through the Forensic Medical Advisory Service, do
9 you receive any cases for consultation?

10 A Yes, sir.

11 Among the other missions and assignments that
12 they request of me, I also have received requests from that
13 organization to review charts of medical legal cases to
14 comment on the adequacy of care.

15 Q And when you receive those charts, do you
16 sometimes end up becoming a medical expert in that
17 litigation?

18 A If so chosen by the requesting attorney, yes,
19 sir.

20 Q Okay.

21 What is your association with the FMAS?

22 A I am an independent contractor, and they call

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1 upon me from time to time to participate in a number of
2 their peer review quality assurance activities, including in
3 the area of chart review for determination of adequacy of
4 care.

5 Q Okay.

6 You mentioned the word "mission." What other
7 missions other than reviewing cases in litigation would you
8 perform for this organization?

9 A Well, they from time to time have asked me to
10 participate in a civilian external peer review panel in
11 which I have been asked to comment on the quality of
12 military care, not necessarily in individual cases but
13 looking at military treatment facilities in general, looking
14 at various infection rates, various hysterectomy or cesarian
15 section rates in a certain segment of the country or in
16 specific patterns of practice in a specific practitioner or
17 in a specific MTF, military treatment facility.

18 They have also asked me to participate in a
19 project funded by the State of Pennsylvania in which it was
20 my mission to determine the appropriateness of either
21 State-funded abortions or State-funded hysterectomies, I
22 can't recall.

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1 They have also asked me from time to time act as
2 an unbiased, objective person to help a particular
3 hospital's quality assurance committee in a hospital or a
4 particular practitioner that I wasn't familiar with, to
5 determine if his care in a particular case or if his
6 particular pattern of practice was up to the standard of
7 care, in my opinion.

8 There may have been a number of other similar
9 assignments that I have been asked for participation in by
10 FMAS.

11 Q Do you in any way advertise your name as--

12 A No, sir.

13 Q --a potential medical malpractice expert?

14 A No, sir, I do not.

15 Q Are you listed by TASA?

16 A Yes, sir.

17 Q Do you know what I mean by TASA?

18 A Yes, sir, I am.

19 Q What does TASA stand for?

20 A TASA is another peer review quality assurance
21 organization known as TASA, which is Technical Advisory
22 Service for Attorneys.

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1 Q Did you contact TASA and ask to be listed with
2 them or did TASA contact you?

3 A No, sir, TASA contacted me.

4 Q Okay. And when did that occur?

5 A I believe it was approximately 1988 or 1989.

6 Q What is your arrangement with TASA?

7 A I am an independent contractor with TASA in which
8 if there is a case that they would like me to review to
9 comment on the adequacy of care, they will call me and tell
10 me that a particular attorney in a particular part of the
11 country would like me to review a case of, and they will
12 list the particular problem involved.

13 And they will ask me if, A, I have the time and,
14 B, if I have the interest and, C, if I have the expertise to
15 be able to render an opinion on the adequacy of care.

16 Q And if you decide to do that and if all those
17 elements fall into place and you do become a medical expert
18 in a case that was referred to you by TASA, how much do you
19 charge per hour for depositions?

20 A TASA has a preset arrangement in which I agree to
21 accept their standard fee. It has been a while since I did
22 a deposition for TASA, so you may need to give me a short

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1 time to try to recall what their fee structure was.

2 Q Well, let me ask you this: Generally speaking,
3 do you find yourself charging more for deposition time when
4 you are working on a TASA case than you do for a case such
5 as this one, which I assume did not come through TASA--am I
6 right about that?

7 This is not a TASA case?

8 A It's my recollection that this is not a TASA
9 case.

10 Q Okay.

11 A And further it is my recollection that TASA's fee
12 structure is less than the fee structure that I would charge
13 either through Forensic Medical Advisory Service or through
14 independent discussions with an attorney.

15 Q If you charge a certain amount when you are
16 working on a TASA case per hour for a deposition, for
17 example, are you then obligated under your contract to pay a
18 certain percentage of that amount to TASA?

19 A Well, it isn't a contract, it's an understanding
20 in terms of the fee arrangement. And the way TASA works is
21 TASA collects whatever fees the attorney agrees to pay in
22 advance, so TASA collects all the money, and then any

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1 assignments that I accept from TASA which are reimbursable,
2 I would give a list of my hours and my duties to TASA and
3 out of the monies collected from the attorney TASA would pay
4 me.

5 Q Okay. TASA pays you less, as far as you know,
6 than what TASA charges the lawyer who takes the deposition.
7 Is that correct?

8 A I would suspect so.

9 Q Okay.

10 And you are able to keep up with that time so
11 that you can be reimbursed from TASA on an hourly basis for
12 the time that you put into a file.

13 Is that correct?

14 A Okay.

15 Well, once I finish either reading over a chart
16 or performing a deposition, then I either call TASA and let
17 them know how many hours I spent or I will send them a bill.

18 I will keep a copy of that bill, and once TASA
19 pays me, then I throw away the bill or erase any memory in
20 terms of what I expected from that organization.

21 Q What is the most recent deposition in a medical
22 malpractice case that you gave, Doctor?

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1 Prior to this one, of course.

2 A Okay.

3 (Pause.)

4 It was this calendar year, 1994. I am just
5 trying to recall any that I have done in 1994 and what the
6 most recent was.

7 (Pause.)

8 You may need to give me a number of minutes
9 before I can remember that.

10 I may need to look at a pocket calendar.

11 Q That's all right. Don't worry about it.

12 Let's do this.

13 Would you look at your pocket calendar later and
14 just pass that information along to--

15 A Well, it will take me less than 30 seconds.

16 The pocket calendar consists of a schedule--well,
17 it's not going to be helpful like I thought it was going to
18 be.

19 MR. LAWRENCE: Off the record.

20 (Discussion off the record.)

21 MR. LAWRENCE: Back on the record.

22 THE WITNESS: Looking at a calendar was

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1 unsuccessful in determining my recollection of the
2 deposition.

3 BY MR. LAWRENCE: (Resuming)

4 Q Have you given a deposition in the last month?

5 A Not that I can recall, no, sir.

6 Q The last two months?

7 A No, not that I can recall, no, sir.

8 Q Okay.

9 Do you have any way of determining when your most
10 recent deposition that you gave in a medical malpractice
11 case occurred?

12 A It's my recollection that I gave a deposition on
13 April 15, 1994.

14 Q Now, I have to comment, even on the record, that
15 you are holding a New York Yankees official schedule.

16 A That is correct.

17 Q For 1994.

18 Is that right?

19 A That is correct.

20 Q Do you keep records of your depositions on
21 baseball schedules?

22 A No, sir.

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1 Q Or did you just happen to have been in New York?

2 A No, I know.

3 It was a deposition given in Detroit, Michigan,
4 and we specifically planned the deposition to be on a day
5 when the Yankees were playing in Detroit. And so I looked
6 at the schedule to see the last time the Yankees were in
7 Detroit.

8 Q Okay.

9 And do you recall the name of that case?

10 A No, sir, I do not.

11 Q Do you recall any identifying, any way of
12 identifying that case, the names of the lawyers?

13 A I think the attorney's name was Matthew Curtis
14 --C-u-r-t-i-s. The law firm was Sommers--S-o-m-m-e-r-s--
15 Silver & Schwartz. The address is Southfield, Michigan, and
16 the date is April 15, 1994.

17 Q Do you remember the name of the patient?

18 A No, sir, I do not.

19 Q The name of the defendant physician?

20 A No, sir, I do not.

21 Q Was that a TASA case?

22 A No, sir.

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1 Q You usually testify, when you testify by
2 deposition or trial, for plaintiffs.

3 Is that correct, Dr. Cohn?

4 A On at least six occasions in my life, I have been
5 requested in one manner or another by an attorney to provide
6 an opinion in which the attorney ultimately turned out to be
7 an attorney for the defense. But only on one occasion has
8 an attorney who ultimately turned out for the defense
9 actually sent me the records and actually requested a
10 formalized opinion.

11 Q So the answer to my question is "yes," you do
12 normally testify for plaintiffs?

13 A Yes. As a consequence of being at the mercy of
14 whomever calls me and not being able to pick and choose
15 which cases I am going to testify in.

16 Q Okay.

17 And did you actually testify by trial or
18 deposition in that defense case?

19 A Yes, sir, I did.

20 Q Okay. When was that?

21 (Pause.)

22 You don't know?

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1 A It's approximately two, maybe two and a half
2 years ago. It might have been three years ago, it might
3 have been a year and a half ago. In that general time
4 frame.

5 Q Okay.

6 In this particular case that we're dealing with
7 today, is it your opinion that Dr. Elizabeth LaRoche
8 deviated from the recognized standard of care for Ob/Gyns?

9 A Yes, sir, it is.

10 Q Okay.

11 Tell me first, before we get into this
12 discussion, what your definition of standard of care is..

13 A My definition of the standard of care is those
14 actions or inactions or judgments or management, either
15 surgical or cognitive, of a case; that is, that which would
16 be the care provided by the reasonably prudent and
17 well-trained obstetrician/gynecologist under the same or
18 similar circumstances.

19 Q Do you see standard of care as representing a
20 range of care, or do you see it as an absolute
21 black-or-white matter?

22 A I see it as a minimally accepted level of care.

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1 Q Okay.

2 A Minimally acceptable level of care.

3 Q All right.

4 Now, in this particular case, would you specify
5 for me the ways in which you believe Dr. LaRoche deviated
6 from the standard of care?

7 A Sir, it's my opinion that Dr. LaRoche deviated
8 from the standard of care when Mrs. Nancy Gorman came to see
9 Dr. LaRoche on February 20, 1991, on which Dr. LaRoche was
10 the responsible physician responsible for examining and/or
11 supervising the care, treatment, and decision-making process
12 of Nancy Gorman, in which Nancy Gorman arrived at that
13 office having found several days, or what she calls "a few
14 days," prior to February 20, 1991, a lump or nodule in the
15 right breast that met the definition of a dominant mass.

16 And the standard of care for any palpable breast
17 mass is, regardless of what other temporizing or diagnostic
18 procedures are utilized, either cytological or histological
19 material is necessary to rule out the presence of breast
20 cancer.

21 And the management decided under the supervision
22 of Dr. LaRoche deviated from that standard in that the

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1 dominant mass, a new palpable mass was not sampled neither
2 cytologically nor histologically. And that represents a
3 deviation from the standard of care.

4 Q Okay.

5 Anything else?

6 A Coincident with that visit, it is a deviation
7 from the standard of care to rely solely on mammography as
8 an indication of whether temporization or histological or
9 cytological sampling ought to be done in the presence of a
10 new palpable breast mass.

11 Additionally, if temporization is chosen as the
12 method--

13 Q I'm sorry?

14 "Temporization"?

15 A Temporization.

16 Q What does that mean?

17 A Delay.

18 Q Oh. Okay.

19 A Waiting.

20 Additionally, if temporization is chosen as the
21 method of management for a new palpable breast mass,
22 awaiting the results of mammography, the standard of care

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1 dictates that the time between the initial presentation and
2 the ultimate tissue sampling should be a reasonable time,
3 the reasonable time being up to two, three, four weeks.

4 And it may be also justifiable to wait slightly
5 more than four weeks, but it is a deviation from the
6 standard of care to temporize more than two, three, four,
7 perhaps even five weeks, especially in a patient whose
8 menstrual history could not be determined because she had
9 had a previous hysterectomy and in a woman with previously
10 diagnosed fibrocystic changes in her breasts and in a woman
11 over 25 years or age, to temporize or delay longer than this
12 time span.

13 Q Let me see if I wrote down all of those elements.

14 You said a woman, this is especially true in a
15 woman who has had a hysterectomy.

16 A Correct.

17 Q Is that correct?

18 A For the reasons that you can't follow the
19 menstrual history and you can't determine when the week
20 following her menses would be, which would be the best time
21 to follow up a new breast mass if temporization is chosen as
22 the method of management.

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1 Q Okay.

2 And also another element was that the woman is
3 over 25 years of age?

4 A Over 25 years of age.

5 Q Okay.

6 And the third was fibrocystic disease?

7 A History of fibrocystic breast changes.

8 Q Okay. Any other manner, have you isolated any
9 other manner in which you believe she deviated from the
10 standard of care?

11 A Those are the deviations from standard of care in
12 February 1991.

13 If Dr. LaRoche believed, and her plan was, that
14 the patient was scheduled to keep an allegedly scheduled
15 appointment for May 7, 1991, and the patient for whatever
16 reason did not arrive at that time, the standard of care
17 requires for the physician either herself or himself to, or
18 to direct their medical staff to, notify the patient of what
19 she believed to be a missed appointment either by letter or
20 by telephone call, especially in view of the fact of a new
21 breast mass that was not even examined by Dr. LaRoche in
22 which temporization was chosen as a method of management and

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1 in which there was a negative mammogram.

2 Keeping in mind that the false negative rate for
3 mammograms in young women is at least 10 to 15 percent and
4 much higher, it was a deviation from the standard of care to
5 not, either by letter or by phone call, call in Mrs. Gorman
6 for an examination.

7 Q Okay.

8 Any other manners, any other ways in which you
9 believe she deviated from the standard of care?

10 A No, sir.

11 Q Okay.

12 All right. Now, I have written down four basic
13 areas that you have just listed for me, and I want to be
14 sure that I have them correct.

15 So let me read these back to you, if that's fair
16 enough.

17 A Yes, sir.

18 Q And bear in mind that we are going to go back
19 over these so you will have the opportunity to explain
20 further.

21 A Yes, sir.

22 Q The first, I think you indicated she presented

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1 with a dominant, a new dominant mass and, therefore, you
2 felt that the standard of care required either cytological
3 or histological examination of that mass.

4 Is that correct?

5 A That's correct.

6 Q Okay.

7 Secondly, I think you indicated that you thought
8 she deviated from the standard of care by relying totally on
9 the mammogram. Her reliance solely on a mammogram. That's
10 the words I wrote down.

11 Is that correct?

12 A To exclude malignancy.

13 I guess that's correct.

14 Q Okay.

15 A Yes, sir.

16 Q All right.

17 Thirdly, you thought that if temporization was
18 chosen as a manner of, I guess, conservative treatment of
19 this new dominant mass, that the maximum delay would have
20 been at most five weeks, two, three, four weeks, and you
21 said no more than five. I think that's what you said.

22 Is that correct?

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1 A That's correct.

2 Q Okay.

3 The fourth was that if indeed there was in
4 Dr. LaRoche's opinion an appointment set up for May 7, 1991,
5 and the patient did not make it, then Dr. LaRoche should
6 have made contact or her office should have made contact
7 with the patient.

8 Is that correct?

9 A Yes, sir.

10 Q Okay. Okay.

11 Have you ever been sued in a medical malpractice
12 case?

13 A Yes, sir.

14 Q How many?

15 A I have been sued four times.

16 Q Okay.

17 What is the most recent case? I am familiar with
18 three of them.

19 A The most recent case is a case that took place on
20 April 5, 1993. And it was a case in which a patient
21 delivered a baby in February of 1993 under the supervision
22 of another physician acting in the role as a supervisory

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1 teaching attending for the residence staff.

2 The patient subsequently came to the clinic on
3 April 5, 1993, stating that she had been bleeding
4 intermittently ever since delivery.

5 Q Dr. Cohn, may I cut you off?

6 A Okay.

7 Q And I don't mean to be rude.

8 But I am assuming that case did not involve
9 issues similar to the ones we are dealing with here, which
10 is delayed diagnosis of breast cancer?

11 A That is correct, sir.

12 Q And you have never been sued as a defendant
13 physician in a case dealing with issues of this kind?

14 A That is correct, sir.

15 Q Okay.

16 And is your April 1993 case still pending?

17 A Yes, sir.

18 Q Okay. Is it set for trial?

19 A It's set for deposition.

20 Q Okay.

21 A But not for trial, to my knowledge.

22 Q Okay. All right.

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1 And what is the name of the patient?

2 A The patient's name is Alanda--A-l-a-n-d-a--
3 Parham--P-a-r-h-a-m.

4 Q All right.

5 And what court is it in?

6 A It's in a District of Columbia court.

7 I don't

8 know the exact name of the court.

9 Q The federal court there?

10 A I don't know the breakdown of the courts, sir.

11 Q Did you treat Ms. Parham in your office on Irving
12 Street?

13 A No, sir.

14 Q Did you treat her here?

15 A No, sir.

16 Q Where did you treat her?

17 A I supervised her care at the Washington Hospital
18 Center in my role as a supervisory teaching attending,
19 beginning at 10:00 a.m. on April 5, 1993.

20 Q Okay.

21 You do some teaching, don't you?

22 A Yes, sir.

1 Q In any of the courses that you teach, do you
2 teach anything relevant, precisely relevant, to the issues
3 involved in this case, diagnosis of breast cancer?

4 A Yes, sir.

5 Among the many topics that I discuss either
6 formally or informally with the residents that I teach
7 include the diagnosis and management of breast disease.

8 Q Okay.

9 Is that a separate course? Tell me, describe for
10 me your teaching responsibilities.

11 A My teaching responsibilities include being
12 assigned by the departmental chairman to act in a
13 supervisory capacity in which I am obligated to remain in
14 the hospital during my tour of duty, either a 12 hours or 24
15 hours duty, in which I am required to participate in all
16 emergency room evaluations, vaginal deliveries, cesarian
17 sections, Gyn operations, consultations requested by other
18 specialties.

19 I am also required to be the supervising
20 attending in any outpatient clinics that are ongoing during
21 those days.

22 The outpatient clinics involve examinations of

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1 patients from a gynecological standpoint, including breast
2 examination. And over the course of my supervision I am
3 called upon to teach residents and sometimes medical
4 students how to do breast exams, how to manage palpable
5 masses, how to manage the appropriateness, interpretability
6 and limitations of mammography, et cetera, et cetera.

7 So it is not an exact formal, didactic series of
8 lectures that I give.

9 Q Okay.

10 A It's hands-on teaching one on one with the
11 resident and has the patient as the focal point.

12 Q Okay. All right.

13 Earlier we identified Exhibit 1 to your
14 deposition, which is the summary of your testimony as of the
15 date that document was drafted.

16 Correct?

17 A That is correct, sir.

18 Q Okay.

19 Now, have you reviewed that document?

20 A Yes, sir, I did.

21 Q Did you draft it? Did you draft the portion
22 dealing with your opinions?

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1 A No, sir, I did not.

2 Q Did you approve the draft?

3 A No, sir, I did not.

4 Q Having reviewed it, do you agree with it?

5 A The copy in front of me here? No, sir.

6 Q You do not agree with it?

7 A There is a number of misspellings and syntactical
8 errors and errors of punctuation that I pointed out. But
9 assuming that all those were corrected, then I agree with
10 what I presume is the ultimate final copy.

11 Q Okay.

12 Substantively you agree with it.

13 Is that correct?

14 A Yes, sir.

15 Q Is it comprehensive? Does it cover all of your
16 opinions?

17 A I'm not sure if it specifically matches one to
18 one the opinions I have listed for you today were the
19 opinions that are listed in this document here.

20 Q Well, is there anything you would want to change,
21 other than--

22 A Okay.

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1 Q I am not talking about stylistic errors, typos,
2 the date that's wrong in there and that kind of thing.
3 Those things happen.

4 But other than those, is there anything that you
5 would want to change?

6 A Well, I would want to make sure that every one of
7 the four deviations from the standard of care that I just
8 cited for you now are included in this document. If they
9 are, then I would not change anything.

10 Q Okay.

11 Well, as you read through it in reviewing it, did
12 any such changes come to your mind?

13 A It's my recollection, keeping in mind that my
14 memory is not infallible, it's my recollection that the four
15 deviations from the standard of care that I cited for you
16 today are included in this draft. But I can't give you 100
17 percent assurance that that is true.

18 Q Having reviewed the medical records in this case
19 that were sent to you, and the depositions, et cetera, and
20 all the other documents that you reviewed, did you agree
21 with the factual basis that was set forth as the foundation
22 for your opinions in Exhibit 1?

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1 A No, sir.

2 Apparently, at the time that I read over the
3 initial draft, I was under the impression that on February
4 20, 1991, Mrs. Gorman, who requested an appointment with
5 Dr. LaRoche had actually physically been seen by
6 Dr. LaRoche, but it wasn't until I read the deposition of
7 Dr. LaRoche that I realized that a nurse practitioner and
8 not Dr. LaRoche had examined the patient and had initiated
9 the plan of care.

10 Q Okay. Any others?

11 A Any other factual points?

12 Q Yes, sir.

13 A Not that I can see at this point, sir.

14 Q Okay.

15 From time to time in this document and throughout
16 this litigation there has been reference to Mrs. Gorman's
17 family history of breast cancer.

18 Are you familiar with those references?

19 A Yes, sir. Yes, sir.

20 Q And, in fact, they appear at least once and
21 perhaps more than once in Exhibit 1.

22 Correct?

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1 A That is correct.

2 Q Do you feel that that is important in this case?

3 A Well, keeping in mind that the highest risk
4 factor for breast cancer in a woman is just being a woman
5 and having breasts. So any woman is at risk for having
6 breast cancer.

7 Especially now in which the incidence of breast
8 cancer has been rising in the past few years, approximately
9 one percent a year and now it is thought that one out of
10 eight women in this country will develop breast cancer,
11 certainly the very fact that a woman has breasts puts her at
12 a high-risk situation.

13 There are certain other characteristics that
14 increase the risk of a woman above and beyond the general
15 population. If a woman has a first-degree relative who has
16 or has had breast cancer, specifically her mother, sister,
17 or daughter, then that is the strongest correlating factor
18 between family history and increased risk.

19 Q Now, that was not the case with Mrs. Gorman. Is
20 that correct?

21 A That's correct.

22 Q Okay. She did not have a first-degree relative

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1 who was a mother, sister, or daughter who had had breast
2 cancer, as far as you are aware?

3 A Right. That is correct.

4 Q Okay.

5 A But any family history of breast cancer, even not
6 necessarily a first-degree relative, any family biological
7 history of breast cancer puts the patient at a higher risk
8 than the overall incidence of the general population.

9 Q And are you able to quantify that higher risk
10 for, in Mrs. Gorman's case, paternal aunts?

11 A No, sir, I cannot.

12 Q Okay.

13 Are you aware of any literature, treatises,
14 articles, any kind of publication which substantiates the
15 statement that you just made?

16 A Which statement was this, sir?

17 Q The statement that--well, let me put it this way:
18 Any such literature that would support the statement that
19 the fact that Mrs. Gorman's family history of the three
20 paternal aunts who died with breast cancer, I think before
21 the age of 43--and correct me if I am wrong--

22 A Yes, sir, that's correct.

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1 Q --made her more susceptible to be a breast cancer
2 candidate. Are you aware of any such literature or
3 publication?

4 A Well, because that is part of my general
5 knowledge, training, and experience, at one point I must
6 have come across that either listening in a lecture or
7 reading over a textbook or an article. So I am aware that
8 that exists somewhere in the body of literature or in the
9 universe of lectures that I have attended. I can't quote
10 you chapter and verse at this time.

11 Q Are some cancers more aggressive than others in
12 women?

13 A Yes, sir.

14 Q Can you explain which ones, or can you explain
15 that statement to me to give me an idea what you mean by
16 that?

17 A Which cancers are more deadly? Is that what you
18 said? Or more aggressive?

19 Q More aggressive. Yes. More aggressive.

20 A Now, you mean cancers in general, or breast
21 cancers?

22 A Okay.

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1 There are histologic types of breast cancer
 2 which, by their very histology and aggressive nature, tend
 3 to make the prognosis worse as a consequence, A, of a
 4 tendency toward more aggressive biologic behavior, and, B,
 5 misdiagnosis or delayed diagnosis on the part of a health
 6 care practitioner, or, C, patient's late arrival at the
 7 doctor's office not recognizing the particular cancer to be
 8 consistent with a cancer.

9 Q Are those cancers more dangerous because they
 10 grow at a faster rate? Is that the problem?

11 A Well, I think the problem is multifactorial.

12 Q Is what?

13 A Multifactorial.

14 Q Okay.

15 A M-u-l-t-i-f-a-c-t-o-r-i-a-l.

16 One of the factors may be that they tend to grow
 17 at a faster rate.

18 Q Okay.

19 What other factors would you list other than
 20 their growing speed?

21 A Well, as I mentioned, some of the early symptoms
 22 are perceived by the patient to be evidence of breast

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1 disease other than cancer, and sometimes a practitioner who
2 practices below the minimally acceptable standard of care
3 will treat these cancers thinking they are a disease process
4 that aren't cancerous.

5 Q Well, I guess, going back to element No. 1, is it
6 your opinion that some breast cancers grow faster than
7 others?

8 A Yes, it is.

9 Q Okay. And some progress faster than others?

10 A That's correct.

11 Q Therefore, some may invade surrounding tissues
12 more quickly than others?

13 A That's correct.

14 Q Is there any way to determine in advance whether
15 or not the cancer in one woman may grow faster than the same
16 cancer in another woman?

17 A You need to give me--you are asking a
18 hypothetical question. I need you to give me all the facts.
19 Is there any way to tell in advance of a biopsy, in advance
20 of a mammogram, in advance of the patient finding a lump?
21 In advance of what?

22 Q Well, when the patient first comes in to see the

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1 physician, and let's say that it is, as in this case, with a
2 new lump. Okay.

3 Is there any way for that physician to determine
4 whether or not this is a cancer that is a fast-growing
5 cancer or a slower-growing or progressing cancer?

6 A On the basis of an initial examination without
7 tissue aspiration or mammography? No, sir, there is no way
8 to tell.

9 Q Okay.

10 A There is no way to tell even if it's cancer at
11 that stage.

12 Q Okay.

13 How can you use needle aspiratory biopsy to
14 determine whether or not that is a fast- or a slow-growing
15 cancer?

16 A If you get a fine-needle aspiration, either
17 cytologically speaking or histologically speaking, of cells
18 that are consistent with a neoplasm, then the standard of
19 care consists of consideration of an actual open biopsy
20 and/or excisional biopsy to determine the exact cell type.
21 And then once the exact cell type is determined, then a
22 decision can be made as to, A, what type of cancer it is

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1 and, B, its general proclivity to spread.

2 Q Okay.

3 And what kind of cancer was involved in the right
4 breast of this patient in February of 1991?

5 A The ultimate biopsy performed in December of 1991
6 revealed it be to be an infiltrating ductal carcinoma.

7 Q That is the ultimate finding?

8 A The ultimate finding in December 26, 1991,
9 revealed the histologic type to be infiltrating ductal
10 carcinoma.

11 Q Have you read all the pathology reports in this
12 case with regard to Mrs. Gorman's malignancies in both
13 breasts?

14 A No, sir.

15 Q Is infiltrating ductal carcinoma one of those
16 more aggressive forms of breast cancer that you were
17 speaking of earlier?

18 A Well, the answer to that question is probably
19 best answered more by an oncologist than by an gynecologist.

20 Q Okay. So you don't really feel qualified to
21 answer that question?

22 A To answer that specific question. That's

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1 correct.

2 Q Okay.

3 Could Dr. LaRoche, in your opinion, have complied
4 with the standard of care in this case had she within that
5 five-week period between February 20, 1991, or following
6 February 20, 1991, referred this patient to a surgeon?

7 A Yes, sir.

8 Q Okay.

9 And had she done that, then if I understand your
10 opinion correctly, then you sitting here today as an expert
11 would not be requiring her under the standard of care to
12 conduct or order a fine-needle aspiration or an excisional
13 biopsy or an ultrasound or any other kind of histological or
14 cytological testing. Is that correct?

15 A Well, except under one condition: If she
16 appreciated the necessity for a general surgeon's
17 involvement on February 20, 1991, and sent the patient to a
18 general surgeon, okay, then she would be in compliance with
19 the accepted standard of care, except in a circumstance that
20 the general surgeon communicated with her that he planned to
21 not biopsy, not aspirate, to rely on a mammogram or to do
22 anything that would be a deviation from the standard of

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1 care, then Dr. LaRoche would have to meet the standard of
2 care by communicating her disagreement with the management
3 approach to the general surgeon.

4 But short of that, then her responsibility is
5 removed once the patient arrives at the general surgeon.

6 Q Let me see if I understood that.

7 Dr. LaRoche has a patient come in with a new--

8 A Correct.

9 Q --mass in one of her breasts.

10 A Correct.

11 Q And she immediately sends the patient to a
12 surgeon for a surgical consult.

13 A Correct.

14 Q And you're saying that she does not have the
15 right to rely upon the opinion of that surgeon as far as the
16 follow-up treatment for that dominant mass?

17 A If the follow-up treatment plan by the surgeon is
18 a deviation from the standard of care, then by not
19 disagreeing, in effect Dr. LaRoche is giving tacit approval
20 of that care and, therefore, in my opinion she would be also
21 guilty of a deviation from the standard of care.

22 Q Then what benefit is it to an Ob/Gyn who is a

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1 primary care physician and is the first health care provider
2 to see a new lump in a patient to get a surgical consult or
3 a consult from any other specialist if that physician is not
4 permitted to rely upon the opinion of that specialized
5 consultant?

6 A Well, she is permitted to do whatever she wants
7 as long as what she is permitted to do is an acceptable part
8 of a standard of care.

9 In other words, just because a physician or an
10 Ob/Gyn refers a patient to a general surgeon for a breast
11 lump, okay, that doesn't mean that her responsibility toward
12 that patient, toward that breast lump is obviated.

13 She has a responsibility to participate as the
14 referring physician at least in communicating with the
15 surgeon to find out what the surgeon's plan was, and if the
16 surgeon's plan put the patient at an added risk of a
17 potentially lethal outcome, then the standard of care
18 requires her at the very least to engage in a discourse with
19 the surgeon, explaining her reluctance to feel comfortable
20 with any delay in which she thought would be appropriate
21 therapy.

22 Q Okay.

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1 MR. LAWRENCE: Dr. Cohn, you are certainly
2 welcome to take a break any time you need to.

3 THE WITNESS: No, I'm fine. I'll be fine.

4 BY MR. LAWRENCE: (Resuming)

5 Q Now I want to go back to the list of deviations
6 from the standard of care that you gave earlier in your
7 deposition. And the first one of those was the physician's
8 response to a new dominant mass. Okay.

9 Is it your position today that there is no
10 exception to the rule that a patient who comes in with a
11 mass as this one was described by the nurse practitioner
12 must have histological or cytological evaluation of the
13 mass?

14 A Well, the standard of care is that all dominant
15 masses need to be evaluated cytologically or pathologically.

16 Now, in a young woman with a--by young I mean
17 less than 25--with a totally cystic mass, who is not being
18 examined during the week after her menses, who is sent for a
19 mammogram to rule out other breast pathology, and if that
20 mammogram comes back negative has an ultrasound to determine
21 the cystic or solid nature of this dominant mass or
22 ultrasound comes back totally cystic, and that patient comes

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1 back for a repeat visit within two, three, four weeks, in
2 other words, coinciding within the week following the
3 menses, and the mass has disappeared, then under those
4 conditions it is acceptable to temporize and not sample
5 cytologically or pathologically.

6 But under other conditions, any palpable breast
7 mass, any dominant mass, any new nodule is cancer until
8 proven otherwise, and needs to be sampled to rule out the
9 diagnosis of cancer.

10 Q Sampled by excisional biopsy?

11 A Sampled by whatever is appropriate at that time,
12 whether it be fine-needle aspiration, whether cytologically,
13 whether it's fine-needle tissue biopsy, whether it's
14 excisional biopsy or open biopsy. There is a variety of
15 acceptable methods, depending upon the particular
16 circumstance.

17 But ignoring the mass is never acceptable.

18 Q Is there a false negative rate with regard to
19 fine-needle aspiration?

20 A You mean cytologically or histologically?

21 Q Either. Either or both, because I am not sure, I
22 am not a physician and I am not sure of the distinction you

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1 are making there.

2 A Oh, okay.

3 Q But let me ask you in layman's terms.

4 A Okay.

5 Q If a physician performs a fine-needle aspiration
6 for purposes of biopsying the contents of a new mass or a
7 new lump, okay, is there any percentage of false negative
8 response to that test?

9 A Okay.

10 If it's a cyst and you're aspirating
11 cytologically--in other words, have the pathologist look at
12 the cells as opposed to chunks of tissue, because you're not
13 getting chunks of tissue, just cyst fluid--and if the cells
14 are cytologically benign and/or if the cystic fluid is clear
15 and the cyst disappears in the next visit two, three, four
16 weeks down the road and doesn't recur, then the false
17 negative rate is zero.

18 There is no documented incident that I know of of
19 that patient turning out to have cancer in a cyst that
20 disappears with negative cytology.

21 In terms of the aspiration by a fine needle with
22 a biopsy, the accuracy depends upon the amount of tissue

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1 obtained. And it is recommended that you attempt, as much
2 as the patient will allow you, to pass the needle in at
3 various angles as much as seven, eight, nine times. And if
4 you get a good core of tissue and have a good pathologist,
5 then the incidence of a false negative evaluation is
6 extremely low.

7 Q But what would it be in term of percent? Can you
8 express it in terms of percentages?

9 A Not to my knowledge. No.

10 Q Okay.

11 Would you assume that that percentage would be
12 set forth in some of the leading treatises that we discussed
13 earlier, such as the Donevan and Spratt text?

14 A I have not come across that particular statistic,
15 but that does not mean that you could not be right that it
16 may appear in one of the textbooks.

17 Q Okay.

18 What is a new dominant mass?

19 A A new dominant mass is defined as a new density
20 that is different in quality and/or quantity from the
21 general breast consistency.

22 Q Different in quality or quantity?

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1 A Quality and/or quantity from the general breast
2 consistency.

3 Q I think I can understand how a mass would be
4 different in quality from the general breast consistency. I
5 am not sure I understand the term quality.

6 A Quality or quantity?

7 Q I'm sorry. Quantity. Quantity.

8 A Well, if the patient has fibrocystic changes in
9 the breast--

10 Q Right.

11 A --and the patient comes up with a new density
12 that feels bigger in quantity, bigger in size, than the
13 fibrocystic changes in the adjacent breast, then that would
14 qualify as a dominant lump.

15 Q Okay.

16 Not all fibrocystic structures are the same size,
17 are they?

18 A That is correct.

19 Q Is it your opinion then that any time a patient
20 who has a history of fibrocystic breast disease gets a new
21 lump that is larger than any other lump that she has in her
22 breast, then that must be subjected to cytological or

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1 histological evaluation?

2 A Well, there are two components to my answer:

3 No. 1, we no longer consider fibrocystic to be a disease, we
4 consider it to be a normal variant. So the recommended term
5 is now fibrocystic changes as opposed to fibrocystic
6 disease.

7 Q Okay.

8 A But any patient who meets the criteria that you
9 said is considered to have cancer until proven otherwise and
10 needs to be subjected to a histological or cytological
11 evaluation unless she meets the criteria that I mentioned
12 earlier: about age 25, totally cystic, et cetera, et
13 cetera.

14 Q She must have that evaluation unless she is
15 younger than 25?

16 A I will say 25 or younger.

17 Q Okay.

18 A And meets all the other criteria that I
19 mentioned: The mass is totally cystic, no other masses
20 found on mammogram, repeat visit two, three, four weeks down
21 the road reveals a disappearance of that mass, et cetera, et
22 cetera.

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1 Q Okay. All right.

2 A The general rule is any breast mass is considered
3 cancer until prove otherwise.

4 Q Any breast mass regardless of size? Because you
5 made that as kind of a blanket statement. Do you mean to
6 qualify that statement with your earlier explanation of
7 quality and quantity?

8 A Okay.

9 Well, certainly any new breast mass and any
10 breast mass that meets the criteria as I have outlined for
11 being a dominant mass.

12 Q Okay.

13 What are the criteria of the--strike that
14 question.

15 What are the elements that you would look for in
16 determining whether a new mass has a different quality so as
17 to define it as a new dominant mass?

18 A The qualities would be its hardness or softness,
19 its mobility or lack of mobility, whether it's a discrete or
20 distinct or indiscrete and indistinct, whether it has
21 homogeneous and smooth borders or not.

22 Those would be the most important criteria that I

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1 would take into consideration.

2 Q In this case, is it your opinion that this new
3 lump that she presented with in February of '91 was a new
4 dominant mass?

5 A Yes, sir.

6 Q And did it meet all of those qualifications that
7 you just listed in terms of the quality of the mass?

8 A I would say it was not --it was not completely
9 mobile. It was not discrete and distinct. It did not have
10 smooth, homogeneous borders. And in terms of the feel, it
11 had, as I recall, it had a--I don't recall any comments on
12 the consistency of the mass as opposed to the consistency of
13 the general adjacent breast tissue.

14 Q Can fibrocystic structures also be only partially
15 mobile?

16 A Yes, sir.

17 Q Can fibrocystic structures be indistinct in terms
18 of distinguishing that from a discrete mass?

19 A They tend to be relatively well-delineated and
20 distinct, sir.

21 Q Relatively?

22 A That's correct.

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1 Q And my question is: Can they be somewhat or
2 relatively indistinct?

3 A Well, the accepted description of fibrocystic
4 changes are that the individual fibrocystic components tend
5 to be well-delineated and distinct.

6 Q I understand what they tend to be and what they
7 generally are. But my question is: Can they be somewhat
8 indistinct, or are they all uniformly and absolutely
9 discrete structures?

10 A Well, anything is possible, but the general trend
11 is for fibrocystic changes to be characterized by the
12 individual fibrocystic components to be well-delineated and
13 distinct.

14 Q What is the difference between--and you are
15 describing this to me as a layman--an indistinct mass and
16 borders not being smooth? Are those basically the same
17 things?

18 A An indistinct mass and borders being smooth,
19 well, no, they are not exactly the same thing.

20 Q Okay. Explain the difference, if you would.

21 A A distinct mass is a mass in which you can feel
22 it to be a self-contained structure in which you may feel

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1 attachment to underlying breast tissue but that particular
2 component tends to be distinct otherwise.

3 Borders are related not to the underlying breast
4 tissue but to the adjacent breast tissue and the borders can
5 either be smooth and homogenous as you would find in a
6 disease process called a fibroadenoma--
7 f-i-b-r-o-a-d-e-n-o-m-a--or it can be nonhomogeneous and not
8 distinct, which suggests but does not prove that the mass is
9 cancerous.

10 Q Okay.

11 Is it possible, then, that a woman may have a new
12 mass which has unsmooth borders and that that mass would be
13 a fibrocystic change as opposed to a malignant tumor?

14 A Well, anything is possible. So I would say, yes,
15 it's possible like anything is possible.

16 Q Okay.

17 Well, is it always the case that if the borders
18 are not smooth on a new mass, that that structure is a
19 malignant tumor?

20 A No, it's not always true.

21 Q Okay.

22 When we were talking about mammograms earlier, is

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1 it your assumption that Dr. LaRoche relied solely on a
2 mammogram to diagnose or interpret the meaning of this new
3 lump?

4 A Well, she states in her deposition that the
5 mammogram superimposed upon her knowing the general
6 consistency and contour of Mrs. Gorman's breasts is what led
7 her to agree with the nurse practitioner's plan.

8 That unfortunately begs the question of
9 Dr. LaRoche not doing the exam. A nurse practitioner named
10 Kim--K-i-m--Baker did the exam and, to my knowledge, was
11 insufficiently familiar with Mrs. Gorman's breast
12 consistency and contour, having, to my knowledge, never
13 examined her before.

14 So I think Dr. LaRoche relied on the mammogram
15 and relied upon her, meaning Dr. LaRoche's personal
16 experience with Nancy Gorman's breasts, yet did not examine
17 the breasts and relied upon the less experienced examiner.
18 And I think both of those synergistically and distinctly
19 represent deviations from the standard of care.

20 Q Well, are you aware of how much experience
21 Ms. Baker had in examining breast lumps?

22 A No, sir, I am not.

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1 Q So you are making your statement only on the
2 basis that, to your knowledge, she had never examined this
3 particular patient's breasts?

4 A Or if she had examined the patient's breasts
5 before, certainly had not done it with the same degree of
6 professionalism and expertise and experience of Dr. LaRoche.

7 Q Are you saying that a nurse practitioner is
8 incapable of making an adequate examination or conducting an
9 adequate examination of breast tissue for new masses?

10 A No, sir; I am saying a nurse practitioner is
11 incapable of determining whether a new mass is consistent
12 with the general past contour and consistency of a patient's
13 breast masses if she has not examined that patient's breasts
14 before and has not done so in a continuous and consistent
15 fashion.

16 Q Can mammography be used to diagnose a new
17 dominant mass or to determine whether or not a new dominant
18 mass is a malignant tumor?

19 A Can mammography be used to determine--it cannot
20 be the ultimate determinant. All it can do is to give you
21 an idea of the calcification pattern in a particular mass.
22 It can, to some lesser degree, describe the nature of some

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1 but not all masses, but it cannot in and of itself
2 definitively diagnose cancer or definitively exclude cancer.

3 Q Well, what is the meaning of--I think in your
4 Exhibit 1 summary and perhaps even here today you indicated
5 that there is a 10 to 15 percent false negative rate for
6 mammograms. Am I correct about that?

7 A Yes, sir.

8 Q Then I think you also said maybe in younger women
9 that percentage could be higher.

10 A That's correct.

11 Q And I want to ask you more about that, too.

12 A Okay.

13 Q But as far as that 10 or 15 percent false
14 negative rate, that is a fairly standard and recognized
15 false negative rate for mammograms. Is that correct?

16 A Across the board for all women, that is correct.
17 As I said before, the rate tends to be higher--in some
18 studies, as high as 41 percent--for premenopausal women.

19 Q Now, does the 10 to 15 percent false negative
20 rate apply to the use of a mammogram for determining whether
21 or not a mass is malignant?

22 A The 10 to 15 percent means that 10 to 15 percent

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1 of breast cancers across the board, higher in younger women,
2 young, premenopausal women, 10 to 15 percent of breast
3 cancers cannot be suspected mammographically and you would
4 miss 10 to 15 percent of breast cancers if you relied solely
5 on mammography to diagnose breast cancer.

6 Q Well, does it mean that if you took mammograms of
7 100 women across the board--I am not talking about younger
8 women, I am talking about across the board, as you
9 mentioned--if you took the mammograms of 100 women and they
10 were all negative for breast cancer, the statistics would
11 indicate that 10 or 15 of those women actually do have
12 cancer but the mammogram was unable to pick it up?

13 A No, sir. It's more appropriate to say if you
14 took the mammograms of 100 women with breast cancer, 10 to
15 15 of them would have normal mammograms, 85 to 90 would have
16 suspicious mammograms.

17 Q Okay.

18 Now tell me about the 41, 40 percent, whatever it
19 was, I think that was quoted in one of your--

20 A Correct.

21 It's my recollection that, based upon either
22 attendance at lecture or by specific directed readings or

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1 optional readings, that the general knowledge is that the
2 incidence of false negative rate for mammograms and picking
3 up signs of breast cancer is across the board 10 to 15
4 percent but it's higher--one study said 22 percent--in
5 premenopausal women. But the highest statistic that I have
6 read is 41 percent.

7 Q And where did you read that?

8 A I don't recall whether I--whether that's included
9 in my general knowledge, reading, training, and experience
10 or whether it's included in the universe of lectures I have
11 attended that I have attended that addresses breast cancer.

12 Q How many lectures do you attend on an annual
13 basis for continuing medical education?

14 A I'd say somewhere between 50 and 100.

15 Q 50 and 100?

16 A Yes, sir.

17 Q So once or twice a week you attend continuing
18 medical education seminars of one kind or another?

19 A That is correct.

20 Q Are those given by residents at the hospital,
21 other physicians in the hospital? Is that how--

22 A They're either given by hospital physicians or

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1 residents or by outside speakers. At two of the hospitals I
2 have privileges at, there is an obligatory morning meeting,
3 Monday morning for one hospital, Tuesday for another
4 hospital, in which continuing medical education credit is
5 given for attendance at various didactic presentations.

6 So assuming that I make it to one to two meetings
7 per week, which I usually do, then that is 50 to 100 hours
8 of continuing medical education meetings annually, give or
9 take a little bit because the frequency of these meetings is
10 decreased in the summertime but I attend some outside
11 hospital meetings. So as a general average, it would be in
12 that general range.

13 Q For some premenopausal women, could the false
14 negative rate for mammograms be as high as 10 to 15 percent?

15 A Could it be as high as?

16 Q Yes. Could it be in that range, 10 to 15
17 percent?

18 A Well, the 10 to 15 percent, based upon my
19 knowledge, training, and experience, reading, and attendance
20 is for women across the board. And I don't know of any
21 study which says that the incidence is exactly the same in
22 premenopausal women. It has been my universal experience

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1 that the incidence is described to be higher in
2 premenopausal women.

3 Q Which statistic would apply to a woman who has
4 had a hysterectomy?

5 A That is an excellent question. There are two
6 ways of defining menopause. One way is the total cessation
7 of menstrual periods for one year. And so if you take that
8 definition, that any woman who has had a hysterectomy is
9 menopausal.

10 Now, of course, we know that not every woman who
11 has a hysterectomy becomes menopausal; many of them still
12 have proper ovarian function, they do not have hot flashes
13 or vaginal dryness. So it is appropriate in a woman who has
14 had a hysterectomy to use another criteria for determining
15 who is premenopausal and not premenopausal.

16 And the other criteria we use is the value of a
17 hormone called FSH, follicle stimulating hormone. In a
18 premenstrual--in the premenopausal woman, even who has had a
19 hysterectomy, the FSH levels tend not to change. And the
20 hysterectomized patient who has reached the menopause, then
21 that can be diagnosed by an elevated level in the blood of
22 FSH, follicle stimulating hormone.

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1 So, based upon the more reasonable criterion that
2 it must be determined that a woman who is in her 30s who has
3 had a hysterectomy, in the absence of hot flashes and
4 vaginal dryness and with no known family history of
5 premature menopause, is within a reasonable degree of
6 medical certainty classified as a premenopausal patient.

7 Q Then so that is your opinion then about Nancy
8 Gorman in February of 1991?

9 A That is correct.

10 THE WITNESS: Can we take a quick break now?

11 MR. LAWRENCE: Sure.

12 (Recess.)

13 BY MR. LAWRENCE: (Resuming)

14 Q Dr. Cohn, after a brief break, let me just finish
15 up a few questions about mammograms.

16 You had indicated in Exhibit 1--I believe this is
17 where I got this statement--that this patient needed a
18 mammogram anyway back in February or thereabouts of 1991 to
19 rule out other breast pathology.

20 A That's correct.

21 Q Do you recall that phrase?

22 A Yes, sir.

1 Q Okay.

2 What other breast pathology were you referring to
3 there? I think I know, but just to confirm my own
4 suspicions.

5 A Well, the purpose of a mammogram in the face of a
6 dominant mass is not to include or exclude the diagnosis of
7 malignancy. The mass is going to be sampled anyway or
8 excised anyway.

9 But there may be occult additional masses that
10 would have a potentially unfortunate diagnosis that needed
11 to be known prior to the patient having any surgical
12 procedure because if the patient had any additional occult
13 suspicious areas, then it would benefit the patient to have
14 one anesthesia, one operative intervention, as opposed to
15 coming back on two or three occasions.

16 Q Okay.

17 A third point that you raised earlier as far as
18 standard of care was concerned was that there may be a time
19 for temporization or an acceptable delay period but that you
20 felt Dr. LaRoche exceeded that delay period. Is that
21 correct?

22 A That's correct.

1 Q And I guess my only question about that is: If
2 you are talking about a two-to-five-week period of delay
3 that is acceptable, is it possible, in your opinion, during
4 that period of time that any given new dominant mass which
5 is a malignant tumor could metastasize to the nodes during
6 that time period?

7 A Well, there has been no documented, to my
8 knowledge, worsening of the stage of the prognosis when a
9 reasonable delay is present between when the diagnosis
10 should have been made and definitive therapy.

11 So, I think it--reasonable includes two, three,
12 four, five weeks--I think it's unreasonable to have a delay
13 of, let's see, 2/20, 3/20, 4/20, of two and a half months.
14 I think that is unreasonable delay and very well could
15 worsen the prognosis.

16 Q Do you know whether or not this patient's lymph
17 nodes had already been infiltrated or invaded on February 2,
18 1991?

19 A Well, certainly there is no way to know
20 absolutely--

21 Q Can I just ask you to give a "yes" or "no"
22 answer, then explain? That would help me.

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1 A Okay.

2 Q If you can.

3 A Okay.

4 Q I mean "yes" or "no" answer, and then explain.

5 A Okay.

6 Your question was: Is there a way to have known
7 definitively absolutely--no?

8 Q No.

9 I am glad I re-asked.

10 A Okay.

11 Q Because the question was: Do you know whether or
12 not the lymph nodes had already been invaded or infiltrated
13 on February 20, 1991?

14 A Do I know personally?

15 Q Right.

16 A No, sir.

17 Q Okay. All right.

18 Now, is there any way to know?

19 A Well, within a reasonable degree of medical
20 certainty, the lymph nodes were not involved as of February
21 20, 1991. And the reason I say that is the following: No.
22 1, there is no documentation in the chart of any clinical

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1 evidence of axillary node involvement.

2 Q Okay.

3 A No. 2, we know that there is a linear
4 relationship between the size of a malignant cancer and the
5 incidence of positive axillary lymph nodes. We further know
6 that when a tumor mass reaches 2.5 centimeters, that the
7 incidence of axillary nodes is 50 percent.

8 So, keeping in mind there is a linear
9 relationship, when the mass was 1.5 centimeters, as
10 described by Kim Baker on February 20, 1991, and further as
11 described by Mrs. Gorman as being the size of the end of one
12 of her fingers, which approximates 1.5 centimeters, then the
13 linear relationship ensures that within a reasonable degree
14 of medical certainty it was more likely than not that the
15 nodes were not involved on 2/20/91.

16 Q But similarly, you could apply percentages to a
17 1.5 centimeter nodule or mass--is that correct--just as the
18 50 percentage figure is applied to a 2.5 centimeter size?

19 A Correct. Correct.

20 Q And so in your readings and in your experience,
21 what percentage of masses that are 1.5 centimeters in
22 diameter have already metastasized to the lymph nodes?

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1 A Well, based upon the known linear relationship, I
2 would give a general percentage breakdown of about the
3 chances of being about 1 out of 3. But that's a general
4 extrapolated statistic.

5 Q Okay.

6 There are statistics available--is that
7 correct--on this?

8 A Not that I have read. I wouldn't doubt you. I
9 have not seen any statistics myself. But I would not doubt
10 that there are statistics available.

11 Q Okay.

12 So what we're saying here is, or would you agree
13 with me, that as of February of 1991, if indeed this new
14 mass was 1.5 centimeters in diameter, that there was a 30
15 percent chance that it had already--or roughly--a 33-1/3
16 percent chance it had already metastasized to the lymph
17 nodes?

18 A I would not disagree with that statement.

19 Q Okay.

20 That percentage could be higher?

21 A And that percentage could be lower.

22 Q But it could also be higher?

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1 A I would look at--I would have to look at the
2 statistics that you state are available.

3 Q Okay.

4 Would you have to look at the statistics to see
5 if it was lower?

6 A I would have to look at the statistics to comment
7 on them in any case.

8 Q That's fair enough. I just want to be sure we
9 understand each other.

10 Now, what clinical evidence would you typically
11 see if there was node involvement?

12 A You might feel hardened or indurated nodes--
13 i-n-d-u-r-a-t-e-d--or you might feel the nodes to be
14 confluent and/or enlarged.

15 Q Do we know whether or not the nodes in this case
16 met any of those criteria?

17 A I don't recall any specific evaluation of the
18 nodes in Kim Baker's note of 2/20/91.

19 Q Okay.

20 I take it the only definitive test for
21 determining whether or not the nodes were involved at that
22 time would be to biopsy the nodes to actually take them out

1 and subject them to histological examination?

2 A That's correct, sir.

3 Q Okay.

4 Now, Dr. Cohn, the fourth point that you raised
5 earlier in terms of ways in which you believe Dr. LaRoche
6 deviated from the standard of care was follow-up to a missed
7 appointment--okay--generally. Am I correct about that?

8 A That's correct.

9 Q Okay.

10 You have read all of these materials. Do you
11 believe that this patient missed an appointment?

12 A I believe that the patient was not aware that she
13 had an appointment on 5/7/91.

14 Her behavior consistently and persistently.
15 throughout her entire association with Dr. LaRoche beginning
16 in 1986 was characterized by reliability, responsivity, and
17 compliance. And it is, especially in a patient who claimed
18 to have been terrorized of getting breast cancer, who states
19 that she saw the ravages of breast cancer in one of the
20 paternal aunts, it's inconceivable and inconsistent that
21 under these conditions with this track record that the
22 patient would suddenly and inexplicably not keep an

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1 appointment.

2 Q Obviously, this is a significant issue in this
3 case, Dr. Cohn. You realize that, the question of whether
4 or not there was an appointment and whether or nor this
5 patient kept the appointment? Do you agree with me on that?

6 A That it was significant?

7 Q That it is a significant issue in this case. You
8 understand that?

9 A Keeping in mind that I have already stated that
10 even if it could be determined that there was indeed an
11 appointment scheduled for 5/7/91, that Mrs. Gorman either
12 intentionally or unintentionally did not keep, even if we
13 assume that, that still does not exclude Dr. LaRoche from
14 the responsibility of failing to follow a standard of care
15 by temporizing two and a half months under these conditions,
16 which is unacceptable.

17 Q Do you believe patients have some responsibility
18 for their own care?

19 A Yes, sir, I do.

20 Q Do you believe Mrs. Gorman had some
21 responsibility for her own care?

22 A I believe all patients have some responsibility

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1 for their own care.

2 Q Okay. So you believe Mrs. Gorman had some
3 responsibility for her own care?

4 A Yes, sir.

5 Q And in taking responsibility for her own care,
6 she had the responsibility to go to the doctor if she had an
7 appointment that had been previously set up. Is that
8 correct?

9 A Not only did she go to every appointment in the
10 past that was set up that she knew about, but in addition
11 she even went to see the doctor when there wasn't an
12 appointment scheduled.

13 Q But that wasn't the question, Dr. Cohn.

14 A Okay.

15 Q The question deals with the May 7, 1991,
16 appointment that is one of the issues in this case.
17 Dr. LaRoche takes the position that an appointment had been
18 set up on that date for the patient to return for a
19 follow-up examination. Okay. Do you recall that from
20 reading the documents?

21 A I recall Dr. LaRoche set up that appointment in
22 November of 1990, even before this February of 1991 episode

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1 was existent.

2 Q That's right. That's right. And what were the
3 reasons for setting it up six months in advance. Do you
4 know?

5 A The reasons included the fact that Mrs. Gorman
6 was on a schedule of pap smears approximately twice a year
7 and she was also allegedly on a schedule of breast exams
8 twice a year, but actually if you look back at the years
9 1989 and 1990 she actually didn't have breast exams every
10 six months.

11 If you look at the records, it's my recollection
12 that in at least two of those years when she was brought
13 back on an every-six-month basis, there was no breast exam
14 performed and/or documented on one of the two visits in each
15 calendar year for two years.

16 Q When Mrs. Gorman returned for her visit on
17 February 20, 1991, did she only have a breast problem?

18 A She had a vaginal irritation problem as well as a
19 new mass problem.

20 Q Did she get a pap smear done on that date?

21 A It's my recollection that she did not.

22 Q Okay.

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1 And without a pap smear, there is no way for
2 Dr. LaRoche to determine whether or not there had been any
3 change in the previous cervical dysplasia condition that the
4 patient had. Is that correct?

5 A Well, considering the patient didn't even have a
6 cervix, it's very unlikely the patient would have had
7 cervical dysplasia on any follow-up pap smear.

8 Q What is your understanding of why the patient was
9 returning every six months for pap smears?

10 A It's my understanding that Dr. LaRoche wanted to
11 bring the patient without a cervix back every six months to
12 assure that any vaginal recurrence of the previous cervical
13 disease was not present.

14 Q Okay.
15 Does that require a pap smear to do that?

16 A That requires a pap smear, yes, sir.

17 Q Okay.
18 (Pause.)

19 If indeed an appointment had been set up for May
20 7, 1991, for this patient, is it your opinion that this
21 patient was negligent in not keeping that appointment?

22 A If an appointment was indeed set up for the

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1 patient and the patient knew about the appointment and the
2 patient did not interpret her February evaluation with
3 mammography and follow-up phone conversations with
4 Dr. LaRoche to supplant this appointment, then under those
5 conditions she should have kept the appointment.

6 Q All right. And one of the reasons she would have
7 kept that appointment, you would think, would be to get her
8 regular six-month pap smear. Is that correct?

9 A If you believe that a pap smear for a patient
10 without a cervix is necessary every six months, then the
11 answer is "yes."

12 Q Well, Mrs. Gorman believed that, don't you think?

13 A Yes, sir.

14 Q Okay.

15 Do you think, in keeping with the statement that
16 a patient has responsibility for his or her own care, that
17 this patient was negligent in failing to come back to see
18 Dr. LaRoche, coming back to see Dr. LaRoche until December
19 of 1991?

20 A No, I do not think she was negligent.

21 Q Okay.

22 Why not, Dr. Cohn?

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1 A She was acting under the assumption that her
2 doctor, in whom she trusted and who had previously under a
3 similar set of circumstances when a new lump appeared
4 referred her directly to Dr. Westmoreland without even
5 bothering to get a mammogram.

6 She, through the phone report of a negative
7 mammogram, through what ultimately turned out to be a repeat
8 mammogram in July of '91 of the left breast only and through
9 a phone conversations with Dr. LaRoche reassuring her as to
10 the fact that she needn't worry about any problem with her
11 breasts at the present time, and superimposed upon the fact
12 that nobody from Dr. LaRoche's office ever called her to
13 tell her that they expected her to come back in May, then I
14 don't think she was negligent.

15 Q Is it your opinion that this patient, this
16 particular patient, Nancy Gorman, was well educated with
17 regard to the significance of lumps appearing in her
18 breasts?

19 A I don't know the exact status of her intellectual
20 education when it comes to the status of lumps in her
21 breasts. I think she knew the potential devastating
22 consequences of breast cancer, having been involved with

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1 that disease process through her family. And I think she
2 knew generally that she was at some increased risk for
3 breast cancer because of the family history. Then I think
4 that she had a certain level of knowledge.

5 Whether it was a knowledge more sophisticated
6 than the average woman who gets gynecological exams, I can't
7 state for sure.

8 Q Generally speaking, in your practice do you find
9 that women who have had long experience, a history of
10 fibrocystic changes, are on a higher state of alert, so to
11 speak, as far as the development of new lumps are concerned
12 in their breasts?

13 A I would say as a general rule, with certain
14 exceptions, yes, sir.

15 Q Generally speaking, they are better breast
16 examiners, better self-examiners than the average
17 population, female population. Would you agree with that
18 statement?

19 A I would say as a general rule that's correct.

20 Q Okay.

21 You have read Mrs. Gorman's deposition. Is it
22 your opinion that that would be true of her as well in this

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1 case?

2 A She stated that she consistently examined her
3 breasts once a month. And so I think that statement alone
4 makes her a woman with more experience in self-breast
5 examination than women who don't do it on a monthly basis:

6 Q Do you think Mrs. Gorman as a patient was
7 justified in not making contact with either Dr. LaRoche or
8 any other physician after she realized following her
9 mammogram and her comparison mammogram in March of 1991 that
10 her new lump in her right breast was actually enlarging?

11 A Well, I have a two-component answer to the
12 question.

13 First of all, there is no such thing as a
14 comparison mammogram. The patient had one mammogram in
15 February 27, 1991. The phrase comparison mammogram implies
16 she had yet another mammogram.

17 Q Okay. I appreciate that, but that's not the
18 point of the question. And I do appreciate that
19 explanation.

20 But the point of the question in making reference
21 to the comparison mammogram was just to give you an idea
22 temporally as to what time period I was talking about. I am

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1 talking about after Dr. LaRoche's last contact, after
2 Mrs. Gorman's last contact with Dr. LaRoche in March of
3 1991.

4 If she then realized that her lump was enlarging,
5 do you believe that she was negligent in failing to inform
6 Dr. LaRoche or any other physician, for that matter, of that
7 fact?

8 A Well, having been reassured by Dr. LaRoche that
9 there was nothing to worry about and, in addition, going to
10 a mammogram unit and finding that there was so little
11 interest in her right breast that they didn't even do a
12 follow-up mammogram of the right breast, then it is not
13 surprising nor is it condemnable on the part of Mrs. Gorman
14 to follow the reassurance of her doctors.

15 Q Would you be surprised that Mrs. Gorman did not
16 tell anyone involved with the taking of the mammogram about
17 her right breast and the enlarging lump in the right breast
18 in July of '91?

19 A Well, I would think that she was so surprised
20 that it just added to her reassurance that so little
21 attention was being paid to the right breast that it wasn't
22 even worthwhile getting a mammogram of it. I would think

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1 that she would be reassured as opposed to being more
2 concerned.

3 Q Okay.

4 So your thinking, if I understand you correctly
5 that--never mind. Strike that. Strike that question.

6 In you experience as an Ob/Gyn since--when? When
7 were you licensed, Doctor?

8 A I was licensed in D.C. in '75, in Maryland in
9 '76-'77, and in Virginia in '76-'77.

10 Q And have you been practicing gynecology since
11 1975?

12 A Well, I was a resident in '75. So if you include
13 residency, I have been practicing gynecology since 1973-74.

14 Q Okay.

15 In that time period, have you been made aware of
16 the concept of denial, for lack of a better term--and I will
17 explain that, if you wish, among cancer patients? Do you
18 know what I am talking about?

19 A Denial among patients who have been made aware
20 that they have cancer?

21 Q Is there a tendency on the part of some patients,
22 female patients, to fear the possibility of breast cancer so

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1 much that they are unwilling to confront the issue or are
2 unable to confront the issue?

3 A I imagine that such patients exist. I have never
4 in my experience found a patient who was so afraid of that
5 diagnosis that she didn't confront the issue and fail to
6 show up for her mammogram visits or fail to be responsible.

7 As a matter of fact, Nancy Gorman can be
8 considered extra-reliable because within just a few days, or
9 as the chart says, several days, of finding the lump she was
10 right in the office asking for evaluation. That is
11 consistent with a patient who is not in denial, it's a sign
12 of a patient who was afraid and wants to make sure that if
13 she's destined to get breast cancer, she wants to know about
14 it early.

15 Q When Mrs. Gorman made contact with Dr. LaRoche in
16 December of 1991, okay, based on your reading of medical
17 records, depositions, et cetera, the other records you have
18 before you, what was the physical description of her right
19 breast?

20 A I think Dr. LaRoche's note documents that the
21 patient stated that the mass was approximately three times
22 as large as it was in February 1991.

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1 Q Okay.

2 Do you recall any other descriptions given by
3 Mrs. Gorman in her deposition of her right breast in
4 December of '91?

5 A Not that I can recall offhand, no, sir.

6 Q Okay.

7 What was the size of the tumor that was removed
8 from Mrs. Gorman's right breast in January of 1992?

9 A I believe it was 2.9 centimeters in greatest
10 diameter. It's my recollection that it was 2.9 centimeters
11 in greatest diameter, but I can--

12 Q Are you saying at the widest diameter?

13 A The greatest.

14 Q Greatest?

15 A When I said greatest--

16 Q We could not hear the word.

17 A Oh, I'm sorry.

18 Q Neither one of us heard it.

19 A I'm sorry. 2.9 centimeters, it's my recollection
20 that her cancer removed in January 1992 was 2.9 centimeters
21 in greatest diameter. But I can also look at the report and
22 get the exact dimensions if you so like.

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1 Q Now, in a patient like Nancy Gorman, who
2 presented in February of 1991 with a 1.5 centimeter lump
3 which progressed to a 2.9 centimeter lump in 10 months,
4 okay, what would you as a practicing Ob/Gyn expect the right
5 breast to look like physically to the patient?

6 A It's hard to state, keeping in mind that her
7 original complaint was not a disfiguration. The original
8 complaint was that she felt a mass.

9 Q Her original complaint in February?

10 A Her original complaint on 2/20/91 was that she
11 felt a mass.

12 Q All right.

13 A She didn't complain about any disfiguration or
14 change in visible contour.

15 Q All right.

16 A So I can't definitively state what her
17 impressions were visibly of the situation in December of
18 1991. What she says is three times as big. I don't know
19 whether she meant that she saw it to be three times as big
20 or she felt it to be three times as big.

21 Q Which she are you referring to? Dr. LaRoche?

22 A I am talking about--

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1 Q Or Gorman?

2 A I am talking about Dr. Elizabeth LaRoche's
3 comments as documented by Dr. LaRoche, Nancy Gorman's
4 comments in December of '91 as documented by Dr. LaRoche.

5 Q Okay.

6 Did you see documented any indication of nipple
7 discharge?

8 A No, sir.

9 Q Skin retraction?

10 A No, sir.

11 Q Do you in fact recall anything in this record,
12 Dr. Cohn, indicating that Mrs. Gorman had, in effect, lost
13 confidence, not gained confidence but lost confidence in
14 Dr. LaRoche?

15 A Yes, sir.

16 Q And when did that occur, based on your reading of
17 these records?

18 A I believe that occurred following the breast
19 biopsy in December of 1991.

20 Q You don't recall any indication in the deposition
21 of Mrs. Gorman that she had lost confidence in Dr. LaRoche
22 as early as June of 1991 and perhaps earlier?

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1 A I recall her stating that she did not go back to
2 see Dr. LaRoche anytime after 2/20/91. But I recall her
3 being reassured as to the situation with the right breast
4 mass.

5 Additionally, if she had lost confidence in
6 Dr. LaRoche, why, then, would she call Dr. LaRoche in
7 December of 1991 to report that she had lost--that she had
8 noticed a change in the mass?

9 Q You are asking that rhetorically?

10 A No, you asked--

11 Q I have an answer if you want me to answer it, but
12 I don't think you want to know my answer.

13 Let me ask you this, Dr. Cohn: If indeed
14 hypothetically the patient had lost confidence in the
15 physician, the primary care physician, Dr. LaRoche, as early
16 as June of 1991 or July of 1991, okay, and if the lump in
17 her right breast was worrying her, as you said, terrorizing
18 her, and if the lump was actually continuing to enlarge,
19 would you be surprised that that same patient would not
20 contact any doctor, some other doctor, another Ob/Gyn,
21 another surgeon, an oncologist, some kind of breast
22 specialist, even an internist?

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1 A Well, first of all, I want to correct what you
2 said that I stated before. I don't think I ever said that
3 the breast lump was terrorizing her. I think I said that
4 the breast lump was a concern. That's why she came on
5 2/20/91, but that the thought of getting breast cancer was
6 terrorizing her.

7 Q Okay. Okay. Then we will add that as another
8 element, that in fact she was generally terrorized about the
9 concept of contracting cancer of the breast. So that would
10 be a fourth element in the hypothetical.

11 A And consistent with that terror, she came in the
12 middle of the wintertime, in February of '91, asking to see
13 Dr. LaRoche and actually saw a nurse practitioner.

14 But in any event, this is a patient who had been
15 reassured on the basis of telephone conversations, a
16 physical examination, by negative mammogram, by follow-up
17 mammogram which didn't even address the right breast. This
18 is a patient in whom the message was loud and clear and
19 consistent, "Don't worry about the right breast."

20 And in the view that she had in which Dr. LaRoche
21 is specially trained and holds herself out to the general
22 public as having special knowledge, training, and expertise

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1 in breast disease as well as in pelvic situations, then the
2 message was overwhelmingly loud, 'Don't be concerned. Don't
3 worry about it. Concentrate on the left breast."

4 So Nancy Gorman's behavior was in no way
5 inconsistent with this persistent loud message.

6 Q Well, we may not be communicating, but I
7 understand your point about the consistent loud message.
8 But what I am asking you is a hypothetical: that the
9 patient no longer believes that message, she has lost
10 confidence in the ability of that physician to care for her.
11 Under those circumstances, do you think this patient met her
12 responsibility of her own care in failing to contact any
13 doctor for a long period of time?

14 A Well, I guess it depends upon the degree to which
15 she had lost confidence. She obviously hadn't lost total
16 confidence because she called back in December. So she
17 still had a modicum of confidence.

18 If she had no confidence, she wouldn't have
19 called back.

20 So, based upon the physical act of the call in
21 December of '91 and the persistent loud message, I think
22 Nancy Gorman's behavior is eminently understandable.

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1 Q Okay.

2 Let me ask you this: Suppose Dr. LaRoche's
3 office had telephoned Mrs. Gorman or sent her a letter and
4 reminded her--well, let me strike that.

5 You indicated that they should make a telephone
6 call or write her a letter. What should that communication
7 have said to Mrs. Gorman?

8 A It should have stated to her, and the corollary
9 documentation should have been placed in the patient's
10 chart, that it is their understanding that for whatever
11 reason she did not keep a regularly scheduled appointment
12 and there are potential serious consequences of failure to
13 come in for an appointment, the consequences include, and
14 just a general description of the potential consequences.

15 Q Do you do that in your practice?

16 A Yes, sir.

17 Q Okay.

18 Do you send a letter or make a telephone call to
19 every patient who misses an appointment?

20 A Yes, sir.

21 Q Okay. And how long have you been doing that?

22 A Since 1977.

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1 Q All right.

2 It's possible after you sent that letter or made
3 that telephone call that the patient still would not come
4 in. Is that correct?

5 A You mean in my personal experience or the
6 universe of patients in general?

7 Q Well, let's take the hypothetical that we are
8 discussing in this case. Suppose Dr. LaRoche's office had
9 sent a letter or made a phone call to this patient and
10 advised her, as you just described, and Mrs. Gorman still
11 did not come in. Okay.

12 Then do you have any opinion as to the
13 responsibility of this patient and whether or not she was
14 negligent and responsible to some extent for her own injury?

15 A Yes. Under those conditions where there is clear
16 documentation in the chart or, even better, a copy of a
17 letter sent certified mail return receipt requested, and
18 which there is no doubt that the patient A, received
19 notification, B, understood she had an appointment, and, C,
20 understood the potential grave consequences of not coming
21 in. And if it's clearly documented in the chart and the
22 patient still didn't come in, then under those conditions, I

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1 would agree that the patient would be negligent.

2 Q There is an allegation in this complaint of
3 punitive damages. Do you know what punitive damages are?

4 A Based upon my reading, apparently punitive
5 damages, at least in the State of Tennessee, is when the
6 health care provider in a medical malpractice case
7 intentionally tries to harm the patient. Is that correct?

8 Q Do you believe--actually, that's not quite true,
9 but that is one element of it.

10 Do you believe that Dr. LaRoche intentionally
11 conducted herself in the care and treatment of this patient
12 so as to harm the patient?

13 A Well, I am not sure I exactly understand your
14 question. But suffice it to say that there is no evidence
15 in the chart that Dr. LaRoche intentionally tried to harm
16 the patient.

17 Q Okay.

18 Do you believe that the care and treatment of
19 this patient by Dr. LaRoche was in reckless disregard,
20 reckless disregard for the care and well-being and safety of
21 this patient?

22 A I don't know what the phrase reckless disregard

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1 means.

2 Q Well, we should all ask the Tennessee Supreme
3 Court what they mean. But that is the test for punitive
4 damages, one of the tests for punitive damages in Tennessee.

5 And so my question to you is: Do you believe
6 that, based on your understanding of those words,
7 Dr. LaRoche disregarded the well-being of this patient in
8 reckless fashion?

9 A Well, once again, sir, based upon my
10 understanding of the words, I just stated on the record that
11 I didn't understand the words.

12 Q Do you think Dr. LaRoche should be punished for
13 her care and treatment of this patient?

14 A That is a legal decision, not a medical decision.

15 Q Well, I am asking you to give me your opinion.
16 In addition to compensatory damages for any harm that was
17 allegedly caused by her care and treatment, do you think
18 above and beyond that she should be punished?

19 A I am not sufficiently familiar with the concept
20 of reckless care or punitive damages or punishing a doctor,
21 I am not sufficiently familiar with that concept so that I
22 can give an opinion to answer that question.

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1 Q Okay.

2 In the Exhibit 1, the document that we have been
3 discussing, your summary of the testimony, and in the
4 complaint in this case--and by the way, have you read the
5 pleadings in this case? Have you read the complaint?

6 A I don't believe I have ever been sent a copy of
7 the complaint.

8 Q Okay.

9 In those two documents and perhaps others, there
10 has been some reference to the fact that during the late
11 '80s and into perhaps up through at least and including
12 February of 1991, Mrs. Gorman suffered a weight loss and
13 mood changes. Okay.

14 A I did notice that, yes, sir.

15 Q Okay.

16 Do those factors have any relevance to the issues
17 that we are talking about today, the standard of care
18 questions regarding diagnosis of breast cancer?

19 A Well, keeping in mind that I am answering on the
20 basis of gynecology and not oncology, I don't know the
21 oncological significance of weight loss.

22 Q Okay.

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1 A But based upon my opinion as a gynecologist, I
2 don't see any relationship to the patient's weight situation
3 and the issues that we are dealing with in this case.

4 Q Okay.

5 So if you were the primary treating Ob/Gyn and
6 this was your patient and she had sustained a weight loss,
7 that would not concern you in terms of whether or not the
8 patient had breast cancer? It would not be indicative or
9 cause you to search further to determine whether or not that
10 was a sign or a clinical sign or symptom of breast cancer?

11 A In and of itself, it's not. The standard of care
12 for working for breast diagnosis and management is clear, as
13 I have stated it, and the pure, isolated fact of a weight
14 loss does not in and of itself alter the standard of care
15 for patient breast examination and diagnosis and management.

16 Q Okay.

17 Well, does weight loss have any bearing in
18 relationship to, and in addition to, the other clinical
19 signs and symptoms that you see in Kim Baker's February 20,
20 1991, note?

21 A Well, keeping in mind that, A, I am speaking from
22 a gynecologic viewpoint, not the oncologic viewpoint, so I

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1 am not going to talk about the potential oncologic decisions
2 against--

3 Q I understand. I understand.

4 A And, B, that the weight loss in this patient
5 appeared to be explainable and understandable for other
6 reasons and, C, there was no evidence prior to 2/20/91 of
7 any evidence of breast cancer other than the referral in
8 '87, which turned out to be a benign fibroadenoma, then once
9 again with those understandings, I see no relationship of
10 weight loss to any breast issues in this case.

11 Q Okay.

12 And what were those other explanations for weight
13 loss?

14 A She had been under some stress based upon her
15 social situation. And in addition she being aware that a
16 high-fat diet is a risk factor associated with an increased
17 incidence of breast cancer, attempted to go on a low-fat
18 diet.

19 Q Was this patient having problems while she was
20 under Dr. LaRoche's care, in your opinion as an Ob/Gyn, with
21 sexual intercourse and her marital relationship, physical
22 relationship, sexual relationship with her husband?

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1 A Well, keeping in mind she got married in June of
2 '89 and she did not see Dr. LaRoche until 1986, I can't
3 comment on the first three years.

4 Beginning in 1989, when she got married,
5 according to Mr. Gorman's testimony, they had a very
6 satisfying intimate component to their marital relationship
7 up until the chemotherapy following the right breast cancer.

8 Q Okay.

9 Would you have that same opinion, setting aside
10 Mr. Gorman's deposition testimony for the time being, is
11 that your opinion if you read just the office records of
12 Dr. LaRoche from June of '89 to February of '91?

13 A Well, keeping in mind that my memory is not
14 infallible, I honestly can't recall any passages in the
15 records which relate specifically to the intimate component
16 of their marital relationship.

17 Q Pain during intercourse, that kind of thing,
18 vaginal dryness, do you recall seeing references to those
19 clinical problems?

20 A From 1989 to 1991?

21 Q Right.

22 A I recall seeing various medications prescribed

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1 for yeast infections. In fact, I believe on one occasion a
2 prescription was given for both Mrs. Gorman and the husband.

3 But other than that, I don't remember any other
4 passages or descriptions.

5 Q Is pain or lack of pain with regard to a new
6 lump, as this patient has in the right breast, a factor to
7 be taken into consideration in determining whether or not
8 the patient has breast cancer?

9 A Well, the workup of a breast mass is the same
10 regardless of whether the patient does or does not have
11 pain. The dominant mass has to have its nature determined
12 by an invasive procedure. Whether it be fine-needle
13 aspiration or fine-needle biopsy or open biopsy or
14 incisional biopsy, it needs to be determined.

15 We know that approximately 80 to 85 percent of
16 patients who have breast cancer do not have pain as a
17 presenting symptom. Some 10 to 15 percent do.

18 So the presence or absence of pain can assist in
19 a presumptive idea of what the ultimate histological
20 diagnosis will be.

21 Q And do you know whether or not Mrs. Gorman was
22 complaining that this new nodule was painful or not in

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1 February of '91?

2 A I don't recall any comments addressing the issue
3 of pain or lack of pain in February of 1991.

4 Q Okay.

5 Just in looking at other factors that may
6 indicate clinically whether or not a patient has breast
7 cancer and keeping in mind the foundation that you have laid
8 that histological evaluation is the ultimate test, does it
9 matter to the clinician what the location of the new mass is
10 on the breast?

11 A Well, we know that the highest incidence of
12 breast cancer, if you divide the breast into quadrants, the
13 highest percentage of breast cancers are found in the upper
14 outer quadrant.

15 However, breast cancers are found in all
16 quadrants and in the nipple aureole complex and in the
17 axillary tail of Spence--S-p-e-n-c-e. And so although it's
18 interesting epidemiologically to note that the highest
19 incidence of breast cancer is in the upper outer quadrant,
20 the anatomic location of a mass in no way changes what the
21 standard of care dictates.

22 Q Do you know what the location of this right

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1 breast lump of February '91 was?

2 A The records indicate that it was in the right
3 upper inner quadrant approximately between 12:30 and 2:00.

4 Q The 1:00 position I think is what Ms. Baker said.
5 Would you agree with that?

6 A Well, another description says 12:30 and another
7 description says 2:00. So taking all the descriptions
8 together, I gave a range of 12:30 to 2:00.

9 Q Okay.

10 So, in the upper inner quadrant?

11 A Right upper inner quadrant. That's correct.

12 Q What percentage statistically of all breast
13 cancers are located in that quadrant? And when I say of all
14 breast cancers, I am talking of all breast cancers included
15 in the study that produced the statistics.

16 A Okay.

17 Well, in the upper outer quadrant, that's when
18 you find approximately 37 percent of breast cancers.

19 Q Okay.

20 A In the upper inner quadrant, I can't recall the
21 statistic. I'm sorry.

22 Q Okay. Less than 37 percent, though?

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1 A Yes, sir.

2 Q In Mrs. Gorman's deposition, Dr. Cohn, there was
3 some testimony by Mrs. Gorman herself that she understood
4 that there was a correlation between the length of a delay
5 in diagnosing breast cancer and deterioration of the immune
6 system.

7 A I recall that passage.

8 Q Do you remember that?

9 A Yes, sir.

10 Q Okay.

11 Do you agree with the conclusions that she had
12 reached about that?

13 A Sir, I think that is an area that falls more
14 appropriately within the field of oncology than gynecology.

15 Q Okay.

16 A So I do not intend to give any testimony in that
17 regard.

18 Q That's fair enough.

19 (Pause.)

20 Dr. Cohn, if you had been in Dr. LaRoche's shoes
21 back in February of '91 and during the spring of '91, and if
22 you became aware of the fact that this new mass in her right

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1 breast was indeed malignant, okay, would you then basically
2 have turned over her care to other specialists, such as a
3 surgeon and an oncologist to treat that malignant tumor?

4 A You mean I knew it was malignant based upon a
5 presumptive diagnosis or a biopsy proving it?

6 Q No; from whatever source. Let's say that you had
7 access to histological confirmation of malignancy. Okay.

8 A That's correct.

9 Q You know for sure that it's malignant.

10 A Then I would refer the patient to a breast
11 surgeon.

12 Q Okay.

13 And would you expect then that that surgeon would
14 make the substantive decisions with regard to the follow-up
15 care of the patient in terms of how extensive the surgery
16 would be and with the oncologist in terms of how extensive
17 the other care might be, whether it be radiation or
18 chemotherapy? And I am assuming that would be, to some
19 extent, in consultation with the patient. But what I am
20 saying is, in terms of your role as an Ob/Gyn, you would
21 basically pass the ball to those other specialists for that
22 kind of treatment. Is that correct?

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1 malignancy diagnosed that this patient might be weighing
2 whether or not to have a lumpectomy as opposed to a mod-
3 radical mastectomy. Correct?

4 A Yes, sir.

5 Q Would you participate in that decision,
6 typically, or would you assume that the surgeon and the
7 oncologist then would take over that process and help the
8 patient make those decisions?

9 A I would not participate in the decision-making
10 process unless the patient specifically asked my opinion,
11 and I would give my opinion based upon my general knowledge
12 of the treatment of breast cancer and not upon any specific
13 knowledge, treatment, training, or experience.

14 Q If a surgeon with a consult from an oncologist
15 recommended a certain course of action that you felt was
16 reasonable, I am assuming you would not disagree with the
17 specialist when you talked to the patient?

18 Do you understand my question?

19 A Well, I earlier testified that there were
20 circumstances in which I would at very least engage in
21 discourse with a specialist if that proposed specialist's
22 management was not within my understanding.

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1 Q I'm sorry. Go ahead.

2 A But if was not within my understanding consistent
3 with what I would expect to be the proper management.

4 Q Right. And I remembered that, and I took pains
5 to include the word reasonable.

6 If the patient is sent to a surgeon and that
7 surgeon is a competent surgeon, you know that surgeon to be
8 competent and you know that that surgeon gets a consult from
9 a competent oncologist--

10 A Okay.

11 Q Okay. And between those two specialists, they
12 arrive at a treatment plan for the patient that is
13 reasonable and it's presented to the patient, and then the
14 patient comes to you and says, "Dr. Cohn, what do you think
15 about this?" Okay. Is it your proclivity under those
16 circumstances to agree with the specialist to whom you sent
17 the patient?

18 A Well, you let out one important factor, and that
19 is has the patient been advised of reasonable alternatives?

20 Q Yes. Okay. But I am assuming that a competent
21 surgeon and a competent oncologist have advised the patient
22 of all of the alternatives and have arrived on the basis of

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1 a full discussion with the patient at a recommendation, and
2 then the recommendation is brought to you by the patient.

3 A Okay. Okay.

4 What I would do is I would first of all inform
5 the patient that my special training and knowledge does not
6 fall within the realm of what she is dealing with.

7 Q Right.

8 A So her overall reliance should be to follow the
9 data given by the competent oncologist and breast surgeon.

10 With that understanding, I would listen to what
11 their recommendation was and I would review for her what, in
12 my opinion, were the benefits, limitations, alternatives,
13 and dangers of the various options and then have her make
14 her own decision.

15 I would at least need to be convinced that she
16 was making a decision based upon knowledge, not based upon
17 fright.

18 Q When a patient has been diagnosed with breast
19 cancer, within the protocol among physicians, among those
20 who are on the treatment team, which I would assume would be
21 the Ob/Gyn, the surgeon, the pathologist, the oncologist,
22 and perhaps others, okay, who becomes the attending

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1 physician after the diagnosis has been made and a referral
2 is made to the surgeon? Who is the primary physician in
3 charge of the care of the patient?

4 A Are you asking who is the captain of the ship?

5 Q Right.

6 A Is that it?

7 Q Exactly.

8 A I guess the oncologist would feel that he or she
9 is the captain of the ship. I guess the breast surgeon would
10 feel that he or she is the captain of the ship. It all
11 depends on your philosophy.

12 Q What is your philosophy?

13 A My philosophy is the breast surgeon is the
14 captain of the surgical ship and the oncologist is the
15 captain of the oncological ship.

16 Q And therefore, the Ob/Gyn is not the captain of
17 the surgical ship or the oncology ship?

18 A I would agree with that.

19 Q Okay.

20 In the complaint in this case, Dr. Cohn, there
21 is--and you haven't read this, so I am just going to read it
22 to you, and if you want to read it, you are certainly

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1 welcome to, although I have got some notes here.

2 Let me just read this to you. This is paragraph
3 18 of the complaint:

4 "As a direct and proximate result of the
5 defendant's negligent acts and/or omissions, the plaintiff's
6 breast cancer advanced from a Stage 1 lesion to a Stage 2
7 lesion, which increased the level of follow-up treatment
8 required, including but not necessarily limited to
9 chemotherapy and radiation therapy, and which has reduced
10 the plaintiff's prognosis and likelihood of recovery."

11 Okay. Do you want me to read that back to you?

12 A No, sir.

13 Q Did you get the gist of it?

14 A I got the gist of it.

15 Q Are you going to testify about that issue in this
16 case?

17 A If I am asked to comment on causation, then I
18 will comment on causation based upon my knowledge and
19 expertise in the interface of breast cancer and gynecology.

20 Q I am not sure I understand what you mean.

21 Are you going to say that as a proximate result
22 of the alleged negligence of Dr. LaRoche that some harm

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1 occurred to this patient that would not otherwise have
2 occurred?

3 A That is my opinion. If i am asked to testify to
4 that opinion, I will, sir.

5 Q Okay.

6 And as an Ob/Gyn, what is your opinion as to that
7 harm that would not otherwise have occurred?

8 A My opinion is that within a reasonable degree of
9 medical certainty, based upon the evidence available in the
10 chart, that Mrs. Gorman on 2/20/91 had a Stage 1 breast
11 cancer and the ultimate confirmation of the stage was done
12 in January of 1992 in which she met criteria for Stage 2B.

13 It is my contention that both the discomforts of
14 management and the type of surgical approach that could have
15 been offered to the patient in February '91 were changed to
16 the point where, A, her prognosis dropped from approximately
17 a 75 to 85 percent 10-year survival to approximately a 35 to
18 40 percent 10-year survival.

19 Additionally, we know that in node-negative
20 patients with Stage 1 or Stage 2 lesions, but certainly in a
21 Stage 1 lesion, that segmental mastectomy, also known as
22 breast conservation surgery, also known as lumpectomy, is an

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1 option that may have been able to be offered to the patient
2 in February of '91 but was not able to be offered in January
3 '92 or December '91.

4 Additionally, when it comes to chemotherapy, and
5 Mrs. Gorman states in great detail the discomforts of her
6 chemotherapy, adjunctive chemotherapy is not necessary for a
7 woman who undergoes and meets deviation from the criteria
8 for a lumpectomy followed by irradiation, which was a
9 reasonable option for her in February of 1991.

10 And in terms of adjunctive chemotherapy, we know
11 that for a node-negative patient adjunctive chemotherapy can
12 be possibly unnecessary in a Stage 1 node-negative patient.

13 So, in summary, she was denied the possibility of
14 having a breast conservation surgery, and in addition she
15 was denied the possibility that she may have been able to
16 bypass chemotherapy.

17 Q It looks to me like you are still thinking. So I
18 am holding off my follow-up question.

19 A I have finished my thinking.

20 Q Okay.

21 Have you included in that list all of the factors
22 that you think were, in effect, worsened by a delayed

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1 diagnosis?

2 A Survivability, type of surgery, possible
3 avoidance of chemotherapy, I think that completes my list.

4 Q Okay.

5 Are you going to testify that you believe that
6 when Mrs. Gorman ultimately contracted cancer in the left
7 breast, that that was a metastasis from the right breast?

8 A No, I am not going to so testify.

9 Q Okay.

10 Do you believe that it was?

11 A I believe that that is a question most properly
12 answered by an oncologist as opposed to a gynecologist.

13 Q All right.

14 So you are not going to basically testify to any
15 issues with regard to the cancer on the left side. Is that
16 correct?

17 A That's correct, sir.

18 Q All right.

19 Okay. Well, let me ask you some questions then
20 about what you said about causation.

21 What is a Stage 1 tumor, in your opinion?

22 A Sir, breast cancer staging is based on the TNM

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1 system--T for tumor, N for nodes, M for metastasis. And
2 there is a schematic breakdown of the T status, the N
3 status, and the M status that determines the stage.

4 In broad general terms, Stage 1 disease can be
5 defined as a small, localized tumor without lymph nodes.
6 Stage 2 disease in general involves axillary metastases, and
7 Stage 3 in general involves advanced local disease. Stage 4
8 in general involves distant metastases, including
9 supra-clavicular node. The exact--

10 Q May I stop you for just a second?

11 A Okay.

12 Q You said that Stage 1, which is what my question
13 was, generally involves a small, localized mass without node
14 involvement. Is that correct?

15 A Generally.

16 Q Generally speaking?

17 A Generally speaking.

18 Q And generally what do you mean by small?

19 A Generally it's a tumor which is less than 2
20 centimeters in diameter.

21 Q Less than 2?

22 A That's correct.

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1 Q Okay.

2 With no node involvement?

3 A That's correct.

4 Now, specifically, there is a schematic diagram
5 in which all the various combinations of Ts and Ns and Ms
6 are looked at, and you can map, based upon among the T and
7 the N and the M status, into which the patient falls.

8 Q Okay.

9 Your opinion is that by January '92 she was a 2B?

10 A Yes, sir.

11 Q Stage 2B? Is that correct?

12 A That's correct, because she was at 2T/N1/M0. 2T,
13 which means tumor between 2 and 5 centimeters; N1, lymph
14 nodes involved; M0, no evidence of distant metastases. And
15 so that falls into the schematic grouping of Stage 2B.

16 Q Now, who publishes this schematic reference that
17 you're talking about?

18 A Well, I have a copy that was provided in the
19 exhibits to Dr. LaRoche's deposition, and it is put out by
20 the American Joint Committee on Cancer, which also includes
21 the American Cancer Society and also looks like another
22 commission on cancer.

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1 Q Typically, in your practice as an Ob/Gyn, do you
2 stage cancers? Do you typically help patients with the
3 staging of breast cancer?

4 A Not with breast cancer, no, sir.

5 Q But you feel that you are competent in this case
6 and qualified in this case as an expert to discuss the
7 matters that we are discussing at the present time?

8 A Well, it's my opinion that any gynecologist who
9 holds himself or herself out as having special knowledge,
10 training, and expertise in, among other things, breast
11 disease at the very least ought to know the staging of
12 breast cancer; maybe not every single combination of T and N
13 and M, but at least in general terms should know the staging
14 of breast cancer.

15 Q Would you agree with me that there are some
16 Ob/Gyns who do not hold themselves out as being specialists
17 in breast cancer?

18 A There are some Ob/Gyns who hold themselves out to
19 the general public as having special knowledge, training,
20 and expertise in Ob/Gyn but not in breast disease?

21 Q I thought that was a qualification that you added
22 to your statement.

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1 A No. I don't know--I don't know of any
2 gynecologist who would admit and that would be proud to
3 admit that they have got training in obstetrics and
4 gynecology but are less than competent in breast disease.
5 That physician wouldn't be well respected nor would he or
6 she remain long in practice.

7 Q Okay.

8 How does that come up in your day-to-day
9 practice, the staging of breast cancers?

10 A Well, it does not come up in my daily--I am very
11 fortunate not to have a daily occurrence of breast cancer in
12 my practice. So it doesn't come up in the daily practice.

13 Q Well, I didn't mean that literally. I mean in
14 your practice. How many patients, how many active patients
15 do you have, Dr. Cohn?

16 A I have no idea.

17 Q Well, estimate it for me.

18 A I couldn't even estimate.

19 Q Did you see any patients today?

20 A No, sir.

21 Q Did you see any patients yesterday?

22 A Yes, sir.

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1 Q How many did you see?

2 A Three.

3 Q You saw three patients yesterday. Were those
4 surgical patients, or did they come into the office for
5 exams or checkups?

6 A They were checkups.

7 Q Okay.

8 Is that a typical day for you?

9 A It's a potentially typical half-day for me.

10 Q Okay.

11 Typically, how many patients do you see a week
12 for all causes: checkups, examinations?

13 A Depending upon how busy I am, what my surgical
14 workload is, what my teaching workload is, it can be
15 anywhere from five to ten, up to hundreds.

16 Q Okay.

17 So there are some weeks when you see hundreds of
18 patients?

19 A Yes, sir.

20 Q Okay.

21 Do you see them at this office in Sterling or at
22 the Washington, D.C., office?

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1 A Neither one.

2 Q You see them at the hospital?

3 A That's correct.

4 Q In a clinic setting?

5 A Yes, sir.

6 Q Okay.

7 Do you see any patients here at this office where
8 we are today in Sterling?

9 A Yes, sir.

10 Q Okay.

11 You are smiling. Am I asking the wrong question?

12 A No.

13 Q Obviously, I don't understand. Why are you
14 smiling?

15 A I have never been asked if I see patients at my
16 office before.

17 Q Well, you have a lot of offices, and I didn't
18 know whether you utilized this office primarily for other
19 matters.

20 A Oh. Okay.

21 No, I have got three examining rooms. I use them
22 for patients.

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1 Q Okay.

2 It's your opinion, as I understand your
3 testimony, that you believe this patient was a candidate for
4 a lumpectomy with radiation back in February of '91?

5 A Well, it's my contention that she was a T1/N0
6 patient, which is a Stage 1 lesion, and patients can be
7 considered as candidates for lumpectomy if they have a Stage
8 1 lesion.

9 Q Is it can be, or in this instance would you have
10 recommended lumpectomy for this patient?

11 A Well, I thought we decided earlier that the
12 surgical approach is handled by the general surgeon, the
13 captain of the surgical shop, and the oncologist, the
14 captain of the oncologist.

15 Q Yes, I thought so, too. But now you have
16 decided, I think, to give me your opinion that you thought
17 this patient, as I understood it, should have received a
18 lumpectomy and radiation rather than modified radical
19 mastectomy and that that was one of the effects of a delayed
20 diagnosis.

21 A I don't believe I said that, sir. I think if the
22 court reporter will read back, I think I said she was denied

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1 the opportunity to consider as an option a lumpectomy.

2 Q Okay. Sort of a loss of chance to have the
3 lumpectomy as opposed to--

4 A I believe that's almost exactly what I said.

5 Q Okay.

6 Would you agree with me that a competent surgeon
7 might have recommended in February of 1991 that this patient
8 undergo a modified radical mastectomy with chemotherapy?

9 A They might have.

10 Q And if they did so, would they have been
11 deviating from the standard of care in doing so?

12 A As long as they advised the patient of the
13 potential advantages, limitations, and disadvantages of all
14 the various potential approaches that would be within the
15 standard of care.

16 Q Would there have been any advantage in February
17 of '91 to performing a modified radical mastectomy rather
18 than a lumpectomy?

19 A Well, once again we are not taking into
20 consideration the patient's ideas. There are patients who
21 view their breasts as betraying them and they don't want to
22 keep their breasts. And so I don't know what Nancy Gorman's

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1 ideas would have been in that regard.

2 But there is multiple factors that need to be
3 taken into consideration, including the patient's feelings.
4 And so not knowing her feelings in that regard, then it is a
5 difficult question to answer.

6 Q If a competent surgeon had recommended modified
7 radical mastectomy with chemotherapy for Mrs. Gorman in
8 February of 1991, would you have disagreed with that
9 recommendation--

10 A Once again--

11 Q --assuming that the patient was leaving it up to
12 the physicians to make the decision, she wanted the safest
13 treatment?

14 A I am not sure what you mean by safest treatment.

15 Q Okay. Then leave that out of the hypothetical
16 and just assume that the patient was leaving the decision up
17 to the physicians.

18 A Would I disagree if the patient who had no
19 feelings, no thoughts, no input, just wanted to be a totally
20 passive observer and, in effect, told the physicians, "Do
21 whatever you want to do, I don't care," under those
22 conditions, then I don't have--I would be astounded if such

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1 a patient ever existed. But if in the hypothetical case
2 such a patient existed and a surgeon wanted to perform a
3 modified radical mastectomy on 2/20/91 for Mrs. Gorman, I
4 would not offer any objections.

5 Q Okay.

6 And with follow-up with chemotherapy?

7 A I would not offer any objections.

8 Q Okay.

9 Do you have any reason to believe that lumpectomy
10 with radiation would have been a better choice for this
11 patient at that time, February of '91?

12 A I need to know what you mean by better choice.

13 Q That choice most likely to--the choice most
14 beneficial to the patient in terms of her health and
15 prognosis.

16 A Well, Dr. Fisher's and his colleagues' studies
17 have shown that for Stage 1 and Stage 2 disease, node
18 negative, that there is no added benefit of a modified
19 radical mastectomy over a lumpectomy, and the findings of
20 Dr. Poisson--P-o-i-s-s-o-n--at St. Luc--S-t. L-u-c--Hospital
21 in Montreal, and the inaccurate findings reported in that
22 situation, that aside, the overall thrust of the study

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1 remains that there is no added benefit in Stage 1 and Stage
2 disease, node negative, in performing a modified radical
3 mastectomy over lumpectomy.

4 Q In any circumstance?

5 A Well, there are other criteria mentioned. You
6 have to have a 1 centimeter margin around the tumor; the
7 tumor has got to be less than 4 centimeters. There are some
8 other criteria involved.

9 Q Dr. Poisson was involved in a high-profile study
10 of breast cancer aimed at evaluating whether or not
11 lumpectomy with radiation had the same benefit to the
12 patient as radical modified mastectomy. Is that generally
13 true?

14 A That's generally true, yes, sir.

15 Q Okay.

16 And he actually, it was later disclosed, he
17 falsified data and it became kind of a controversial study.
18 Is that correct?

19 A Well, the allegation is that he falsified data.
20 He stated that he widened the enrollment criteria. What the
21 exact difference is I am not sure.

22 Q Is that study still a recognized and

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1 authoritative study among physicians today because of that
2 falsified data?

3 A Well, despite the anxiety and angst that the
4 disclosure of Dr. Poisson's situation created, the idea
5 remains that under the selected conditions which I
6 mentioned, there is no added benefit to a modified radical
7 mastectomy over breast conservation surgery followed by
8 radiotherapy.

9 Q Is that statement true, in your opinion, even in
10 a situation where a woman under 40 has contracted breast
11 cancer and who has a history of fibrocystic changes, is
12 premenopausal, and has a family history of breast cancer?
13 Under all those circumstances, do you still believe
14 lumpectomy equates with modified radical mastectomy?

15 A Well, we do know that the recurrence rate tends
16 to be slightly higher in women under 35 for lumpectomy as
17 opposed to modified radical mastectomy. And Mrs. Gorman at
18 this time was 37.

19 But despite that fact, none of the factors that
20 you mentioned would make it totally outrageous that
21 Mrs. Gorman would choose a lumpectomy as opposed to modified
22 radical mastectomy.

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1 Q Well, what I am asking you about is which of
2 those two choices is the safer one in terms of being able to
3 assure the patient that you were eradicating the cancer to
4 the best of your ability and minimizing the possibility of
5 recurrence?

6 A Which one maximizes the ability to avoid
7 recurrence? Is that what you're asking?

8 Q Right.

9 A Well, the Fisher studies indicate that there is
10 no difference. The bias on the part of the general surgeons
11 is that they would rather do a modified radical mastectomy.

12 Q Why is that their bias?

13 A I could speculate for a number of reasons. But
14 since I don't know, I would rather not speculate.

15 Q Okay.

16 Obviously, chemotherapy brings with it
17 significant physical changes and probably psychological
18 changes. It is a difficult process to go through.

19 In the case of Nancy Gorman, is it your opinion
20 or will you testify that the effect of chemotherapy on her
21 was worse because of any delay in the diagnosis of the
22 cancer in her right breast?

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1 A I think any worse effect because of the delayed
2 initiation of chemotherapy is more oncological than a
3 gynecological question. The only opinion that I would hold
4 is that she was denied the opportunity to consider not
5 having chemotherapy.

6 Q Okay.

7 But once we assume that she is going to need and
8 requires chemotherapy for treatment, then you are going to
9 defer to an oncologist for this, for that testimony?

10 A That's correct. As long as I am confident of the
11 knowledge, training, experience, qualifications, veracity of
12 the oncologist, et cetera, et cetera.

13 Q Okay.

14 Are you familiar with the oncologist who has been
15 declared to be an expert in this case for the plaintiff?

16 A No, sir.

17 Q Dr. Howard Ozer?

18 A No, sir.

19 MR. LAWRENCE: Am I pronouncing that right?

20 Ozer?

21 MR. JOHNSTON: Ozer.

22 MR. LAWRENCE: Okay. O-z-e-r.

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1 BY MR. LAWRENCE: (Resuming)

2 Q Do you know Dr. Ozer?

3 A No, sir.

4 Q Have you talked to him?

5 A No, sir.

6 Q Have you read his summary of his expected
7 testimony?

8 A No, sir.

9 Q If you knew the results, Dr. Cohn, of the
10 estrogen receptor tests on the first tumor of the right
11 breast, would that change your opinion as to whether or not
12 the patient should have undergone a modified mastectomy as
13 opposed to lumpectomy?

14 A No, the receptor status would not have changed my
15 opinion with regard to the surgery.

16 Q Okay.

17 Have you read the results of the receptor tests
18 in this case?

19 A Yes, sir.

20 Q Okay. What did they indicate?

21 A They indicated that the assay--a-s-s-a-y--for
22 estrogen receptor protein was negative, and for progesterone

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1 receptor protein was positive.

2 Q Okay.

3 Can you give that some meaning in the context of
4 this case in terms of the prognosis of the patient?

5 A Generally speaking, the prognosis is improved if
6 you have positive hormone receptors. The presence of the
7 progesterone receptor protein is beneficial but not as
8 beneficial as if she had been estrogen receptor positive.

9 Q Does the fact that she was ER-positive--is that
10 the correct term?

11 A She was ER-negative.

12 Q She was ER-negative?

13 A I believe she was estrogen receptor negative,
14 sir.

15 Q I had them just the reverse.

16 A Progesterone receptor positive.

17 Q Okay.

18 A Would it be acceptable to just double check that?
19 Because you and I had different--

20 Q Yes. Yes. I would appreciate it if you would.

21 Pause.

22 A Here it is. Estrogen receptor reactivity,

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1 negative. Progesterone receptor reactivity, positive.

2 Q Okay.

3 And in terms of the rapidity at which one could
4 expect this particular tumor to grow, are you able to tell
5 me what the impact of an ER-negative finding is on that
6 issue?

7 A I don't know of any impact of ER receptor
8 negativity in terms of the growth rate of the individual
9 tumor.

10 Q What about the progesterone value?

11 A Likewise.

12 Q Okay.

13 A No known effect that I know on the growth rate of
14 the individual tumor.

15 I am assuming you mean growth rate prior to
16 excision.

17 Q What is the purpose of conducting this test?

18 A There is a difference in the prognosis in terms
19 of estrogen receptor positivity or negativity. And there is
20 also a predictability in terms of the likely response to
21 hormonal manipulation; that is, manipulation of the hormonal
22 milieu--m-i-l-i-e-u--depending on the positivity or

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1 negativity of estrogen receptor protein.

2 Q What does that mean to a layman? Can you
3 interpret that for me?

4 A It means if you are unfortunate enough to get
5 breast cancer, you are probably a little bit better off
6 having estrogen receptor positive than negative.

7 Q In terms of prognosis?

8 A That's correct.

9 Q Okay.

10 Now, Dr. Cohn, I guess the final point that you
11 made when we were discussing causation in your opinions, or
12 perhaps it was not the final point, but one of the points
13 you made was a reduced prognosis, which you expressed in
14 terms of percentages related to a 10-year survival rate. Do
15 you recall that testimony?

16 Q Okay.

17 Are those percentages taken from a chart that you
18 have utilized or referred to in this case?

19 A No. They are based upon my general knowledge,
20 training, experience in breast disease.

21 Q Are those numbers linked to, for lack of a better
22 word, the presence or absence of node involvement?

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1 A Yes, sir.

2 Q Okay.

3 So, if indeed hypothetically this patient did
4 have node involvement back in February of 1991, then her
5 10-year survival rate would not be in the 75 to 80 percent
6 range, would it?

7 A Well, if that were the case, then she would have
8 a T1/N1 lesion. And looking at the staging criteria for
9 T1/N1, that would be Stage 2A. So she would have a worsened
10 prognosis than if she were axillary node negative.

11 Q Are you able to assign, from your experience, a
12 percentage for the 10-year survivability rate for this
13 patient had she been node-positive in February of 1991, with
14 a 1.5 centimeter node?

15 A I can't give you an exact figure, no.

16 Q Why not?

17 A Because I don't happen to know the exact figure
18 of the 10-year recurrence of patients with Stage 2A.

19 Q How were you able to arrive at the exact figures
20 for Stage 1 and Stage 2B? I thought you said it came from
21 your experience--

22 A Right.

1 Q --rather than from any reference or statistics or
2 charts that has been published?

3 A That's correct.

4 But nowhere in my experience do I recall a
5 distinction in the recurrence rate when you subdivide Stage
6 2 into Stage 2A and 2B. I don't know whether 2A has a
7 better prognosis than 2B or whether they're lumped in
8 together as a Stage 2 disease.

9 Q Okay.

10 Is it safe to say and would you agree with me
11 that her survivability, her potential for surviving for 10
12 years, under those circumstances, i.e., Stage 2A in February
13 of 1991, would have been less than 75 to 80 percent?

14 A Yes, sir.

15 Q And would have been closer to the Stage 2B, 35 or
16 40 percent, to use your numbers?

17 A I don't know that for certain, but I would find
18 that likely, sir.

19 Q Okay.

20 The key element again being the fact that the
21 cancer had spread beyond its local origin and spread into
22 surrounding tissue and gotten into the lymphatic system?

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1 A That is correct.

2 Q Are you able to determine when the mass in this
3 patient increased from a Stage 1 to a Stage 2B?

4 A No, sir.

5 Q The best you can do is to say that in February of
6 1991 she was a Stage 1 and at some point over a period of
7 time of 10 months it had advanced to at least a Stage 2B?

8 A That's correct, sir.

9 Additionally, as I mentioned earlier, there is no
10 worsening of the prognosis when a reasonable delay, which I
11 defined as two, three, four, five weeks between diagnosis
12 and definitive therapy, is present. And so therefore, using
13 that knowledge, then the lesion did not progress from a
14 Stage 1 to a Stage 2 for approximately five weeks or
15 greater. And five weeks from 2/20 would be about 3/27 or
16 end of March, early April. It's unlikely that the lesion
17 would have progressed to Stage 2.

18 Q Okay.

19 As far as you are able to determine, have we
20 discussed all of the opinions that you hold with regard to
21 this case that you will testify to in court? And I am
22 including in that question all of your opinions with regard

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C O N T E N T S

WITNESS

EXAMINATION

Howard Lewis Cohn, M.D.

by Mr. Lawrence

3

E X H I B I T S

COHN DEPOSITION NUMBER

IDENTIFIED

Defendant's Exhibit 1

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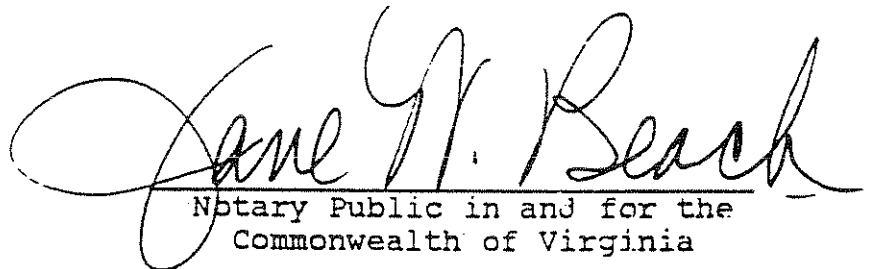
Defendant's Exhibits 2 through 5

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CERTIFICATE OF NOTARY PUBLIC & REPORTER

152

I, JANE W. BEACH, the officer before whom the foregoing deposition was taken, do hereby certify that the witness whose testimony appears in the foregoing deposition was duly sworn; that the testimony of said witness was taken in shorthand and thereafter reduced to typewriting by me or under my direction; that said deposition is a true record of the testimony given by said witness; that I am neither counsel for, related to, nor employed by any of the parties to the action in which this deposition was taken; and, further, that I am not a relative or employee of any attorney or counsel employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.


Notary Public in and for the
Commonwealth of Virginia

My Commission Expires

MARCH 31, 1996

Look-See
 Concordance Report

 UNIQUE WORDS: 2,049
 TOTAL OCCURRENCES:
 8,647
 NOISE WORDS: 385
 TOTAL WORDS IN FILE:
 24,522

 SINGLE FILE
 CONCORDANCE

 CASE SENSITIVE

 NOISE WORD LIST(S):
 NOISE.NOI

 INCLUDES ONLY TEXT
 OF:
 QUESTIONS
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