IN THE COURT OF COMMON PLEAS

HANCOCK COUNTY, OHIO

REBECCA DEVINE :
and :
DEREK DEVINE :
Plaintiffs :
vs. : Case No. 98-99-PT
BLANCHARD VALLEY MEDICAL :
ASSOCIATES, INC., and :
RICK D. WATSON, M.D., :
Individually, c/o :
BLANCHARD VALLEY MEDICAL :
ASSOCIATES, INC., and :
FRANK R. COSIANO, M.D., :
INC., COSIANO, M.D., and :
FRANK R. COSIANO, M.D., : Pages 1 - 115
Individually, and ERNESTO :
ECHAVARRE, M.D., and :
ERNESTO ECHAVARRE, M.D., :
Individually, and :
BLANCHARD VALLEY REGIONAL :

ESQUIRE DEPOSITION SERVICES

HEALTH CENTER, INC., :
f.k.a. BLANCHARD VALLEY :
HOSPITAL, and JOHN DOE, :
and JOHN DOE CORPORATION :
Defendants :

Deposition of DAVID S. ETTINGER, M.D.

Baltimore, Maryland

Monday, April 19, 1999

Reported by: Beatriz D. Fefel, RPR.

April 19, 1999

1:50 p.m.

Deposition of David S. Ettinger, M.D., held at the offices of:

Johns Hopkins Hospital
600 North Wolf Street
Oncology Center
Room 147
Baltimore, MD 21287

Pursuant to notice, before Beatriz D. Fefel, RPR, a Notary Public of the State of Maryland.

APPEARANCES:

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C O N T E N T S

E X H I B I T S

(Exhibits are attached to the transcript.)

Thereupon,

DAVID S. ETTINGER, M.D.

a Witness, called for oral examination by counsel for the Defendant, Ernesto Echavarre, M.D., having been first duly sworn by the Notary Public, was examined and testified as follows:

EXAMINATION BY COUNSEL FOR THE DEFENDANT ECHAVARRE

BY MR. CASEY:

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

A David S. Ettinger.

Q And you are a medical doctor?

A I'm a medical doctor.

Q Doctor, my name is Pete Casey; we've been previously introduced. And Lawrence Huffman and Nancy Moody are here for the other Defendants, and Justin Madden for the Plaintiffs. We are here today to take a discovery deposition of you. I think that you have given depositions in the past, have you not?

A I have.

Q So you're familiar with this process?

A Yes.

Q And if there's anything, therefore, that I ask you, or any of us ask you that you don't follow us or you think there's any confusion, you'd like clarification, please stop us and we will try to do that.

Please let me finish a question before you start an answer. By the same token, I'll try and do the same for you. Please give verbal responses as opposed to nods or umh-humh, hunh-unh.

First of all, I should have asked you a little earlier, are you under any -- I don't think that this will be a long deposition, but are you under any time constraints --

A No.

Q -- this afternoon? Okay.

And we are here at your office at Johns Hopkins Hospital?

A Oncology Center, yes.

Q Oncology Center. And the address here is?

A 600 North Wolfe Street, Baltimore, Maryland,

21287.

Q And as I indicated earlier, you are a medical doctor and you work in the specialty of oncology --

A That's correct.

Q -- is that correct?

And I have a forty-five-page CV.

MR. CASEY: I'm not sure, did you get us this, Justin?

MR. MADDEN: Yes.

Q That I'll show you just to find out from you if that is relatively current.

A No, there is one that has three more pages, but this is, goes up I think to '95.

Q Would it be possible for us -- do you have that?

A Let's see if I can get one.

Q It doesn't have to be now.

A That's okay.

(Discussion off the record.)

Q (By Mr. Casey) There's quite a few

additions to it.

A Umh-humh.

MR. CASEY: Should we mark this, I guess? Do we need to?

MS. MOODY: I don't think so.

MR. CASEY: I'll see that you all get the additional, extra pages.

MR. HUFFMAN: That's fine. Thank you.

Q (By Mr. Casey) The CV that you have provided us now is up to date in terms of your positions, your appointments, what you're currently doing?

A Except for one position. As of June -- as of July, rather, of '98, I've kept my position as Associate Director for Clinical Research but I gave up the position as Associate Director for Clinical Affairs.

Q Oh, okay. That would have been an administrative position that you hold?

A Yes, both administrative.

Q All right. The CV certainly lists with

particularity where you've been over the years, where you went to medical school. When did you become Board-certified in -- you are Board-certified first in internal medicine?

A Yes.

Q And then in oncology?

A Yes, the next year, the year after.

Q Any other specialties or subspecialties?

A No.

Q Are all of the licensing information, are these all active licenses?

A No, the only one that's active is Maryland.

Q Maryland, okay.

All right. And you became a Diplomat in the American Board of Internal Medicine in '96 and Oncology, as you say, in '97, a year later?

A I think '76.

Q What did I say?

A '96. I think it's '76.

Q '76 and '77?

A Yes.

Q Okay. You have been here at Johns Hopkins since -- well, for how long?

A Since '73. I did my Fellowship here from '73 to '75, and then stayed on the faculty.

Q What is your title here?

A Well, my administrative title is Associate Director of Clinical Research. I'm a professor of oncology and medicine at the Johns Hopkins School of Medicine, University School of Medicine, and I'm an associate professor of gynecology, obstetrics and otolaryngology and head and neck surgery in the same school. And the latter two appointments are because when I was younger, I treated head and neck cancer and ovarian cancer. I don't make the salary of a surgeon.

Q Okay. Is there any private practice involved in your current activities?

A No. I see patients, but I don't have a private practice.

Q Through the hospital?

A Through the hospital, that's correct.

Q All right. I understand from having taken a

look at your CV that you are very heavily involved in research, true?

A Thirty percent of my time.

Q All right. That's what I was going to ask you. If you could break down for us the time you spend in research, actively seeing patients, clinical practice, and any other duties that you might have.

A Fifty percent effort in clinical practice, thirty percent effort in various activities of research, and twenty percent activities in administration and teaching.

Q And in terms of the clinical practice, how does that break down, particularly? Do you deal particularly in lung cancer or other, all sorts of cancers, or --

A Eighty percent is lung cancer and fifteen percent is sarcomas and five percent is everything else.

Q Would the majority of your research also be toward the area of lung cancer?

A Yes. Actually, initially it was drug

development, but now it's drug development as well as lung cancer, and some of it applies to lung cancer as well.

Q I saw some articles on a new drug that I think you were involved in the clinical trials, and the name of it escapes me, but it was thought to be effective in lung cancer cases. Do you recall the name of that? It was fairly recently, '98.

A The drugs that I've been involved with in lung cancer would be Topecan (phonetic) for small cell, Taxol for non-small cell, as the major drugs, and I've written on those areas, Carboplatin, as well as other drugs that I've written on, but --

Q All right. Any of the drugs that you've been involved in that proved particularly useful in lung cancer?

A Taxol/Carboplatin is the standard for non-small cell lung cancer.

Q What was your involvement in that development, clinical trials?

A We -- yeah, clinical trials, but we

developed, we did the phase one drug testing here, and I happened to be the PI of the phase one contract here in 19 -- we've been using that drug since 1984.

Q Is that a drug that was used with Rebecca Devine, do you know, from looking at her records?

A It was used, actually, sure, Taxol Carboplatin.

Q How long have you been engaged in reviewing and offering testimony in medical, what I'll call medical/legal matters?

A Since '85; my first case was my own patient.

Q You testified for that patient?

A That's correct.

Q All right. What's the scope of your activity, say over the last three or four years, in terms of reviewing and testifying?

A Oh, over the last four -- I mean --

Q Or whatever time period you can --

A Over the time frame of fifteen years I may have reviewed about a hundred and sixty-plus cases, and I may have given -- and they are sixty percent for

the plaintiff, forty percent for the defense. And I may have given testimony in -- or a deposition, rather, not testimony, a deposition in maybe sixty, give or take a few, in that range. And then trial, maybe thirty over that fifteen-year -- it's more than that now. It's been fifteen years.

Q Have you done any prior reviews for Mr. Madden or anyone in his firm, which is Spangenberg, Shibley & --

MR. MADDEN: Liber.

Q -- Liber?

A I think I've done one. I don't remember. I had to ask him, actually.

Q Was that for Mr. Madden, or for someone else?

A No, Weinberger, I think.

Q Peter Weinberger. Do you recall how long ago that other case would have been?

A I don't, I don't.

Q Do you recall having given testimony in any Ohio cases other than that one? I presume that was,

may have been an Ohio case for Peter Weinberger. Any other Ohio cases other than that one?

A I don't think I have given testimony. I've reviewed a record or two from Ohio, and the last one I remember was for the defense.

Q Do you remember who that was, what attorney?

A I think John Irwin was the attorney; I think he's a doctor as well. And the person he was defending happened to be a lawyer and a doctor, so it was just lawyer first, then a doctor. I think Irwin came in the other way; doctor first, then a lawyer.

Q Okay. What are your fees for reviewing a case?

A Well, this case started a year ago, so it's three hundred dollars. Now it's four hundred dollars an hour.

Q And your fee for giving deposition testimony?

A The same. Everything is the same.

Q Four hundred dollars an hour?

A No, it's -- since we started on this one,

it's three hundred dollars.

Q Oh, we've been grandfathered in then?

A Absolutely.

Q And then should this matter go to trial, what?

A The same thing.

Q The same thing?

A Portal to portal, though.

Q Yeah. If this matter goes to trial, do you anticipate, or have you and Mr. Madden discussed whether you'll be coming in live or --

A We haven't discussed it. I know that trial begins May 31st. I know I'm going to be away. I think that's on the docket, isn't it?

MR. MADDEN: No, October.

A October. Whatever you want.

Q Do you accept any reviews, any cases through expert services?

A No.

Q You don't allow any services to use your name --

A No.

Q -- or to contact you?

A No.

Q So whatever work you do in this area is done on a attorney-to-doctor basis?

A By word of mouth.

Q Did Mr. Madden have involvement in that case that Peter, you had for Peter Weinberger, do you remember?

A I don't remember, to be honest with you.

MR. MADDEN: The answer is no to your question, counsel.

MR. CASEY: You didn't have to answer that, but now that you have you have waived your right to refuse to give us information.

Q All right. Doctor, when did you first come to hear about, or were you contacted about this matter?

A February 2nd, 1998.

Q And was that by telephone, or letter, or --

A By letter.

Q Letter. Had there been some contact prior to that date asking whether you would in fact take a look at the case, or --

A It could have been, but that I don't remember.

Q Do you have that letter here? May I take a quick look at it?

(Witness handing.)

Q This letter would reflect that you had had a discussion about this matter with Peter Weinberger?

A Yes. Oh, it says by telephone? Okay.

Q Just discussed with you last week.

A Okay. Then it must have been by phone.

Q Okay. Over the course of time since you first heard about this case, I presume that you have received medical records and other materials?

A Yes.

Q Do you by any chance have a listing of what you have received?

(Witness handing.)

Q It would save us probably a lot of time if

we could -- do you need this?

A No.

Q Is that for our purpose?

A It's for your purposes.

MR. CASEY: Shall we mark this one, or just keep it? It's up to you guys.

MS. MOODY: Mark it.

(Document was marked Ettinger Deposition Exhibit No. 1.)

Q (By Mr. Casey) Are there any materials that you have reviewed that do not -- this record includes, what we've marked as Exhibit 1, actual medical records from both Findlay and the Medical College of Ohio, radiography and depositions. Is there anything that you've reviewed that is not included on the listings that you've given us?

A No.

Q Did you have to do any, or did you do any research of any type in forming the opinions that you're prepared to express in this case?

A No.

Q I don't know if this will be helpful to you or not, but just chronology-wise, Mr. Huffman represents Doctor Cosiano --

A Right.

Q -- Miss Moody represents Doctor Watson, and I represent Doctor Echavarre and the hospital which was in this case, has been dismissed.

I presume that we would not be gathered here in your office today unless you had some opinions to express, so I'll tell you the way I would like to proceed at this point, if it's okay. I would appreciate it if, starting with Doctor Cosiano, then Doctor Watson, then Doctor Echavarre, if you could just in a short-hand fashion give me a thumbnail, a quick sketch of your criticism or criticisms against each individual doctor, and then we can go on and discuss, if we need to, discuss them in greater detail. Would that be okay with you?

MR. MADDEN: I'll just interject an objection. If you're going to ask for a thumbnail, he may have other opinions that arise, I know you're

going to follow up on it, I just don't want to be precluded later on --

MR. CASEY: I understand.

A Okay. In 1994, both Doctor Cosiano and then Doctor Watson, and then, of course, Doctor Cosiano saw again the patient. An abnormality was seen on the chest X-ray. There was a CAT scan that showed not only the abnormality, but also an abnormality in the hilar area and it wasn't followed up sufficiently, that is, with appropriate tests; therefore, this was a breach of the standard of care, in my opinion, by Doctor Cosiano and Doctor Watson.

And, similarly, in 1996, in January, when Doctor Echavarre - excuse me if I pronounce his name wrong - saw the patient again knowing the information relating to the abnormality on the chest X-ray, and appropriate studies weren't done in January 1996; therefore, there was a breach of the standard of care. And when the patient was finally diagnosed in April of '97, she lost a substantial chance for longevity.

Q Do you have any criticisms of Rebecca Bish-

Devine, Rebecca Bish-Devine?

A It's my understanding, and, again, in the deposition there was some mention made at one time that she, one time she did not come back for a follow-up visit, but other than that, I have no specific questions or comments regarding Rebecca Bish other than the fact I would have thought if there was an abnormality on any chest X-ray, if I was sitting there, I might be a little more insistent about what was happening, why wasn't it being evaluated.

Q You mean putting yourself in her position?

A Yeah. But I'm a little more knowledgeable, obviously, because I'm a physician.

Q The incident that you referred to, was that failing to return to Doctor Watson's office?

A Yes.

Q Did you read the -- did you have the deposition of Derek Devine? I see you did. Did you read that deposition?

A I read it, yes.

Q All of them, all right.

Before we get into -- are those notes that you've made concerning this matter?

A These are summaries of the -- there's no editorialization. These are notes from the chart.

Q All right. Well, why don't you continue to go ahead and use those if you need to now, and we can --

A You can have my copy.

Q I can?

A Absolutely.

Q And this one, too?

A And that's my, the hours I've put in.

Q All right. Well, may we --

A You can have that, too.

(Documents were marked Ettinger Deposition Exhibit Nos. 2 & 3.)

Q (By Mr. Casey) We are dealing here with several specialties: we're dealing with Doctor Watson who is a pulmonologist; Doctor Echavarre who is a surgeon; Doctor Cosiano who is a family --

MR. HUFFMAN: Family practitioner.

Q -- family practitioner. You yourself are an internist and oncologist. Do you feel able to testify and give opinion testimony regarding the standard of care that is applicable to these doctors in these other specialties?

A Yes, I can.

Q Is that because it involves the area of cancer, and particularly lung cancer?

A Yes.

Q Do you also expect to give opinion testimony regarding changes in prognosis depending upon what something, if something had been done differently at certain periods of time?

A Yes.

Q All right. Doctor Cosiano -- well, what's your understanding as to how long Rebecca Devine had been experiencing respiratory difficulties prior to her first seeing Doctor Cosiano for that?

A I thought it was sometime in 1993, although my notes start, at least what I wrote down, October 1994.

Q And what type of complaint did she have then at that, in that area?

A In October of 1994 she complained of a sore neck and wheezing.

Q Her complaint of the sore neck, does that, is that indicative of any subsequent problem that she had?

A Not that I know of.

Q Or was that just a collateral symptom?

A A collateral symptom.

Q All right. Do you see the wheezing as of that time as being significant in terms of her later history?

A Absolutely.

Q Could you explain why, in what way and why you feel it's significant?

A Well, I think you have to explain wheezing as a symptom of a number of diseases, both benign and malignant, and you have to try to explain why a person wheezes. If it's infectious, for example, like asthma, one can wheeze. If you have an obstructing

lung lesion or compression of a bronchus, one can wheeze. So there are many reasons why one can wheeze and it behooves the physician if a patient is complaining of that and the patient's being seen by the physician for that, to explain it.

Q Is it your opinion that her wheezing back when she first saw Doctor Cosiano for it and he sent her to Doctor Watson was in fact because of an obstruction of the bronchus or of some lung lesion, as you just stated?

A Or from some lung lesion.

Q Do you have an opinion as to what the lung lesion was, or where it was that was causing the wheezing at that time?

A There was a left upper lobe mass that actually was subsequently shown on the CAT scan of October 11th, 1994, a one-point-six-by-one-point-nine left upper lobe mass associated with hilar lymphadenopathy.

Q I want us to be on the same track, and I may on occasion, and some of the other attorneys on

occasion, may refer to that as the nodule.

A Okay.

Q So if we do, you know and we know that we're talking about that left upper lobe mass that later on in the CT scan was sized at one-point-six to one-point-nine centimeters, correct?

A Yes, that is the nodule, but there's also an associated question of hilar adenopathy.

Q But my question to you right now is what was causing the wheezing, and you feel it was the nodule rather than the hilar adenopathy?

MR. MADDEN: Objection.

A Oh, it could be either.

Q It could be either?

A Absolutely.

Q All right. What do you see as her risk factors for lung cancer?

A She has a lung mass, she has hilar, she has suspected hilar adenopathy.

Q Well, I don't mean radiologic findings. I mean just in terms of the person, there are risk

factors, one is a smoker, one has a family history --

A Right.

Q -- these sorts of things. Before we get to the diagnostic aspect of it, does she have any risk factors?

A She has no risk factors.

Q One can have benign lesions in the lung, can't one?

A Absolutely.

Q In a patient such as Miss Devine, Mrs. Devine where there's no real other risk factor, is it more probable than not that a lung nodule, this hilar mass, would be benign processes rather than malignant processes?

A You mentioned the nodule and then you mentioned the hilar mass.

Q I'll split it up if that's necessary.

A I'll split it up. The nodule, eighty percent of nodules in a twenty-eight year old sitting there alone would be benign. When you have the hilar consideration of, hilar adenopathy with the nodule,

we're talking about a reasonable degree of medical certainty, one better think of malignancy, even though her age is twenty-eight.

Q And why is that?

A Because benign diseases don't spread. Usually benign diseases from a nodule don't cause hilar adenopathy. It can from an infection etiology do that, but in that situation, since cancer does that equally as well, you have to rule that out.

Q But the hilar process could also have been benign, true?

MR. MADDEN: Objection.

A I said yes.

Q All right. The combination, I think what you're telling me is the combination of both of them makes it something that one would want to investigate more than seeing it singly?

A Yes.

Q Now, Doctor Cosiano, as I understand it, back in 1994, sent at that time Ms. Bish to a pulmonologist, Doctor Watson. Was that not

appropriate, for him to do that?

A Very appropriate.

Q All right. The patient did not return to, as I understand it, Doctor Cosiano with any complaints of problems with her breathing or her lungs until December of 1996. Do you fault -- '95, I'm sorry. Do you fault Doctor Cosiano for that period in between there in some fashion?

MR. MADDEN: Objection. Go ahead.

A Yes.

Q Oh. How so?

A It's my understanding he did not speak or discuss with Doctor Watson what the findings were, what Doctor Watson thought, and I think this lack of getting further information is below the standard of practice, even for a family practitioner.

Q Do you feel that Doctor Cosiano had an affirmative duty to, after he sent the patient to Doctor Watson, to find out what was going on?

A Yes.

MR. MADDEN: Objection.

A Absolutely. It's his patient.

Q So he, in your opinion, he is not free to assume that whatever is happening is being taken care of because he doesn't hear anything from either the patient or the referring physician?

A He can't assume anything until he knows.

Q Have you ever been in private practice?

A In the Army.

Q I wouldn't call that private practice.

A That's the closest I can come to that; otherwise, I've been in academic institutions.

Q When were you in the Service?

A '73 -- '71 to '73. Once in an Army hospital, Leavenworth, Kansas, Fort Leavenworth, Kansas.

Q All right. Doctor Watson, then, the patient was referred to Doctor Watson by Doctor Cosiano. He saw her; he did some investigation. What should he have done during that period of time that he didn't, what should he have done that he did not do?

A Do a bronchoscopy and try to establish the

diagnosis.

Q Is it your understanding that he offered that as an option to the patient?

MR. MADDEN: Objection.

A I think he discussed that in the deposition, that he did, but I didn't see it anywhere in the notes, if I'm not mistaken.

Q I want to show you what's been, what we looked at at his deposition, if I could come around here with you. This is a chart note that he testified was made on November the 14th, 1994, and you see reference here to bronchoscopy?

A Yes.

Q Would that indicate to you that he discussed bronchoscopy with Rebecca Bish at that meeting?

MR. MADDEN: Objection.

A I don't know what it means. It means, I think, it may have come up, but --

Q Well, you read his testimony. Do you recall what he said about that?

A And he said that, I think, he discussed it

with her.

Q Let's assume that he did, all right, and that that was one of the courses that was discussed with the patient and the patient didn't want to pursue that course. Should he have somehow gone further, made her do it, insisted on it, taken a stronger stance?

A Oh, I think he -- well, I think he --

MR. MADDEN: I'm just going to enter an objection. Go ahead.

A Since his thinking all along was, it seems to me, that it wasn't a cancer, I think he should have been more insistent that in the differential is cancer and to rule it out we need to get a tissue diagnosis. If a patient then refuses that, usually a physician, that would be the procedure of choice, in my opinion, usually a physician does write patient recommended bronchoscopy, patient refuses; therefore, we wouldn't be here.

Q You will recall from Doctor Watson's testimony - and Ms. Moody can correct me if I'm, if I

get any of this wrong - but I think he basically testified to the fact that he was concerned about the nodule to the degree that he actually went to a chiropractor's office to view an earlier chest X-ray which showed the nodule and that he saw no increase in size, and with her age, no smoking history, no familial history that he was aware of, felt that there was, it was less likely that this process was malignant. Is that basically, do you agree that that was basically his thinking that he was following then --

MR. MADDEN: Objection.

A That was basically --

Q -- in shorthand?

A That's basically what he was thinking, absolutely.

Q Okay. But was that not appropriate for him, to consider the fact that this nodule had not increased in size?

A I think one looks at a nodule, one looks at calcifications, and, again, the added thing, that is,

the hilar area that's full, and, again, when you have -- it's not just a nodule alone - I don't want to keep on reharping on this, but I think it's important - you have a hilar fullness which changes everything. It's not a nodule sitting on the periphery just saying I am benign. For one thing, there were no calcifications in it; for another thing, a radiologist on the CAT scan says this is malignant. There was no note that he went to speak -- that is, the primary lung cancer has to be ruled out. There's no note that he went to that radiologist and said, tell me why.

Q Well, that's what every radiologist is going to say when faced with that kind of a film, isn't it --

MR. MADDEN: Objection

Q -- really?

A I think a radiologist would -- I think a prudent doctor would speak to the radiologist.

Q But a prudent doctor also takes the radiological finding and applies to it things such as

symptoms, clinical history, and other factors, true?

A Absolutely.

Q Do you have an opinion as to whether had a bronchoscopy been done, that they would have been able to reach the area of that nodule in doing a bronchoscopy?

A Oh, they may have. It depends on the type of equipment. But they would have done brushings, they might have needled it, do a transbronchial biopsy of the hilar adenopathy. There's various things one can do.

Q The hilar adenopathy, you couldn't get a brushing of that?

A That's correct.

Q You'd have to approach that in a different fashion?

A That's correct.

Q All right. But just in terms of the nodule that we're calling it, would they not have had to have reached that point in order to have gotten any effective reading, so to speak?

A That's correct.

Q And do you have an opinion as to whether or not -- and I don't know if Doctor Watson in his testimony said anything about whatever technique they used for that, or is there a difference between Findlay or here?

A I don't know.

Q Do you think they could have reached it?

A It may have, it may have not. I can't tell you that. It wasn't done, so we don't know.

Q All right. Had they not, had a brushing, a bronchoscopy been ineffective in helping to reach a diagnosis, what then would be the next step?

A You would have looked at the node and tried to needle that, transbronchial biopsy.

Q And the hilar mass, or hilar adenopathy, what did you say about how you would approach that --

A That could be --

Q -- from a diagnostic standpoint?

A That could be done through a bronchoscopy and pick out a node. And obviously you'd have to make

sure there's a node there to biopsy.

Q As you look at the whole process that went on here, her history from what was found at, finally at Findlay and then at the Medical College of Ohio, do you have an opinion as to primary and secondary sites?

A Oh, the second --

MR. MADDEN: Objection.

A The secondary site was in the bone, osteometastasis, in May of 1997.

Q Do you feel that the node was the primary site?

A The mass was the primary site.

Q The mass was the primary site.

A Now, when I say secondary site, I mean metastatic disease.

Q Okay. Right.

A Because when you stage a patient, it's stages T, N and M, M meaning metastatic. When you see secondary sites, by definition most people refer to the metastasis. When you talk about nodes in the hilum or the mediastinum, that's regional disease. So

in this situation it goes from the mass to the lymph node and then from the mass out to the distant sites.

Q And the nodule, then, what does that represent?

A That's the primary cancer.

Q I thought you just said the hilar adenopathy was the primary.

A No, nodes are not, lymph --

Q I misunderstood you, fine. Thank you for clarifying that.

MR. HUFFMAN: Just so I get it clear, the so-called nodule which is described on the October '94 X-ray in your opinion is the primary cancer?

THE WITNESS: Yes.

MR. HUFFMAN: Okay.

Q As such, do you find it surprising that that mass or that lesion did not change over a relatively long period of time?

A It's --

MR. MADDEN: Objection.

A It's a slow-growing tumor, heterogeneous to

it, really. The parts that metastasized are actually usually more, the more aggressive cells. Moreover, there are tumors, when you look at doubling times, that can go -- an adenocarcinoma can go anywhere between thirty days and five hundred and fifty days. So it depends. And all you've got to do is take a ruler and measure tumors, and we've done that in tracing back and things; we've found one seven years. So, it's not an all or none phenomena. Is it unusual? Yes, slow-growing tumors are unusual, very slow.

Q Slow enough that between the time of the chiropractor's film, which I think was in early 1994, and the film that was taken by -- I was thinking of the film, the film that was taken at Doctor Echavarre's request in January of '96, there does not appear to have been any growth?

A That's correct.

Q That's highly unusual, is it not?

A It's unusual.

Q Just unusual, all right.

A It's unusual.

Q Okay. Are you able to give us an opinion as to -- are you able to stage the cancer at the time that she was seeing Doctor Watson in 1994?

A Yes.

Q Tell me about that.

A She's at least a Stage II, possibly a Stage III, III-A.

Q III-A. And a Stage II would represent what?

A Hilar adenopathy. T1/N1.

MR. HUFFMAN: T1/N --

THE WITNESS: 1.

Q And what connotation does that staging carry for the prognosis for the patient?

A Twenty to forty percent five-year survival with a chance of cure.

Q But not a probability of cure?

MR. MADDEN: Objection.

A Well, probability is fifty-one. If you say, if you're telling me probability is fifty-one percent and I give you a twenty to forty percent five-year survival in that group of patients, the answer to that

is yes, in that group of patients there's a twenty to forty percent five-year survival, a good percentage of those patients will be cured; however, they're subject to second primaries from one to three percent.

Q Sure. What would be, what would the course of -- assuming diagnosis back in 1994 when she was seeing Doctor Watson, what course of treatment do you believe she would have had to have undergone at that time?

A In 1994, there would be surgery and either followed by radiation or radiation/chemotherapy.

Q In lay people's, person's terms, based on the whole history that you see here, what was found at MCO and everything else, does this appear to have been an aggressive cancer, not so aggressive? I mean, how would you explain that to me as a layperson without using the T and Ns and whatnot?

A It was relatively slow growing.

Q Are you able to give us an opinion, again at the point when Doctor Watson, when you say Doctor Watson should have done a bronchoscopy, whether there

had been -- well, I guess from the staging you've given me you don't believe that there had been metastatic spread by that point?

A That's correct.

Q Now, there's been testimony, and Doctor Watson produced for us a document which reflected that at the time of the last recorded visit with Rebecca Devine-Bish, that she was due to come back to see him in, I believe, two months. You do agree that a patient has some responsibility for their own well-being and care, true?

A Absolutely.

MR. MADDEN: Objection.

Q All right. Do you have any understanding from either talking to Mr. Madden or anything that you see in the record as to why Rebecca Bish did not return to see Doctor Cosiano in that time frame?

MR. MADDEN: Objection.

A I can't recall.

MS. MOODY: Watson.

Q Or Watson? Who did I say?

MS. MOODY: You said Cosiano.

A I can't recall from the deposition of her husband why, so I don't know.

Q All right, okay. You would agree that had she returned to see Doctor Watson in two months, as has been indicated, that that would have given him another opportunity to reassess the situation and to make the recommendations that you have previously testified to?

MR. MADDEN: Objection.

A I'm not sure that's correct in the sense that if he did another X-ray, since we already know it would have been the same, so he would have made the same recommendation that he did before, let's watch.

Q Well, okay. In terms of the progression of the disease, did that two months, had she returned -- let's say that there had been a change and he took a different course in two months, she came back to see him and he took a different course, would she still have been in the same category, do you believe, that you've previously testified to?

A Yes.

Q All right. The next time this issue comes up is when she goes to see Doctor Cosiano in December of 1995, right?

MS. MOODY: Umh-humh.

Q And at that point he sends her to Doctor Echavarre?

A Yes.

Q And was that -- and I think you may have knowledge from the reading of the deposition and whatnot that Doctor Cosiano has said that he was told that Doctor Watson felt it was benign, he had been giving her some inhalers and whatnot that hadn't been working, and he sent her at that point to see Doctor Echavarre. Was that appropriate on his part?

A Yes.

Q Any issue with you about him needing to send her back to Doctor Watson or, instead of a new physician?

A No, I have no problem with that.

Q You find sending her to a general surgeon as

appropriate as sending her to a pulmonologist?

A If the general surgeon does bronchoscopy.

Q And apparently Doctor Cosiano knew that Doctor Echavarre did that?

A Okay.

Q All right. The appointment was made, she went to see Doctor Echavarre, and he asked for -- he had a new chest X-ray done --

A Yes.

Q -- you're familiar with that?

Okay. You've seen his note which reflects that he wanted a CT scan, a second CT scan to be done? Did you see that on his note?

A The note of 1/18/96 says repeat chest X-ray and compare. Did I miss something?

Q I direct your attention to this report, this X-ray report which reflects that - this is not Doctor Echavarre's handwriting - but that he had told someone that he wanted a follow-up then with the CT scan.

A Okay.

Q Do you see that?

A Yes.

Q Were you not aware of that before?

A I was not aware of that.

Q Doctor Echavarre, based on the radiological study that he had done and on comparison with the earlier ones by Doctor Watson, felt that there had been no change in size of the nodule?

A Yes.

Q And you've reviewed those X-rays, I believe?

A Yes.

Q Do you agree with that assessment --

A Yes.

Q -- by him?

A Yes.

Q All right. Was it appropriate for him to want to get a CT scan?

A Yes.

Q All right. Do you have an opinion as to whether the CT scan, if a CT scan had been done at that time, that it would have provided any additional information that Doctor Echavarre didn't already have?

A In my opinion, it probably would not have provided any more, additional information.

Q Now, Rebecca Bish did not return to Doctor Echavarre's office; you're aware of that fact?

MR. MADDEN: Objection.

A I'm not aware of that.

Q You're not aware of that. What's your understanding as to what happened next with her?

A She was seen at Blanchard Valley Hospital by Doctor Banett, no change compared to X-ray of 10/3/94. This was on 1/19. He must have been the radiologist, I'm sorry.

Q Yeah.

A And then the next --

Q That was '9 -- '96?

A '96.

Q Well, let's go back for a moment. Was it your understanding, then, as far as you understood from the sequence here, that Doctor Echavarre had had an X-ray done, had compared it with other X-rays, had felt it was the same, and had sent her on her way?

A That's my -- that he didn't want to do a bronchoscopy. That's my understanding.

Q You now know from the note, from the information I've provided you - and I'll ask you to assume that to be true - that Doctor Echavarre wanted to get a CT scan?

A That's correct.

Q All right. I will also provide, are you aware that Doctor Echavarre's office, Doctor Echavarre has testified that his office tried to get ahold, as far as his knowledge was concerned, that his office tried to get ahold of Rebecca Bish and was not able to do so and eventually the matter sort of slipped between the cracks; is that your understanding?

A I think I read that somewhere in a deposition.

Q All right. Do you recall reading in Derek Devine's testimony that in fact his wife had called Doctor Echavarre's office, had been told that the doctor wanted her to have a CT scan before he saw her again, and that she, for reasons of her own, never

went back to get that CT scan?

MR. MADDEN: Objection.

A I don't recall that, but if it's there, I --

Q Accept that.

A I'll accept it.

Q Accept that that is in the record, okay?

A Okay.

Q Would you feel that Miss Bish at that time bore some responsibility for the, what occurred subsequently?

MR. MADDEN: Objection.

A She bore some responsibility if she understood why the CAT scan was needed and that there is a possibility of cancer. If she did not understand that, then the responsibility goes back on the shoulder of the doctor.

Q Is it not your understanding that throughout this process, that Miss Bish certainly, from the time she first saw Doctor Watson, understood that there was a possibility that there was cancer involved here?

MR. MADDEN: Objection.

A It's my understanding that she may have been made aware of that, but not to the degree that it was high on the list, because the implication, the thought process of the doctor was that this was a benign condition.

Q I understand that.

A So the issue then becomes is how serious were they about the diagnosis of cancer.

Q And I'm not quibbling with you on what the doctors felt --

A Right.

Q -- was going on.

A Right.

Q But isn't it true that one of the, in that list of things that they, the doctors told her on more than one occasion might be happening, cancer was on that list?

MR. MADDEN: Objection.

A Except in the radiology report, I did not see that on the notes.

Q If in fact Doctor Echavarre wanted her to

have a CT scan before he saw her again, and if she, for whatever reason, refused to have that done and did not go back to see Doctor Echavarre, are you still critical of Doctor Echavarre?

A Yes.

Q Why?

A He should have been more insistent and told her that there is a possibility that you can have cancer and it's based on this, these reasons, therefore, you should have it. And if she refused, he should duly note it in the chart.

Q All right. Had Doctor Echavarre, as you suggest, been more insistent and had she come back in for a CT scan and as a result had a bronchoscopy which led to a diagnosis in early -- by the time all that would be done I suppose we'd be talking about the end of January, first part of February 1996, can you tell me what opinion you have as to the stage of her cancer at that point and what her prognosis was at that point?

A Stage II or III, same prognosis.

MR. HUFFMAN: That's in January of '9 --

THE WITNESS: '96.

MR. HUFFMAN: '96.

Q Now, this is a year since you last gave us that prognosis of when she last saw Doctor Watson --

A Yes.

Q -- is that true?

A Yes.

Q It's still the same staging, in your mind, and the same prognosis, a twenty to forty percent five-year survival?

A Twenty to forty percent Stage II, more likely than not in October of 1994, possibility of Stage II, still in 1996, could be a Stage III, which drops it to III-A, to fifteen to thirty percent.

Q Well, in fact, wasn't it more likely that it was Stage III-A than that it was Stage, still Stage II as of January 1996?

A More likely? The only time we would know it's more likely if we were there to biopsy it.

Q I know. But you're giving us a lot of opinions --

A Right.

Q -- that we weren't, there's never been any biopsy to --

A I said, I think I said that, in my wording.

Q I don't think it came out that way, that's why I wanted to --

A More likely III-A.

Q All right. And what, then, are the percentages with III-A?

A Fifteen to thirty percent.

Q I was taking the deposition of a physician who gave me -- on a breast cancer case last week, and he gave me percentages out, not only at five years, but at ten years and twenty years. Do you normally project out those percentages that far?

A No. The reason you got that from the breast doctor is that adjuvant therapy, and he actually probably quoted the Bonadona (phonetic) article that takes it out at April 19 -- whatever the year was that

it was published in the journal, went out twenty years. We don't have that in lung cancer.

Q All right, all right. So the best you can do here is the percentage, the five-year survival rate that you've given us?

A Right.

Q And in giving us your opinions regarding the prognosis, the staging and prognosis for January of 1996, tell us briefly what you base that on.

A Excuse me?

Q What do you base that on, the fact that you think it's now more likely a Stage III-A?

A Because a year has -- since it's more than a year, it's about fourteen months or so, has gone by, fifteen months, tumors do progress, and this seems to be progressing in an order that goes from lymph nodes in the hilum, and if you did biopsies of the lymph nodes and the mediastinum, even though on CAT scan they might appear normal, you might find - and we're all talking about the probability, to a reasonable degree of medical certainty - you might find

microscopic disease, which makes it a III-A disease.

Q You may have included this in your answer already, but do you have an opinion as to whether there had been metastatic spread at that point?

A In my opinion, there was not.

Q And your opinion there had not been metastatic spread at that point is based on what?

A Is based on the fact that except for the wheezing, she's been doing, she's done fairly well, she hasn't had any weight loss, and there is no evidence that we can find to point to spread. That's not to say it can't be there anywhere else.

Q I think you've already agreed with me that there was no change in the nodular size --

A That's correct.

Q -- between Watson and Echavarre. How about the hilar adenopathy, had there been any change there, to your knowledge, or based on your observation?

A I've got too many papers here.

To my knowledge, no.

Q Now, do you again fault Doctor Cosiano, if

this patient did not go back to Doctor Echavarre -- I believe Larry can correct me on this, that Doctor Cosiano retired sometime in mid-1996.

MR. HUFFMAN: August '96.

Q All right. And I don't believe that she came back to see him between December of '95 and August of '96.

MR. HUFFMAN: That's correct.

Q Are you critical of Doctor Cosiano in that time frame?

MR. MADDEN: Objection.

A Since he was still in practice and she saw, she saw the surgeon in January of 1996, I have to assume he was getting notes, or he got a note from the surgeon.

Q He got no note from the surgeon.

A Then he should have called. So he's guilty by not following up.

Q Which is the same criticism --

A That's correct.

Q -- that you gave regarding the Doctor Watson

period?

A That's correct.

Q Now, I believe, as you pointed out, the next time this really comes up is when she saw Doctor, it starts with a Doctor --

MS. MOODY: Davis.

Q -- Davis and was diagnosed as having pneumonia which ultimately led to studies, radiographic studies which led to her diagnosis, true?

A That's correct.

Q I was struck by something, and please tell me technically what was going on here. The chest X-ray that was done for her, to diagnose her pneumonia, apparently showed no, did not show, reveal any of the cancer. Am I right about that, or do I have that wrong? I may be wrong about that. Let me just see.

A Well, I couldn't tell you because I don't --

Q You know what, I'm wrong about that. So just forget that. It was just a technical thing anyway.

Do you have any criticism of anybody else's care in this case?

A No.

Q What is your understanding as to her staging at the time that she was diagnosed in Findlay by Doctor Gupta, I believe it was?

A It's my understanding she was Stage III-B, but in actuality at that time she was Stage IV.

Q Stage B, define Stage III-B for me.

A In other words, T4 lesions are into the big structures, the great vessels, the aorta and where you can't resect, and that makes it T4. T4 in and of itself is Stage III-B. So the T4/N, it doesn't make a difference what the N is by definition of the 4. But that was sometime in April.

Q Of '97?

A Of '97. And since she had bone metastasis one month later, she was Stage IV at that time. So her prognosis of five-year survival is approximately two percent.

Q For the Stage IV?

A Yes.

Q And it's the metastasis that makes --

A Yes.

Q -- her the Stage IV --

A Yes.

Q -- as opposed to the Stage III-B?

A Yes.

Q What survival rate does the Stage III-B carry with it?

A Five, around five percent. But in some cases, with an aggressive therapy, fifteen, five to fifteen percent now. We're getting better.

Q Do you feel that she received the appropriate types of care and therapy for her condition?

A Well, she went to the Medical College of Ohio and they diagnosed Stage IV disease and they treated her with chemotherapy.

Q So just to go back briefly to the physician that I'm actually the most concerned about, Doctor Echavarre, you feel that where he, he should have been

more -- is it your understanding that Doctor Echavarre, like Doctor Watson, because of the failure of this, of the nodule to increase in size and because of her lack of other risk factors, felt that this was more likely a benign process?

A Yes.

Q All right. So you feel like Doctor Watson, he was wrong in making that assumption to begin with?

A Yes.

Q And that he should have been more, as you put it, insistent in bringing the potential of cancer to the forefront of his, whatever discussions he had with Miss Bish at that time?

A In my opinion --

MR. MADDEN: Objection.

A -- yes.

Q If that occurs and the patient still refuses to follow the suggested course, it's on the patient's shoulders at that point?

MR. MADDEN: Objection.

A That's correct.

MR. CASEY: You know, I think that's all the questions I have at the moment.

(Thereupon, a short recess was taken.)

MS. MOODY: Doctor Ettinger, I'm Nancy Moody and I'm representing Doctor Watson and his corporation in this case. I'd like to ask you some follow-up questions, and I will certainly try not to be repetitive.

EXAMINATION BY COUNSEL FOR THE DEFENDANTS WATSON AND BLANCHARD

BY MS. MOODY:

Q Would you agree that when Miss Bish presented to Doctor Watson in October of 1994, that she presented with a solitary pulmonary nodule?

A She has a solitary pulmonary nodule as well as the hilar mass, hilar adenopathy.

Q Okay. What's the definition of a solitary pulmonary nodule?

A The definition of a solitary pulmonary nodule is a round -- is a mass surrounded by normal lung on all sides.

Q Okay. Now, the hilar lymphadenopathy that you're talking about was not contiguous with that mass, was it?

A No.

Q Is that part of the definition of a solitary pulmonary nodule, that the hilar mass is not contiguous; is that one of the factors that you consider?

A No, no. You consider, you consider -- what you consider is, you have the solitary pulmonary nodule and then you have something else, which is the lymph nodes; that's separate from the mass. Now, can you have a mass, a mass that is centrally located attached or very near? Yes. Small-cell lung cancer is usually, classic, it's hilar adenopathy with a mass right next to it, but when you talk about the classic solitary pulmonary nodule that we talk about, whether it be benign or malignant, we're talking about a round mass that is surrounded by air, by lung tissue.

Q And is that the case with this mass?

A The mass was -- yes, the mass, there was a

solitary nodule that was surrounded by air.

Q And when you're talking about strictly solitary pulmonary nodules -- and can I refer to it now as SPN so it will go a little faster?

A Solitary pulmonary nodule. As a matter of fact, if it was attached to the hilum, the radiologist wouldn't have been able on the CAT scan to put measurements of one-point-six by one-point-nine. I mean, that's why some of us carry a ruler and mine says "science is measurement." We measure.

Q Doctor, would you agree that roughly one in five hundred chest films reveal a solitary pulmonary mass?

A It sounds about right. I don't know the answer, but I believe you if you say that. I don't know the answer per se. The chest X-rays I see are all abnormal.

Q And of these solitary pulmonary masses that are diagnosed on, say, routine chest films, twenty to forty percent of those are malignant depending on which study you're reading?

A Yes. If you're reading a surgical one, it's forty percent. If you're reading a clinical one, it's twenty percent.

Q As far as Miss Bish was concerned - and we've gone over this a little bit - to your knowledge, she had no family history of malignancy?

A Not that I know of.

Q Assuming that cancer was discussed with her in October/November/December of 1994 and that that was something that was a consideration with this mass, would an accurate history from the patient regarding a family history of cancer be important to the treating physician?

A Yes.

Q Would it be negligence on the part of the patient not to inform the treating physician that she has a family history of lung cancer?

MR. MADDEN: Objection.

A Well, it would be not prudent. Negligence? I mean, that's a word -- I don't know if it would be negligent, but it might be -- it's inappropriate. I

mean, I would assume the physician asked the family history, mother, father, brother, sisters and immediate family, grandparents and uncles and aunts, and usually you get an answer. A lot of times patients don't give all the answers.

Q Well, certainly a history of lung disease in a situation like this is an important factor for the physician to consider if he's trying to diagnose the problem?

A That's correct.

Q What, in your opinion, is the probability that a woman of Becky Bish's age, twenty-eight years, what is the probability that she would develop an invasive lung cancer?

A Very unusual.

Q Like one in three hundred thousand or so?

A I don't know. But the average, the average lung cancer patient is sixty-one years of age.

Q And she also was a non-smoker?

A Non-smoker, makes it even less.

Q No secondhand smoke exposure?

A Oh, I don't know that.

Q You just don't have any information one way or the other?

A And I have no information on radon, either.

Q Would you agree that less than one percent of solitary pulmonary nodules are malignant in nonsmoking patients younger than thirty-five years of age?

A Less than one percent?

Q Umh-humh, yes.

A It might be correct. I don't know.

Q Would you agree that the American Cancer Society is a reliable source of information about cancer?

A It's a reliable source of information.

Q In October of 1994, Doctor Watson attributed any wheezing that Becky Bish was having to asthma, more likely than not. Do you disagree with that finding in October of 1994?

A Yes.

Q Why?

A Because he did not diagnose the cancer that was there and in more probability that was the cause of the wheezing.

Q So it's your testimony that the cause of the wheezing in October of 1994 was the pulmonary nodule and/or the hilar lymph adenopathy?

A Oh, I think it could be a combination. Usually, when you have lung cancer in the older population it's usually chronic obstructive pulmonary disease. So can you have asthma as well as lung cancer and wheeze from either or both? The answer to that is yes. So if I -- but do I say do you have to? When you have a mass that is a nodule plus hilar adenopathy with no diagnosis, it behooves you to make the diagnosis.

Q Do you agree that there was no change in the mass, the nodule between February of 1994 and October of 1994?

A It's my understanding. I don't have -- I didn't go back as far as February 1994.

Q You haven't reviewed the films from

February?

A Is that the chiropractor -- yeah, I think I did in there. No change.

Q No change, okay.

And obviously you have reviewed the films from October 1994 forward?

A Yes.

Q Can you describe for me what you observed as the size of the lesion in the October 1994 film?

A Oh, I didn't -- you know, measuring, you can measure. I didn't disagree in the measurements, so -- I'm not, and I'm not a radiologist, so if I thought even here, I review things with the radiologist just to be a hundred percent sure.

Q So you're, just so we're clear, you're not going to be testifying at the time of trial in this case that this tumor now was one-point-nine versus one-point-eight or, you know, some other centimeter measure, your opinion, as I understand it today, is that it didn't change?

A I don't expect -- yeah, I don't expect to

argue millimeters, okay?

Q All right. How about, would you be able to characterize the border or the edges of the tumor?

A I don't plan on doing that, either.

Q Do you have an opinion as to how long it took the nodule that was seen on the X-ray in October of 1994 to form?

A Oh, I think a lung -- a cancer, in general, that's been in the body from eight to ten years, and this is a general statement. Obviously the cancers that grow faster, like testicular carcinoma, it would be, it would be less time in the body. Breast cancers are a good example; there are very fast and slowing growing; the fast growing would be less than the slow growing. But the standard dictum would be eight to ten years. It starts at one cell, goes to two, four to eight, and by the time it becomes detectable it already has a billion cells, which is one cc, one cubic centimeter of -- one cubic centimeter has one billion cells in it. So you would have to work back from the one-point, possibly from the one-point-six by

one-point-nine mass and work back to the one cell, and I think you would need a mathematician to do that. You would have to actually calculate, then, the doubling time. It could even be longer, because if you know -- the doubling time could be calculated by knowing what the lesion is here, take the time three years later or two and a half years later, and there could be in some fashion a, a doubling time. It could be one of the slowest, it could be one of the slow growing tumors.

Q Knowing what we know about the fact that it didn't change in about a two-year period, can we extrapolate from that that it was probably there a long time before October?

A Yes. But what you can't extrapolate is it would have to take into consideration it's a heterogeneous tumor, and the part that metastasized and spreads to lymph nodes is usually more aggressive by a significant amount and that stays local, and that is the problem with tumors in general. That's why therapy -- because heterogeneity means the differences

of cells in the population; that's why some respond better than others.

Q Would you agree that a solitary pulmonary nodule that's stable in size in the chest on X-ray for about two years can be considered benign with a high probability?

A If that was the only thing that was there and nothing else, you might consider it. However, from personal experience I saw one that was there, stable for four years, and on the fifth year it started to grow and it metastasized. So can it happen? Yeah. The classic definition, the classic finding of a benign lesion is if you find calcifications. If you find a solitary irregular mass, those are the type of things you want to make a diagnosis.

Q But if you're using calcification as a factor, the configuration of the calcification, if you will, is important in describing the tumor as benign, isn't it?

A You would, yes, I think -- put it this way.

You would talking about to a reasonable degree of medical probability. If I've seen -- if I've had calcifications seen in a lesion, I can with some asurety tell the patient that that is benign. If I see a mass de novo, and that is a mass that's there and it's new, there's no calcifications, then you have to base that on other factors. And hindsight is interesting, that going and looking down the road and seeing what happened. We know what happened to this mass.

Q Did you see any calcification in the mass when you reviewed the films, or from any information that you have; was there calcification in the mass?

A As far as I know from all the notes I've read, there were no calcifications.

Q And the type of calcification that needs to be present to determine whether a tumor is malignant or non-malignant doesn't show up very often on diagnostic films, does it?

A No, it actually shows up more often in a CAT scan. As a matter of fact, you can use the numbers,

what they call the Hounsfield numbers, Hounsfield numbers actually developed here to look at whether a lesion has calcifications in it or not. But a lot of times it's in the gray zone, so you've got to biopsy it.

Q It's just one factor that you --

A One factor.

Q -- use in determining whether a tumor may be benign or malignant?

When you viewed the films between October of 1994 and December of 1994 - those are the films that Doctor Watson had available to him - did you see any mediastinal lymph nodes --

A No.

Q -- or any mediastinal widening?

A No. Well, the widening would take into consideration the hilar part of that, too. But no, not in the mediastinum. Mediastinal lymph node, is there a mediastinal lymph node -- I just want to clarify it. You mean clinically, pathologic mediastinal lymph node, and the answer is no.

Q In your opinion, is it highly unlikely that a tumor would be an adenocarcinoma and not change in size in two years?

A Oh, I think it's -- highly unlikely? I think it's unlikely. You like to see some growth. Does it happen? Yes, adenocarcinomas are notorious, can be slow-growing tumors.

Q But more likely than not, they're fast growing?

A More likely than not they're fast growing -- well, they're well differentiated, poorly differentiated and moderately differentiated. So well differentiated can be very slow; poorly differentiated can be fast.

Q Isn't it true that bronchoscopy can be useful in diagnosing larger nodules, really, than we're dealing with in this case?

A Well, actually, the bigger the tumor, the easier it is to biopsy. This is not something small. One-point-six by one-point-nine is not a small tumor. Small would be a half centimeter. This is relatively,

as compared to other tumors, this is not that small. But you're right, any time a tumor is bigger, it's easier to biopsy.

Q Do you have an opinion as to whether or not this tumor in its location could have been reached with bronchoscopy for a biopsy?

A I said that I wasn't sure. I said and if you couldn't reach it that way, you can do a needle biopsy of the hilar mass. And then if you couldn't do it that way, there are other techniques as well.

Q You've already said, I think, that the hilar mass did not change in size either?

A Yes, that's correct.

Q I think that you said that you did not note anywhere in the records that Doctor Watson had offered bronchoscopy to Miss Bish and that she had declined?

A I didn't note it in the regular notes, that's correct. He showed me that; I saw that.

Q This page?

A Yes.

Q And also on --

A The X-ray.

Q Well, and on December 12th of 1994, when he met with Ms. Bish in the office, he made a notation that the question of biopsy was discussed. I think if you read his deposition he explained this, and she declines, and he made a note of that --

A Yes.

MR. MADDEN: Objection.

Q -- in December.

I think it was your testimony, in responding to Mr. Casey's questions, that if a patient is offered a diagnostic procedure and refuses, then the problem is with the patient and not with the physician?

MR. MADDEN: Objection.

A I said exactly that, with the proviso that it has to be documented that the patient was told that cancer, that a serious illness is a possibility, patient refuses appropriate diagnostic procedures. I think in this time of, litigious times, I think you have to be -- you've got to document that, clearly.

Q And, again, you may have answered this

already. Malignant tumors usually grow quickly with a doubling time and volume between one and fifteen months?

A Doubling time and volume between one and fifteen months? Thirty days to a hundred to thirty times a hundred and fifty? That's five-fifty. Yeah, I think that. Thirty days to five-fifty. Five-fifty would be almost a year and a half; that would be pretty slow.

Q Have you testified in a case involving diagnosis and management of a solitary pulmonary nodule?

A I have.

Q Can you tell me --

A I couldn't even remember, because it related to lung, same thing like this, related to lung cancer. So I couldn't even hazard a guess.

Q Do you know when that was?

A I apologize, I just don't keep that type of record. I've not been in Federal Court yet.

Q Do you know if you gave deposition testimony

in the case?

A Oh, I don't even -- to be honest, I don't remember.

Q You were asked your opinion about whether or not Ms. Bish coming back within two months from her last visit with Doctor Watson would have made any difference in her treatment. I think your response was probably not because an X-ray would have been done and it wouldn't have changed; is that correct?

A That's correct.

Q But if she had followed up within that two-month time period it at least would have been an opportunity for Doctor Watson to reevaluate her clinically?

A That's correct.

MR. MADDEN: Objection.

A That's correct.

Q You testified that in January of 1997, that Ms. Bish was either Stage II still or possibly Stage III-A. There isn't really any way that you can differentiate between those two stages at that point

in time because there's no pathological staging; isn't that correct?

A That's correct. The only reason I said that is you got to believe the tumor's growing and therefore the place that it would grow, at least the way it's been growing, would be into the, maybe into the mediastinal lymph nodes, and by definition that makes it a III rather than a II. But you can't tell other than getting a mediastinoscopy to look into the lymph nodes.

Q Is there any way to objectively measure or evaluate the hilar lymphadenopathy that you see on the October 1994 film?

A What you see is what you got. In other words, you look at the size of lymph nodes; anything less than a centimeter, a centimeter or less is considered nonpathologic; anything above that you got to be concerned. Does that mean there's no cancer or any disease in any of the lymph nodes? The answer to that is no.

Q Were you personally able to measure any

hilar lymph nodes?

A No. There was a fullness there.

You mean on the chest X-ray, or are we talking about on the CAT scan?

Q On any diagnostic --

A No. I think the CAT scan had lymphadenopathy there, but I'd to go over it and look again, because you don't have a fullness. The fullness you see on chest X-ray but you can't measure it, unless it's widened, you can't measure lymphadenopathy, but on a CAT scan you can.

Q Do you see patients at all for the purpose of diagnosing cancer?

A On occasion, but it's rare.

Q Did you provide a report for this case?

A No.

Q Did you discuss this case with any other physicians?

A No.

Q You didn't take the films and go over them with a radiologist?

A No.

Q I'm sorry, I don't recall your response to this. But are you still an associate professor of otolaryngology --

A Yes.

Q -- head and neck surgery? What does that entail?

A Nothing.

Q So you have no duties or activities related to that title?

A I got that title because I did it when -- I did work in head and neck oncology when I was younger, so they still allowed me to have it.

Q So they just haven't taken that title from you?

A Since there's no money involved, they don't care.

Q And the same would be true of the professorship in gynecology and obstetrics?

A Yes, associate professor, yes. And I do see patients in both those areas, but it's occasionally.

Q I assume that your license to practice has never been revoked or limited in any way?

A No.

Q You're Board-certified in internal medicine and oncology?

A Yes.

Q Have you ever been recertified?

A No.

Q Is that not required?

A It is if you're younger. If you're my age you've got a grandfather clause. It's about time I get some grandfather clauses.

Q Are there any articles in your CV that relate specifically to the treatment or diagnosis of solitary pulmonary nodules?

A If they're malignant, there are a number of articles in there. If they're not malignant, no. In other words, there are articles that I've reviewed with regard to surgery that would be could be a solitary pulmonary nodule, Stage I disease. The NCCN guidelines, which is the National Comprehensive Cancer

Center guidelines, I happen to be the panel chair, and that is on non-small cell lung cancer, how you treat various things you find. But it's all with the proviso that it is malignant, not non-malignant.

Q And that's something that you've, a paper that you worked on, or guidelines you've worked on fairly recently?

A About three years ago.

Q You said that you have never been in private practice, the closest thing that you've been to private practice was in the Service; is that correct?

A That's correct.

Q What percentage of your annual income is attributable to medical/legal work?

A Maybe about ten percent. It depends. It could be a little higher.

Q Do you know how many new cases you took for review in 1998?

A No. Maybe ten, fifteen. It's hard to say; it varies.

Q Would that be an average number of cases

that you would take, new cases that you would take for review in a year?

A It might be.

Q Is the money that you obtain from doing medical/legal review money that you can keep yourself as opposed to giving it to Johns Hopkins?

A I don't give it to Johns Hopkins.

MS. MOODY: Okay. I don't think I have anything further. Thank you.

MR. HUFFMAN: Doctor, I've got a few questions with regard to some of the issues that have been raised here.

EXAMINATION BY COUNSEL FOR THE DEFENDANT COSIANO

BY MR. HUFFMAN:

Q I'm not quite sure about this hilar lymphadenopathy that you see on the, I believe it's the October '94 films. Is that the same thing as saying that there is lymph node involvement with cancer?

A Yeah, more likely than not. I mean, I think it's a probability.

Q Are you able to say how many lymph nodes are involved?

A No.

Q Isn't there some generally-accepted law, maybe - that may not be a very good term - that if a certain number of lymph nodes are involved, that the cancer is going to be noncurable?

A No. What the rule is is where are the lymph nodes. So, for example, N1 lymph nodes, which are hilar lymph nodes, make up, for all practical purposes, make up Stage II disease. T3/N0/M0 because of the size of the tumor is also -- it used to be in Stage III, now it's in Stage II disease because the prognosis and the treatment is about the same. Hilar mediastinal lymph nodes make up Stage III-A disease, and if it's on the opposite side of the mediastinum, that is, mediastinal nodes on the opposite side with the primary, makes up III-B disease. So it's the staging that equates with survival, not -- obviously the number of nodes are important, but not as important as it is in breast cancer. When you say one

to three, greater than three and then ten or more, there's a difference.

Q In this case was the, as they would call it, the nodule on the same side of the mediastinum as the lymph nodes?

A Yes.

Q So that's not as dire a situation had the adenopathy been on the other side of the mediastinum?

A If it was on the opposite side of the mediastinum, it's Stage III-B.

Q Are you able to exclude there being lymph node involvement on the side opposite the nodule?

A Well, to a reasonable degree of medical certainly it's like -- it's time. So if she was III-B in 1994, the median survival of III-B is about nine months. So either she's the luckiest woman alive or, which is possible, or she didn't have mediastinal disease.

Q Are you aware, Doctor, of what Doctor Cosiano's expertise was with regard to the diagnosis of cancer?

A He's a family practitioner.

Q Which tells us what, with regard to --

A He does triaging. He's a primary care physician.

Q Are you critical of him when he testifies, or of his skills, talent level, whatever, when he said I've never diagnosed cancer in a patient?

A That surprises me. But I don't expect him, for the most part, to diagnose lung cancer, although I would expect him to have seen patients coming in with bad disease, metastatic disease, for as long as he's been in practice. But to diagnose, that's not his responsibility.

Q Okay. So when he immediately decided that Rebecca should see Doctor Watson in October of '95, he did the right thing?

A Yes.

Q And he called right from his office, got an appointment, had her there the next day?

A Yes.

Q That's certainly an indication of somebody

who was trying to get her promptly into the proper --

A In my opinion, yes.

Q And he sent her to a Board-certified pulmonologist?

A My understanding is Doctor Watson is, yes.

Q Are you acquainted in any way from the records you reviewed as to what the relationship, or the expected relationship was between Doctor Cosiano and Doctor Watson?

A Well, from the chart --

Q No, including the deposition testimony.

A Well, there appeared to be very little. In other words, the referral was made and then Cosiano, that was it. And that's where I find the problem.

Q Well, you recall Doctor Watson's testimony about reporting to Doctor Cosiano?

A I don't recall that.

Q I want you to assume that he testified that when Rebecca came to him, that he assumed the primary care for her pulmonary status, that he did not correspond with him in writing, did not have any oral

conversation with Doctor Cosiano regarding Rebecca, and that that's the way they conducted their relationship with this kind of a patient. Are you still --

A If that's the way it is up in time, up until the time that Miss Devine went back to him --

Q I'm sticking right with the October '94.

A If that was the understanding, then he did his job.

Q Okay. And, in all fairness, you feel that he, without that information you were saying, well, he should have called up Watson or done something to find out what Watson had discovered in his investigation?

A In my opinion, the answer to that is yes, unless, as you state, if there was the understanding that the care now is transferred --

Q Right.

A -- to another doctor, then I would -- reasonable people would say that what Doctor Cosiano did was appropriate.

Q Okay. If Doctor Cosiano had called Doctor

Watson up, as you had first thought, well, maybe that's what he ought to have done, or maybe still think that, what would Watson have told him?

A Watson would have told him what he has done, that he thinks it's a benign condition, and that I will follow her for her wheezing and asthma, or whatever, and that's it.

Q In effect, he would have reassured Cosiano that there's nothing to worry about here?

A That's correct.

Q So even if Watson had a duty to check up and call -- I'm sorry, even if Cosiano had a duty to call Watson and check up on things, how would it have changed the course of this lady's disease and/or treatment, if he had been reassured by Watson everything's fine?

MR. MADDEN: Objection.

Q Do you understand my question?

A No.

Q Well, in malpractice, as we do it in Ohio, it's one thing to say, well, hey, someone didn't do

something that they should have done, and you have opined here earlier, with perhaps some change in that, but you have opined earlier that Cosiano should have called up Watson and talked to him and said what happened, and you've opined that that's a departure of the standard of care. In Ohio we're always interested in, well, how did that, the departure from the standard of care hurt this lady. Now --

A Oh, I understand.

Q So if Watson would have told him, hey, I've done some X-rays, I've checked this lady out, I've examined her, I've looked into this thing, everything's okay --

A Yes.

Q -- how did Cosiano - just a minute, Justin - how did, under your view of this thing, how did what Cosiano failed to do hurt this lady?

MR. MADDEN: I show an objection, and I just think the hypothetical involves too many variables. If you can answer, go ahead.

A Yes, for that part of her care, the answer

would have been it wouldn't have changed one iota until August.

Q Okay.

A She went back.

Q Okay. She comes back to his office. We're this far along. Now she comes back in August, right?

A Yes.

Q And what's the matter with her when she comes in in August?

A She's still wheezing.

Q Doctor, look at your records again.

A Feels like choking last two to three days. Thyroid question. Still wheezing. Been to Doctor Watson. Took CAT scan.

Q What's the date of that, Doctor?

A 12/15. Is that what that is?

Q Yeah.

A I made a mistake. I put it there.

Q So she comes in on 12/15 -- so let me ask you this, then. Do you have then any criticism of Doctor -- your criticism then apparently begins in

December of '95 when she comes back and she's got the same problems?

A Yes.

Q By the way, her stage is still the same, isn't it?

A That's correct.

Q So basically this lady isn't any worse off, as far as we know, than she was in August of '94, is she?

A That's correct.

Q She's not any worse off in December '95, right?

A That's correct.

Q So now he immediately sends her to Doctor Echavarre, doesn't he?

A That's correct.

Q Was that an appropriate referral?

A That's a very appropriate referral.

Q Bingo, right, same day?

A Right.

Q And Doctor Echavarre does the things that

you've discussed with Mr. Casey?

A That's correct.

Q Now, your criticism of Doctor Cosiano apparently is still, well, he should have done the same thing, he should have been checking up with Echavarre, right?

A That's correct.

Q What would Echavarre have told him?

A That --

MR. MADDEN: Objection.

A That I find nothing.

Q The lady's fine, there isn't any cancer; isn't that what he testified to in his deposition, that he didn't think there was cancer?

MR. MADDEN: Objection.

A That's what he testified to.

MR. CASEY: Objection to your characterization of it. But go ahead.

Q I mean, he would have reassured Doctor Cosiano, if Cosiano had inquired, that there was no cancer, right?

A Yes.

MR. MADDEN: Objection.

Q So how did it hurt this lady if Cosiano didn't call up and get reassured?

MR. MADDEN: Objection.

A Because in part, for both of them, I don't know what -- and it goes back to what the patient by these doctors was told and the seriousness of the possibility, that cancer is a possibility there. And that relates then back to the family doctor; he does know the word cancer.

Q I understand. But he sent this patient to Echavarre for diagnosis, examination, to find out what's wrong, right?

A Yes.

Q So if that doctor to whom you send them says she hasn't got cancer, I don't believe she has cancer, how did Doctor Cosiano hurt this lady by not calling up and getting this reassurance?

A Because he never asked by himself, and in the same way with Doctor Watson, never found out why

he said that she didn't have cancer and ask appropriate questions. You don't make the assumption when a person, a reasonable physician sees a mass and sees a, and sees adenopathy, a reasonable -- there should be a discussion, and that didn't happen.

Q I thought we had agreed that if Doctor Watson testified that he assumed that this patient was transferred to him, that he assumed --

A That was Watson.

Q That's Watson, okay. Now we're up to Echavarre.

A And the patient was referred to him as a surgeon. Doesn't -- usually surgeons, at least where I work, don't assume the care of the patient.

Q Wait. Don't you recall the discussion between Doctor Cosiano and this lady before he sent her to Echavarre, what he wanted to do with her?

A Bronchoscopy.

Q No. Who he wanted her to go to?

A I don't recall that.

Q Well, just accept my word for it, if you

will, Doctor, and consider this --

A I will.

Q -- a little bit of a hypothetical. That he said to her, I want you to go back, or would you like to go back to Doctor Watson, okay? And she said, no, I don't want to go to Watson, for whatever her reasons were. So he didn't select a surgeon because he thought, Doctor, that there wasn't going to be some surgery involved. Now, you don't know anything about the medical community in Findlay, Ohio, I assume?

A I don't.

Q Do you know how many people there are in Findlay Ohio --

A No.

Q -- that you could have referred this lady to?

A No.

Q Well, Echavarre, being a thoracic surgeon, is an appropriate referral, isn't he?

A That's correct.

Q Doctor Echavarre gets her in his office, he

takes some more films, he wants to do a CAT scan, but he never contacts Cosiano, does he?

A That's correct.

Q Rebecca Bish never contacts Cosiano, does she?

A That's correct.

Q In fact, nobody ever says a word to him?

A That's correct.

Q If he had called up Echavarre, what would he have told him?

MR. MADDEN: Objection.

A That I think it's a benign granuloma or considered tuberculosis or histoplasmosis.

Q No referral was ever made back to Cosiano, was it, no return of the patient?

A No.

Q The patient never came back to him, right?

A That's correct.

Q Now, are we agreed that when Echavarre was seeing the patient she was in the same stage as she was in October of '94?

A That's correct.

Q When did the stage change?

A Oh, about April, a year from the time -- before the diagnosis was made.

Q Well, Echavarre saw her in January of '96?

A Yes.

Q When did the stage change to II-B or III?

A Oh, no. II-B or III?

Q Well, I guess, I guess what I want to know is when did the stage change from what it was in October of '94?

A I think I said that, and I don't exactly remember what I said. I have to look.

(Witness reviewing documents.)

A Yeah, I said about January 1996.

Q In January of '96. That's about the time she was seeing Doctor --

A Yeah, I think -- yes. Echavarre.

Q So when she was seeing Doctor Echavarre in January of '96, what was her stage?

A I said it's either II, II or III-A.

Q What do you see in any of the X-rays or other studies to indicate that the stage has changed?

A Well, the stage has changed just by the tumor growing.

Q But I thought it was the same size.

A But you can't tell microscopic disease.

Q Well, I mean, there is no evidence of microscopic disease, was there?

A Well, you're right.

Q So there was nothing to biopsy, there's nothing to tell us that there was any, any microscopic disease in January of '96, is there?

A If you biopsy, you could tell that.

Q How do you know if you would have biopsied it?

A That's why I gave you my answer as II, probable -- the question was asked of me what do I think the stage is to a reasonable degree of medical certainty. I said more likely than not, it's probably III-A but it could be a II. And the other way -- in October '96 I went the other way, I said more likely

than not it's a II, could be a III-A.

Q I guess I'm --

MR. MADDEN: Excuse me. You said October '96; I think you meant October '94.

A October '94, I apologize.

Q I guess what I'm struggling with, what is it that you see in the X-rays or any other evidence to indicate to you that this, the stage of this tumor has advanced, if that's the correct term, from what it was in January of '95?

A Oh, she is clinically Stage II-A -- or II.

Q So she's still --

A Clinically Stage II.

Q She's clinically Stage II --

A Yes.

Q -- in January of '96 when Echavarre sees her?

A That's correct.

Q And when did she advance from clinical Stage II? Sometime after January '96, right?

A Yes.

Q When?

A For that we can look on a scan or X-ray and know that answer. The answer to that is April and May of 1997.

Q So you're not able to say that this lady was anything other than Stage II until April or May of 1997; is that right?

A From the clinical standpoint?

Q Right.

A Of what I have objectively, the answer to that is yes.

Q Do you have any other, anything else on which you can, could, or will give any other opinion?

A Absolutely.

Q Okay. What is it?

A I said it's based on what I know about growth of tumors, and what I know, what would have happened if a biopsy was done, and I said since tumors -- even though obviously you're looking at a tumor that is, you're taking a ruler and measuring it, that a tumor is a sphere so you don't know if the

tumor's growing inward, you can't measure that. In any case, I said to a reasonable degree of medical certainty, in January of 1996, if the tumor had progressed, if the tumor's progressing, it would have been more likely than not a III-A. But from the standpoint -- the only way you would know that is if you biopsied it.

Q But what do you have, what objective evidence do you have that the tumor had -- to tell you when the tumor advanced or got bigger or -- I mean --

A Objective evidence? None.

Q Yeah. In other words, between January of '96 and April of '97, we don't have any objective evidence, do we?

A That's correct.

Q And it's your -- I mean, excuse me for saying so, Doctor, but it's your supposition that there was some growth sometime, but exactly when you can't tell me, can you?

A Oh, no.

MR. MADDEN: Objection.

A I've already given those answers.

Q Well, tell me what the stage of the cancer was, then, in August of 1996.

MR. MADDEN: Objection; asked and answered. I mean, he's --

MR. HUFFMAN: I can ask him the same question three times if I want to.

Q You tell me, Doctor, what was the stage of the tumor in August of 1996?

MR. MADDEN: First of all, I disagree. But, secondly, he's been through, between -- if you're specifying it to objective evidence, he's answered the question.

MR. HUFFMAN: Thank you.

Q Now, Doctor, can you tell me what the stage of the tumor was in August of 1996?

A Yes. It was Stage IV.

Q In '96?

A August of 19 -- let me just take a look.

August of 1996 it was Stage IV.

Q And what do you base that on?

A Based on what I know about cancer of the lung.

Q What testing or anything else had been done since January of 1996?

A None other than X-rays. Other than X-rays, the --

Q What X-rays were done? Are you sure you're not talking about August of '97?

A August of '97? I'm talking about --

Q I'm talking about six months after Echavarre saw the patient.

A Yeah.

Q Six months after Echavarre saw the patient it was --

A Yeah.

Q Well, what do you base that opinion on?

A What I know about cancer.

Q Well, what do you know about cancer on which you base that opinion?

A Growth of a tumor and what happens to cancer in general. It doesn't just appear one day and voila,

voila. It doesn't appear in one day and there is metastatic disease. It has to start from somewhere, sometime.

Q When did it start?

A Oh, I think sometime after -- a year before it was, a year before it was finally diagnosed. So April of '96.

MR. HUFFMAN: I think I'm about done here. I think that's all the questions I have, Doctor.

EXAMINATION BY COUNSEL FOR THE DEFENDANT ECHAVAARE

BY MR. CASEY:

Q If I may ask a quick question to follow up on something that Nancy asked you about. I think the answer's probably self- evident, but I don't think I asked you this question directly. But she asked you if you would agree that had Rebecca come back to Doctor Watson as had been planned, at least in his mind, or in his notes, that that would at least have given him a further chance to evaluate and perhaps change his evaluation of the patient, and you agreed

as to how that was the case?

A Yes.

MR. MADDEN: Objection.

Q And I presume that you would also hold that position regarding Doctor Echavarre, that had Rebecca come back for the CAT scan and then seen Doctor Echavarre, that too would have offered him the opportunity to further evaluate and perhaps reevaluate the patient and her situation?

MR. MADDEN: Objection.

A Yeah, I said that. And I also said, though, I think, except from previous findings, if everything was unchanged, they wouldn't have done anything different.

Q Oh, I agree that's what you feel --

A Right.

Q -- based on the opinions in the record expressed --

A Right.

Q -- by both Doctor Watson and Doctor Echavarre?

A Right.

Q But you do agree with me simply on the proposition that it offered another opportunity for evaluation and/or reevaluation?

A Yes.

Q Okay. If you were to assess -- keeping those factors in mind, if you were to assess a percentage of responsibility to Rebecca Bish for her own care and well-being, or lack thereof, in this context, what would it be?

MR. MADDEN: Objection.

A I don't know the answer to that.

MR. CASEY: Okay. I think that's all I have. Thank you, Doctor. Justin -- I'm sorry. Anybody else?

MR. HUFFMAN: I don't have any other questions.

MR. CASEY: Want to discuss signature?

THE WITNESS: I want to read it.

(Thereupon, at 3:59 o'clock p.m., the examination of the witness was concluded.)

ACKNOWLEDGMENT OF DEPONENT

I, David S. Ettinger, M.D., do hereby acknowledge I have read and examined the foregoing pages of testimony, and the same is a true, correct and complete transcription of the testimony given by me, and any changes and/or corrections, if any, appear in the attached errata sheet signed by me.

_____ _____

Date David S. Ettinger, M.D.

CERTIFICATE OF NOTARY PUBLIC

I, Beatriz D. Fefel, 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 by me; that the testimony of said witness was taken by me in stenotype and thereafter reduced to typewriting 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 the action.

Beatriz D. Fefel

Beatriz D. Fefel
Notary Public in and for the
State of Maryland.

My Commission Expires:

August 1, 2000.

April 28, 1999

David S. Ettinger, M.D.
Johns Hopkins Hospital
Oncology Center, Room 147
600 North Wolfe Street
Baltimore, MD 21287

Re: Rebecca and Derek Devine vs. Frank Cosiano, M.D., et al.
Deposition of David S. Ettinger, M.D.

Attached for your review and signature is a copy of the above-referenced deposition. We ask that you read the transcript carefully. If it is necessary to make any corrections, please do so on the enclosed errata sheet, indicating the page, line number, and correction. The errata sheet(s) must be signed and dated. Also, you must sign the Acknowledgment of Deponent enclosed in the transcript.

Additionally, under the Maryland Rules, if you do not complete the reading and signing within thirty days, you may have waived your right to make corrections. Therefore, your prompt attention to this matter is greatly appreciated. Please return the transcript, the Acknowledgment of Deponent, and any errata sheets to our office at 401 E. Pratt Street, Suite 425, Baltimore, MD 21202.

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ERRATA SHEET

Case Name: Rebecca and Derek Devine vs. Frank Cosiano, M.D., et al.
Witness Name: David S. Ettinger, M.D.
Deposition Date: April 19, 1999
Job No.: 17704

Page No.	Line No.	Correction	Reason For Correction

_____ _____
Signature Date