Condensed Transcript

IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO

RICHARD RICHNAFSKY, et al.,
Plaintiffs,

vs. Case No. CV-05-559008

SHUKRI EL-KHAIRI, M.D., et al.,
Defendants

DEPOSITION OF

PAUL GOLDFARB, M.D.

April 3, 2006
4:04 p.m.

3075 Health Center Drive
Suite 102
San Diego, California

Cheryl A. Simon, RPR, CSR

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APPEARANCES

FOR THE PLAINTIFFS:
BECKER & MISHKIND CO., L.P.A.
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(440) 323-7070

FOR THE DEFENDANTS:
ROETZEL & ANDRESS
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Deposition of Paul Goldfarb, M.D.
April 3, 2006
4:04 P.M.
(Exhibit-1thru3 marked for identification.)

PAUL M. GOLDFARB, M.D., having been first duly sworn, testified as follows:

EXAMINATION

BY-MR.LEAK:

Q. Could you please state your full name.

A. Paul Goldfarb.

Q. Dr. Goldfarb, my name the Doug Leak. I'm here on behalf of Dr. Shukri and his surgical group. I take it you have been in depositions before?

A. Yes.

Q. You know the ground rules. I'm going to ask you a series of questions about your opinions in this case. If you don't understand one of my questions, let me know. I will rephrase it for you. Okay?

A. Okay.

Q. If you need to take a break, let me know.

Can you tell me, where are we located right now? What is the name of the facility, and is this your office?

A. This is our office. We are in the ambulatory surgery center -- Ambulatory Center at Sharp Hospital.

Q. What is the name of your group?

A. Oh, I guess the major group is called Oncology Associates.

Q. Okay. "Of San Diego" --

A. Yes.

Q. -- a medical group? Is that what's on your letterhead?

A. Right.

Q. And then how many offices do you have?

A. This is it.

Q. And how long have you been at this facility for?

A. Three years.

Q. And can you tell me the nature of your practice?

A. I do surgical oncology.

Q. And what exactly, what kind of patients do you see on a regular basis?

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A. I see people who either have cancer or think they have cancer. My job is to both make the diagnosis and do surgical treatment on cancers. For those patients that need multi-modality therapy or combination therapies, we work with medical oncologists who are in the office and radiation therapists who are in the community.

BY MR. LEAK:

Q. You know, I have a copy of your CV, and we don't have to mark it -- I don't know where I just put -- but it was one that was faxed March 2006.

Is that the one you faxed over, Pam?

MS. PANTAGES: Yes.

MR. LEAK: I'll show it to the Doctor. We don't have to mark it.

BY MR. LEAK:

Q. I just want to make sure that's your most updated CV.

A. There are a couple -- there are things we could add, I guess.

Q. Okay. Can you let us know?

A. Sure. I'm on the IRB for Scripps

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Health. I'm on Scientific Review Committee for Scripps Health, and I'm on the Scripps Health Network cancer program. And there's another article that got published. You only have ten articles?

Q. That's what this one reflects?

A. There's another page, so there's 14 articles and there's a 15th that talks about electroporation as a form of chemotherapy for cancer. I can get you that page.

Q. Okay.

A. None of them apply to lung cancer.

Q. That was my next question.

Is there anything in your publications or presentations that pertain to lung cancer?

A. The "Access to Care," with a set of the screening guidelines for the detection and treatment of the common cancers. And it specifically addresses what's appropriate screening studies, what are appropriate diagnostic studies, and what's therapy for different stages of cancer.

Q. And that's No. 10 on your CV?

A. Yes.

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Q. And two other things that you are adding, the Scripps Health --

A. IRB and Scientific Review.

Q. What are those two?

A. We have set up a network -- an IRB and a scientific review for cancer trials that will be launched at all five of the Scripps hospitals, so that we have one centralized review process for cancer studies, and I'm on both committees that review those.

Q. Is Scripps something local to the San Diego area?

A. Yes. It's a consortium of five hospitals.

Q. Doctor, I want to go through what you have reviewed in this case. We've established already that you haven't reviewed any depositions, correct?

A. That's correct.

Q. And what I have marked as Exhibits No. 1, 2, and 3, can you identify them for the record, then?

I can help you out. Looks like two of them are correspondence from the law firm of Becker & Mishkind and then a time

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line of events. Could you identify them for the record?

A. They are two letters from Becker & Mishkind and a time line. One's dated August 2005 and one's dated March 2006.

Q. With regard to the time line, how did you get that? Was that -- did you request something like that or did you --

A. No. I got a correspondence that came March 22nd and that was included with the other information to be appended to the medical records.

Q. And I take it, from what I see, is that there may have been some pages missing in the medical records that were supplemented by that March 22nd correspondence?

A. I guess there's information that came to light after they sent me the original book. In fact, a lot of this stuff is duplications of what was there already.

Q. Okay. Then I don't have to mark these. Does this look like -- I'll say for the record, you have got a copy of the expert report of Dr. Walsh, Dr. Ettinger, and -- guess what. I think this is the second

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page of Exhibit No. 1.
A. Okay.
Q. First of all, Jessica Perse, do you know who that is?
A. She's a lawyer who contacted me originally.
Q. So she's the first one that contacted you?
A. I believe so.
Q. Did you talk to anyone else in that law firm?
A. I can't remember.
Q. Because -- okay. So your report was addressed to Jessica Perse?
A. Right.
Q. Did you have any contact with a John Burnett?
A. Maybe, but I don't know.
Q. Okay. And then we know that Pam Pantages recently joined this law firm. She's been your contact person in terms of setting up the deposition --
A. Yes.
Q. -- since then?
Okay. With regard to Dr.

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Ettinger's report -- first of all, do you know Dr. David Ettinger?
A. No.
Q. What do you know about the cancer center at Johns Hopkins there, it's reputation? The Sidney Kimmel facility?
A. In fact, I was back there doing grand rounds, and so I know the physical presence. And I gave a talk at the head and neck group. Also I'm involved in supporting a trial that they are doing.
Q. Are there any particular rankings for cancer centers around the country that you are familiar with?
A. Yeah, sure. There's mine and everyone else's, and so mine's good; everyone else's is almost as good, but thank God you are here.
Q. What about the Sidney Kimmel? Is there any -- where it's ranked in the country?
A. Sure. We have got a Sidney Kimmel Cancer Institute here. Sidney Kimmel just supported cancer research around the country, and so his name has been replicated in

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multiple centers. But we have a Sidney Kimmel Cancer Institute at Sharp Healthcare.
Q. How about Johns Hopkins, have --
A. We haven't replicated Johns Hopkins.
Q. Okay, but do you know if there's any national rankings with regards to Johns Hopkins Cancer Center?
A. I've worked with several of the people at Hopkins. I think they are excellent. I think they are fine. I'm not aware of a Newsweek article or anything that says if you have cancer fly to Baltimore, so I don't know how you would rank it. I think they have a reputable and excellent program and they have a good medical school.
Q. Doctor, part of your CV -- and I don't know if this came from Pam or if you provided it to her, but it comes with -- the first page is your fee schedule and the last page is a biographical sketch. And do you normally send those to attorneys in these kind of cases?
A. No. The fee schedule, yes. The biographic sketch is if I'm going to go give

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a lecture and somebody needs to know more about it me, or if I'm doing some community outreach they will ask to have it included in the drawer with the CVs, and normally it doesn't get sent.
Q. And those are your most updated -- your fee schedule?
A. I don't know. Let's check.
MR. LEAK: Off the record.
(Discussion off the record.)
MS. PANTAGES: Back on the record.
THE WITNESS: These numbers are all accurate.
BY MR. LEAK:
Q. I don't have to go through your background. It's all on your CV.
Let's go through what you have reviewed in this case. We've excluded any depositions, and then we have a binder here of medical records, and I -- I think they are self-explanatory.
Anything else? What is in the back here?
A. The CT scans. I've reviewed the CT scans. I've not reviewed the slides.

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Those were the additional records; that's made mention of in the second letter.
Q. Okay. Gotcha. So when you talk about CT scans, you are talking about the abdominal CT scan of November 2001?
A. The study done in 2001 that showed the lesion in the lung and then the study done in 2003.
Q. In June 2003 --
A. Right.
Q. -- where the diagnosis of the lung cancer was made?
A. Correct.
Q. Do you know Dr. Friedman in San Diego, radiologist?
A. No.
Q. And the reason I ask that is -- his name is Paul Friedman. You are not familiar with him?
A. Never heard of him.
Q. He reviewed some films in this case, and I'm trying to figure out whether you had any -- like you referred Ms. Pantages --
A. Right.

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Q. -- or if you had any involvement in that.
A. I've never heard of him.
Q. And in the context of this case, were you provided any kind of reports from Dr. Friedman as to his interpretations of the CT scans or other films?
A. We discussed the impressions of the radiologist, but I have not seen his report or his declaration.
Q. And when you say the impressions of the radiologists, are we talking about the radiologists back in 2001 and 2003, or the one that recently reviewed them?
A. The expert retained by the firm.
Q. And what did you learn from that discussion?
A. That his interpretation was essentially consistent with what was seen by the original radiologist.
Q. Okay. Are we talking about the 5 millimeter nodule and the 2 centimeter nodule seen in the CT scan of the abdomen from 2001?
A. Yes.

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Q. And --
A. But the whole study was presumed -- was interpreted -- the whole study was interpreted correctly at the time it was done.
Q. And have you used that information at all in forming your opinions here today or in this case?
A. Yes. My opinions on causation are predicated on the fact that the interpretation of the films were accurate.
Q. Okay.
A. I reviewed the films independently, but I would defer to a radiologist, and I have not seen any information that would imply that anyone thought that those interpretations were inaccurate.
Q. And in what way have you -- you mentioned your opinions on causation. In what way have you used that information about those interpretations being correct to form the basis of your opinion?
A. Well, as my declaration states, the question that I was asked to address primarily was: Was this patient curable at

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the time that that CAT scan was taken? One, was she curable at that time? And two, more likely than not, is the lesion that was seen at that time the cancer that was diagnosed in 2003?
So the answer to both questions would be yes.
Q. We're going to get into the substance of your opinions.
A. Right.
Q. I want to find out what you reviewed and forms the bases of your opinion. And I take it with the 5 millimeter nodule, does that play a role at all in your opinions?
A. I was told this afternoon that Dr. Ettinger feels that that 5 millimeter nodule is inconsequential and doesn't represent cancer. Assuming that -- I'll certainly accept the same hypothetical, and certainly that was my impression after reviewing the films again today.
Q. I wanted to talk -- before we get to the substance of your opinions, your experience as an expert witness. How long

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have you been doing expert reviews for?
A. I'd say 15 years.
Q. And over that 15 years, do you have an approximation of how many cases you have reviewed?
A. I probably get sent 8 to 10, to 12 cases a year. Of the cases that get sent to me, I probably agree to serve as an expert in between 8 and 10 in any given year. Of the ones that I agree to be an expert in, about 60 percent are plaintiff's, 40 percent are defense. Of the cases that go to deposition, it's closer to 50/50. Of the cases that go to trial, up until the last two, three years, it had been about 70 percent defense and 30 percent plaintiff.
Q. Has that been a steady trend for, let's say, over the last five years?
A. You know, give or take 10 or 15 percent in any given year, yes. I think if I'd say anything, I think over the last several years I've seen more plaintiff's cases going to trial that I would have thought years ago would have settled.
Q. Have you figured out why or --

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A. Yeah, sure. I think it's just the change in the malpractice climate that with the changes in malpractice insurance carriers and, you know, insurers going into default, that there's been a more aggressive stance taken by carriers sort of forcing cases into trial that years ago would have been settled or just done away with.
Q. Have you spoken or given any presentations to attorneys who are defending or prosecuting medical malpractice cases?
A. Not that I can remember, never.
Q. Have you ever attended any such meetings that maybe are presented by either the plaintiff's firm or the defense firm?
A. No.
Q. Or for the bar?
A. No. No. Why would I go if they didn't want me to talk?
Q. Have you ever worked for the law firm of Becker & Mishkind before?
A. I think I may have looked at one or two other cases, but I don't think any of the cases I've looked at have ever gone to depo, but I could be wrong.

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Q. Okay. When you see the letterhead, are there any names that you recognize from prior experience?
A. Uhm --
Q. I'm assuming not Pam, since --
A. Right.
Q. -- she is new to that firm.
A. David Kulwicki.
Q. You don't think that particular case that you had with David Kulwicki went to deposition?
A. I'm sure I never flew to Cleveland to testify for them. It may have gone to depo, but I don't know.
Q. Have you ever testified live or by video for a case venued in Cleveland, Cuyahoga County, or Ohio, for that matter?
A. Twice.
Q. And those two cases, were they for plaintiff or defense?
A. Once of each.
Q. Do you remember the attorneys that you reviewed the cases for?
A. Yeah, Lancione and so that was the plaintiff's case and then there was a case

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for a guy named Jones that was a defense case.
Q. Mark Jones?
A. Yes.
MS. PANTAGES: We know everybody. We all know each other.
THE WITNESS: It was a breast cancer case.
BY MR. LEAK:
Q. Do you know how long ago the case was for Mark Jones, if it was Mark Jones, presuming?
A. It was long enough ago that people were impressed that they had this Rock and Roll Hall of Fame that they opened up. And I can remember standing looking out at this gray rain and people saying, "Oh, look, that's The Rock and Roll Hall of Fame."
MR. LEAK: '95?
THE WITNESS: Yeah, ten years, that would be about right.
MR. LEAK: '95, '96?
MS. PANTAGES: Yeah. I was working on my house.
MR. LEAK: Cleveland is not always

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gray. It just --
MS. PANTAGES: Yes, it is.
THE WITNESS: You know, far be it --
MS. PANTAGES: More likely than not.
THE WITNESS: -- from me to disagree with an attorney, but I went to medical school in Buffalo, and unless it's dramatically different in Buffalo --
MR. LEAK: I was born in Buffalo, I know it well.
BY MR. LEAK:
Q. What is your --
MS. PANTAGES: Medium gray.
BY MR. LEAK:
Q. What is your experience -- are all the cases that you review cancer cases?
A. No.
Q. What other type of cases have you reviewed over the years -- and I know it's been a number of cases -- when you go outside the area of cancer?
A. I've done product liability cases for both -- actually, mostly defense in

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product liability. I've done medicolegal practice -- medical -- legal malpractice, and it's difficult to -- and I don't -- I can't tell which side I was on. They are so confusing.
Then I've testified in general surgical cases and surgical misadventure cases.
Q. In the cancer cases, I take it that's the predominance of your review is cancer cases?
A. Yes.
Q. What percentage deal with lung cancer?
A. 10 to 20 percent overall, and essentially limited to cases pretty much like this.
Q. Where there's an alleged latent diagnosis and you have to go to do staging or what the treatment may have been different or those kind of issues?
A. I think I see it as issues that surround epidemiology of lung cancer. And so if a patient ends up having a pneumonectomy and then didn't recover from a pneumonectomy, I wouldn't become involved in that. I don't

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do those type of major surgeries on my own, and so I wouldn't feel it appropriate; but certainly I'm comfortable in discussing cure rates and epidemiology in these cases.
Q. In your practice, how would you break it down in terms of the types of cancers percentagewise that you focus on?
A. I think it varies, I think. I treat esophageal, head and neck, gastric, pancreatic and bile duct cancers, soft tissue sarcomas, melanomas, other GI tumors like rectal cancers and colon cancers. Lung cancer is unusual for me. If I see patients, often times I'll see people with metastatic nodules in the lung. I will see some people with primary lung. If they need surgery, I would have a thoracic surgeon do the case and scrub with them.
When I do esophagus surgery, which is sort of the same sort of surgical approach, we'll do those as cosurgeons.
Q. Did you do any medical research for this particular case?
A. You know, I consulted the staging manual and that's about it.

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Q. And that's the HECC cancer staging manual?
A. That's correct.
Q. And that's the 6th edition?
A. Yes.
Q. And why did you go to this textbook?
A. Well, the issues that I'm addressing basically deal with whether she was curable or not. And so the underlying issue there is how much cancer did she have defines on whether she's curable or not, and so the staging manual is a good resource that we all use. It gives us the same vocabulary to describe the cancers that patients have and also talk about curability.
Q. So your opinions come down to basically how big, extensive the surgery was, staging, and then what kind of treatment she could have had if an earlier diagnosis was made?
A. In this case the assignment is really simpler than that; isn't it? It's really basically -- I don't think there's much -- surgery she would have had, it --

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it's predicated on the hypothetical that there was a cancer there in 2001 and that the 2 centimeter nodule identified on the CAT scan in fact represented a cancer. If that hypothetical is correct, then the therapy is pretty straightforward. She would have had a resection of that portion of her lung; so I don't think that's an issue. The issue then becomes how much cancer did she have at that time and as a result of how much cancer she had, how curable was she?

Q. Why don't we go there now, on what she had.

You say it's based upon a hypothetical. What do you mean by that, when you say it's based upon a hypothetical that she had cancer, that 2 centimeter lesion represents cancer?

A. It's my opinion that when I look at the film that what I'm seeing represents the cancer that was diagnosed in 2003. Nobody followed up and nobody did a biopsy, so that's an opinion based on my interpretation of the studies as well as the clinical course, but I'm willing to

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acknowledge that that's an opinion, and so my partnership is based on that observation.

If Dr. Ettinger were to say no, no, no, that's not cancer, that's something completely different, then that's a different hypothetical, and we'd have to discuss that. But assuming that we both agree that what we see there is a cancer, then it becomes a fact, I guess, in terms of this case.

Q. And you are basing your opinions on your assumption, your opinion that that 2 centimeter lesion seen on the CT scan in the abdomen and pelvis is the cancer that we're talking about from 2003?

A. Right. But I guess I wouldn't characterize the CT scan the way you do, and I can understand why we would do it differently.

The CT scan of the abdomen, as part of the study, did an evaluation of her lower chest. And in fact when you look at the CT scan, it was a specific, focused view looking at that nodule in her lung in that they went back and reimaged it using different levels of contrast to better

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characterize it. So it was not a random pick-up on a CT of the abdomen. It was a study of the lower chest and abdomen, and the study carefully described the nodule in her lung.

Q. Now, can you anatomically describe what area that CT of the abdomen and pelvis covered?

A. Well, it started in her lower chest, and clearly demonstrates this 2 centimeter nodule in the right lower lobe. It then scans through her abdomen and looks at her complete abdomen and her pelvis. I can't tell you how low she looked in the pelvis. If you want, we can put the films up, we can look at it again. Certainly the report describes what they saw.

Q. Well, you agree there's pathology seen subsequently in 2003 that you can't find on that film because it doesn't go high enough?

A. No, I can't -- no, no, no. What you can say is it sees what it sees. Okay?

It sees a nodule in the lung. It looks at the pancreas and sees no lesion in

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the pancreas; and we know that in 2003 she in fact did have a lesion in her pancreas.

And in terms of the mediastinum, to the extent it looked at the mediastinum, it sees no evidence of abnormalities. The study did not go further up, and so we then have to decide what's the probability of there being mediastinal spread based on the information that we have available in 2001, not based on what we saw two years later.

Q. Well, it didn't show the hilum, right?

A. Not completely, no.

Q. And we know that in June of 2003 there's a 6 by 4.7 centimeter mass in the right hilum?

A. But I believe that's a lung lesion that's extending into the hilum, and then there are multiple nodes described as being there as well; so I think that that was the 2 centimeter mass growing up into.

Q. How do we know that didn't exist in that area of the hilum in 2001 if we can't depict it on the CT of the abdomen?

A. To some extent I'd defer to the

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radiologist to describe how much he can see and what he can't see, but certainly there is no evidence of consolidation of the right lower lobe on the x-ray.

There's no evidence of any other changes in the right lung that is described in 2003. And I guess most importantly in terms of this discussion about, gee, there was disease there that we missed, we see the pancreas in excellent detail and we know that in 2003 she had two foci of metastatic cancer in the pancreas, but the pancreas is completely normal in 2001 and, in fact, it's described as normal in the report. And so the argument that, oh, there must have been this disease in the mediastinum that we missed -- you can't pick and choose your disease. You can't say there's disease in the mediastinum we missed, but, oh, the stuff in the pancreas wasn't there; that came later.

Q. Well, aren't there circumstances where you could have disease in the mediastinum and then subsequently spread to the pancreas?

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A. My job as an expert is to discuss what's more likely than not. All right? Once we get into the discussion of could something happen and is this possible, and maybe something goes on, that's God's problem. I mean, God will tell us what happens in an individual. But in terms of populations of patients, it would be highly unlikely to have the 2 centimeter mass that was demonstrated and then have a 6 centimeter mass central to that that we don't see.

And I guess I'd defer to the radiologist to discuss the fact that what we see in 2003 is what started in 2001 and then extended into the mediastinum, because I believe that in the -- let's look at the report for 2003.

Q. I believe this is yours.

A. If I can find it. If you have it at hand, that would be great.

Q. These are well labeled. You should be able to get to that.

MS. PANTAGES: I think it's before that.

THE WITNESS: CT chest.

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MS. PANTAGES: There you go.

THE WITNESS: So the question is -- what's described in 2003 certainly describes a much more extensive process, which would have been visible on the studies done in 2001. And what's also interesting is that the 2 centimeter lesion is no longer there. Right? Because it's now grown and been subsumed. And so if in fact there was this big cancer in the center of her chest in 2001, then you would have seen the second lesion extending down to the inferior aspect of the lung, which represented consolidated lung downstream from the big hilar mass.

Q. Now, you are saying based upon what you have seen in 2003 that a CT scan of the abdomen and pelvis would pick up at least findings consistent with that.

A. Well, let me just reclarify my point.

Q. Okay.

A. The portion of the CT of the abdomen looks at the lower part of the chest, so it's not a study looking at the abdomen; it's a study looking at the lower chest.

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Yet that study describes no abnormalities. And when I looked at the films also, there were no changes in the inferior lung. It looks completely normal. Okay?

And so what you are trying to do is pick out the part of this that you want to be there in 2001 that we can't see. And then you say, oh, but this other stuff that we should be able to see that we don't see; that wasn't there in 2001. And oh, by the way, the stuff in the pancreas that we see in 2003, that wasn't there in 2001; that all came later. But a 6 centimeter mass in the mid portion of the chest, that was there.

Maybe, Chief. But, you know, there's no evidence that would support that.

And the fact that the 2 centimeter mass is now subsumed by this big tumor mass implies that they were not two processes but the 2 centimeter mass grew to become the thing you see in 2003.

Q. Now, wouldn't a CT scan of the chest in 2001 be more detailed of the upper chest and go above the base of the heart that could reveal those findings in 2003?

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A. Absolutely. But it's my understanding that that's not the plaintiff's problem in a sense. It's the defense -- it's the doctor who is supposed to order the study. And since he failed to order the study, it's appropriate for me to make an interpretation assessment based on the information that is at hand, and I can assume that that study would have been normal.
Q. That's where I want to go. I don't want to talk about, you know, what should have been ordered or what, because you're here to tell me what your causation testimony is. And you are saying you would assume that a CT scan of the chest that would have shown the upper chest and more areas that we know --
A. Wasn't done.
Q. Okay. And you are assuming it's normal. And I wanted to know all your -- the bases of your opinion that that would have been completely normal in 2001.
A. Sure.
First is there's what we see is a 2 centimeter lesion in the lung which we

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assume is the cancer. So she had a T1 lung cancer that was 2 centimeters in size.
For any patient with a T1 lung cancer, the chance of having a positive mediastinal node even if you looked is between 10 percent and 20 percent.
Q. Okay.
A. That's histologically; that's not even CT scan demonstrable.
Q. So I understand this, you are saying based on the size of the nodule in 2001 of being 2 centimeters, that it's only 10 -- I'm sorry.
A. 10 to 20.
Q. 10 to 20 percent of those kind of patients will have mediastinal involvement?
A. Have lymph nodes involved in the mediastinum; that's right.
Q. Why in this case, then, are you of the opinion that --
A. Let me finish. I guess I should finish that.
Q. Okay.
A. So, one, the tumor is small enough that the chance of nodes being involved is

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less than 50 percent.
Two, we did look at the abdomen and there's no disease in the pancreas, and so if in fact there was no disease in the pancreas in 2001, it's more likely than not that it hadn't spread to the mediastinum as well.
Q. So going back to number one, on the size and when 10 -- 10 to 12 percent --
A. 10 to 20.
Q. Why am I going back to 12 percent?
A. I don't know. That's what she should be saying.
Q. Why doesn't Mrs. Richnafsky fall under that category of 10 to 20 percent?
A. Right, absolutely.
MS. PANTAGES: Objection.
THE WITNESS: There's a 10 -- I'm sorry.
MS. PANTAGES: Objection.
THE WITNESS: There's a 10 percent chance that she does, but, again, my job is to talk about what's more likely than not; so greater than 50 percent the extent of disease she had will have negative nodes. Is it

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possible that she could have positive nodes? Yes. But "possible" is, I thought, not the standard that needed to be met in a case like this. What you need to talk about is what's more likely than not. And for cancer that's that size, more likely than not the nodes will be negative and more likely than not if treated at that time she would be cured.
Q. I know we covered this briefly about the pancreas being appearance normal in the CT scan in 2001. Am I taking your opinion to be that the growth rate to spread to the lymph nodes in the mediastinum and to be able to spread to the pancreas is the same growth rate, and that's why you would expect to see these appearing at the same time, lymph nodes positive and metastasis to the pancreas?
A. No. No. I think I'd turn it around. Okay? So if what you are saying is there was a 6 centimeter mass in her mediastinum in 2001, right? Then I would argue if she had that much cancer in the mediastinum, more likely than not we would

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have seen what we saw in the pancreas. The negative isn't necessarily true. What I would say is for a lesion that's 2 centimeters, more likely than not the nodes are not involved, and it's highly unlikely she would have metastatic spread to the pancreas.

We can't see the mediastinum, but we certainly can see the pancreas, and there's nothing there.

Q. At what point, then, sizewise, would you start to expect to see something in the pancreas? Like you said, you would expect to see it at a 6 centimeter mass in the mediastinum. Is there something in between 2 to 6 centimeters that you would start to see something in the pancreas?

A. I think what you say is the larger the tumor is, the more likely it is to spread to nodes; having spread to nodes, the bulkier the disease in the mediastinum is, the more likely it is to have distant spread. And specifically to the pancreas, I don't think there are any studies that address that. What we say is that for small cancers

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it is unlikely she would have this spread. And the fact that it was there 19 months later I don't believe can be used as an argument to justify the position that it must have been there 19 months earlier.

Q. What is micromets, micro metastasis?

A. Micro metastases are metastases that are too small to be seen. It's the disease that's cured with adjutant therapy.

Q. And is there any chance that she had micro mets to either the lymph nodes or the pancreas as of November 2001?

MS. PANTAGES: Objection as to "possibilities."

THE WITNESS: The problem with that sort of an argument is I'm always loath to use arguments that have no clinical relevance. So there would be no way in 2001 of seeing this microscopic spread, and in fact we would have treated her for cure recognizing that in all likelihood we would get it out.

But in answer to your question, sure, 1 in 10 of the people that we take the

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tumors out will have microscopic spread to their lymph nodes.

BY MR. LEAK:

Q. Now, where is the precarinal --

A. Precarinal.

Q. -- carinal and subcarinal areas?

A. It's in the center of the chest. It really discusses where the trachea splits.

Q. And that's not visualized on the CT scan of the abdomen of 2001?

A. That's correct.

Q. And what were the findings in those regions in 2003?

A. She had lymph nodes that were slightly enlarged in those regions.

Q. And when you say slightly enlarged, what do you mean by slightly enlarged?

A. I mean whatever the guy said in the CT scan report.

MS. PANTAGES: That is 2003?

THE WITNESS: Yeah. Thanks.

So there are pretracheal lymph nodes that are 1.7 centimeters in greater size, and then there's lymph nodes that grow around the bifurcation that are about 4

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centimeters in size.

BY MR. LEAK:

Q. Is that the 4.2 by 3.2 centimeter measurement?

A. Yes, that's a mass; so that's several lymph nodes.

Q. That's a significant size, isn't it?

A. Well, it's describing a series of lymph nodes, right? So in fact any lymph node that is over a centimeter is considered to be suspicious, but you could have four lymph nodes and each node would be one centimeter in size, and it wouldn't have the same significance as a specific 4 centimeters of tumor mass, and I mean that's how it's described, right? Suspicious adenopathy blends over and the whole area measures 4 centimeters.

Q. How do we know that region of those lymph nodes that's not visualized in 2001 didn't have enlargement back then if we don't have any images of it?

A. Well, again, you know, we have what we have. And what we have is a CAT

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scan that shows a small peripheral lung nodule. And we know from extensive work what the likelihood of that having spread to the carina is. And since the doctor didn't order a CAT scan to look at the area, it's reasonable to assume that what is historically rel- -- what is historically appropriate is what happened in this case. You can extrapolate from other series.

Q. You used the term that you have extensive work in your -- in forming that opinion. "Extensive work," are you talking about literature, your experience --

A. What do you mean? I missed it.

Q. When you were giving your answer there, I think as a basis of your opinion you used the term "we have extensive work."

A. Oh, there have been several studies that look at T1 cancers and talk about the risk of spread to nodes in T1. There's a lot of interest in that, and so that's all I was referring to.

Q. Any particular studies that come to mind that you are referring to?

A. Yeah. There was a study done many

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years ago by Nile Martini basically looking at T1 lung cancers.

Q. So the underlying basis of your opinion is that this was a T1 nodule in 2001, in November of 2001, correct?

A. The opinion is predicated on the idea that the nodule we see is the cancer she had, that she had a 2 centimeter cancer.

Q. And that's all it was limited to was the 2 centimeter nodule that we see on that CT scan?

A. That's what we see on the CT scan, and that is her cancer. All right. And then her chance of spread is based on what we know about people with cancers that large since nobody ordered the appropriate studies to work her up further.

But also recognize at that time she had no symptoms. She had no other problems. And in fact she was well for 19 months. If she had an extensive disease then, she had Stage III or Stage IV disease, it would be unlikely that she would go 19 months without significant symptoms.

Q. Let's talk about symptoms, then;

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because isn't it true that we know she has -- she's Stage IV in June of 2003, correct?

A. Right.

Q. And isn't it true she only had a three-week history of productive cough leading up to that diagnosis?

A. Right.

Q. And we know also from bronchoscopy that it was almost 90 percent occlusion of the bronchus, correct?

A. I thought it was of a lobar bronchus, not the main bronchus of the whole lung.

Q. Then I guess my question is that you are saying if she was Stage III or IV in 2001 you would expect some symptoms, but then we have a history of her knowing she's Stage IV with only a three-week history of pulmonary symptoms. How do you reconcile that?

A. I think that the symptoms for whatever time she had the symptoms are her symptoms. We know that her survival from the time of diagnosis with Stage IV disease was not an extended period of time. And so it

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would be difficult to argue that she had Stage IV disease in 2001 and then lived for 19 months with no problems.

Q. But sticking to symptoms, based upon what you know about her history, you can have a patient that is Stage IV that can go without symptoms leading right up to the diagnosis. And she's just a three-week history and we know she's Stage IV.

A. Well --

Q. How do you explain the lack of symptoms for that period of time outside that three-week history she provided?

A. Because at the time -- well, I don't know. I don't know. I mean, all I can tell you is at the time she was asked these questions she's confronting this problem, and so when you are asked at that time: How long have you been short of breath, and how long have you been coughing up blood? The normal reaction of a patient is to minimize her symptoms. So did anybody go back and aggressively question her: Well, you know, three months ago were you having trouble getting up a flight of stairs?

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I mean that would be inhumane. There would be no reason to do that.

But the average life expectancy of someone with Stage IV disease is not two and a half years with no therapy. And so to argue that she had Stage IV disease back in 2001 and then did so well with no therapy would be highly unlikely.

Q. Well, how about someone Stage III in 2001?

A. Not with multi-mediastinal disease, because she would have progressed. My understanding, the average life expectancy in that group is between six months to a year, and that's with therapy. So we're saying she's Stage III with no therapy for 19 months and the only thing that she has is a little shortness of breath at the end of the 19 months?

Q. What do you base that upon? Any particular studies that you are referencing, textbooks?

A. I can't give you the specific reference, but there are certainly articles that look at the treatment of advanced lung

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cancer and what the average life expectancy with treatment is. When the earlier studies were done in which they had a nontreatment control -- and certainly in the work, I was chief of staff at San Diego Hospice. When you look at what happens to people with lung cancer who go to hospice care and don't get therapy, they all die within a few months. Nobody lives with advanced lung cancer for 19 months with no therapy.

Q. What is the difference between Stage III and Stage IV in terms of a patient with symptoms and survivability?

A. I think that's too broad. In essence Stage IV is metastatic disease, right?

Q. Right.

A. And so Stage III, the scheme of things is often they are either inoperable for cure or it's going to be difficult to operate for cure. And some of those people we are looking at giving neoadjuvant therapy, but none of them would go with no therapy.

Q. Talking about her symptoms -- and I think you mentioned that you don't know how aggressively people asked her questions on how

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far back her symptoms started. And you also mentioned people like her minimize their symptoms. Do you have anything to indicate that Mrs. Richnafsky minimized her symptoms when she gave that history that led to the diagnosis?

A. I think that misstates the testimony a bit.

I think the point I was trying to make is that a young woman confronted with an advanced cancer and then you start asking them "How long have you had these symptoms?" my personal experience in working with patients is the patients in that situation, when confronted with those sorts of issues, would want to believe they had symptoms for a shorter period of time which they believe would make them more curable.

Q. Okay.

A. And I think nobody would go back and look aggressively to see if in fact she had symptoms that she hadn't acknowledged.

Q. But, of course, you have no firsthand knowledge of the circumstances in this case with Mrs. Richnafsky on the history

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she gave and how long they may have existed?

A. No. That's true.

Q. Did you see any reference that she had a hiatal hernia?

A. Yes.

Q. Do you know when that was?

A. I think the first CT scan describes a large hiatus hernia.

Q. What kind of symptoms does a patient generally have with that?

A. You can have regurgitate; you can have heartburn; you can have hoarse voice; you can have bronchitis and pneumonia; you can get esophageal cancer.

Q. Did you see anything like that with Mrs. Richnafsky in the medical records, any symptoms or any complaints or --

A. No, but I'd hasten to add that you can certainly have a large hiatus hernia with no symptoms; so the absence of symptoms doesn't rule out the presence of a hiatus hernia.

Q. In rendering your opinions, you know, we have talked about what you visualized on the x-rays, the 2 centimeter --

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what you would expect to see had what we're talking about in 2003 existed in 2001 -- we're talking about radiographically. I want to talk about whether you took into consideration the size of the mass, the size of the lymph nodes in terms of going back in time to figure out the spread and where it existed beforehand.

A. I think what you are interested in is sort of the bogus concept of doubling times.

Q. You call it bogus?

A. Yes.

Q. What do you mean by that?

A. I think there's no clinical relevance to the concept of doubling times. I think that nobody ever uses it in treating patients. I think that in this setting, where you only have a single point in time observation, it's even more specious. Right?

I think when you talk about doubling times in which you don't know what you are looking at -- so, for instance, if you say the patient has 6 centimeter lung cancer, well, in fact a lot of that is

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pneumonia and swelling and changes that have nothing to do with cancer.

In fact, in this case, they make the point that they used the PET scan to more carefully characterize the size of the tumor which was smaller than what the CAT scan described it as. And so I -- well, here.

The only doubling time concept that I'm really familiar with that is truly -- there's one tumor model in which we've identified the fact that you truly begin with one cell, which, of course, addresses the whole issue of does cancer start from one cell, but in this tumor you actually start from one cell, and then in less than a year you end up uniformly with about seven and a half pounds of tumor. All right? So every baby can grow from one cell to seven and a half pounds in nine months, and we're talking about 19 months. And the question is it went from one ounce to six ounces. I don't know. I think the whole thing is weird. I think there is no scientific validity to it and I think there's no support for it.

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Q. Is there research and literature out there on doubling times?

A. Is there research in the human model? Talking about people or in laboratories where you grow stuff in a petri dish?

Q. Well, I guess my question is: We know there's physicians out there that follow the doubling time concept and come up with opinions, correct? I mean, it's in the literature and --

A. In terms of what? Nobody bases clinical judgments in treatment of patients based on doubling times that I'm aware of.

There may be a vision that says, "Something was growing faster, so I'm going to use a different sequencing of my drugs." But nobody has their patient come back at six weeks, gets another x-ray and says, "Gee, you know, you're incurable and you're going to die, and we'll send you to hospice because I've measured this nodule in your lung twice and there's no way we can treat you."

So no, there's no clinical relevance. And no, I'm not aware of any --

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I'm not aware of any clinical literature that talks about using it in terms of treating patients.

Q. I see your point in terms of no clinical significance and treating patients, but --

A. Right.

Q. -- sitting in this arena, is determining doubling time beneficial for us to go back and determine the extent of the cancer when it existed in 2001 or, for that matter, 1998, 1999 --

A. Uh-huh.

Q. -- when it started? Can we use that?

A. Well, I think the question is well phrased, okay, because I think the use of doubling time is good for you. All right? But I don't think that it has any relevance. Okay? And so I'm loath to use a theory that doesn't have any place in the treatment of patients in trying to asses what's going on. If that was true, then when you see this patient with a 2 centimeter cancer, you'd say "We are not going to treat you because

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somehow I know that this tumor is going to grow and we'll never get there." But that's bogus. That's not how we take care of patients. And so we -- you know, I don't know how -- I can't put it any more strongly than that.

And I'd be happy to read Dr. Ettinger's -- here. I'll read Dr. Ettinger's deposition, and if he actually makes points that seem to alter my opinion, I'll make you aware of that and make myself available to rediscuss that issue. But there's -- I've never seen an argument that seemed valid to me.

Q. I think I've got your point.

A. Good.

Q. Is that --

A. I mean you asked the question three times. I think it's only fair.

Q. Right. And if I can summarize it, it sounds like you won't follow that approach of doubling time when, to you, it's not something that is used in a clinical setting to treat patients.

A. No. I'll go further than that.

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I think there's no validity to the argument. I think any -- you are not looking at pure cancer cells. I mean, what you look at when you look at a nodule, there's cancer cells, there's the stroma, there's blood vessels, there's fluid. And so when you say this represents a million cells, well, what represents a million cells? Half of what you are looking isn't even cancer cells. As the cancer grows, whatever growing means, you have cells dying, you have cells spinning off, and you have cells that stay quiescent, as well as those that double. So you can't make the assumption that when you see a tumor it represents this many cells and then it's going to go to twice as many cells in a certain period of time. It doesn't mean that, and we know biologically there is no validity to it. Tumors don't grow that way.

Q. And so what you are saying is in your opinion you can't go back to 2001 look at that 2 centimeter nodule and say 90 percent of that is cancer cells.

A. What you can say is 90 percent of the people with a tumor this large will be

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cured by appropriate therapy. And that recognizes the fact that there are a subset of people where the tumors spread earlier than you'd expect, where the lymph nodes really are involved even though you don't see it, where there's something else that's going on. But for the vast majority they will be cured with that tumor burden. And we treat all hundred the same way because we can't pick out the ten.

Q. Are you able to tell us when this cancer first seeded in Mrs. Richnafsky? Knowing what you see in 2001, knowing what happened in 2003, are you able to go beyond 2001 and say, now this is when it first existed?

A. First, I think it's a -- it's not a relevant question. Okay? So I don't see any need to answer the question because -- with all due deference, it's like the bear in the woods. I don't care what happened a year earlier. We didn't take a picture then. We didn't look at her. We didn't know what's going on. What we know is in 2001 she had a cancer burden of X, and here is

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how we would have treated her. One.

Two, cancers grow at different rates.

Q. Now, if you don't follow the doubling time approach, my question is: Is it a difference of opinions, or do you think that the people that do follow that are just dead wrong?

MS. PANTAGES: Objection.

THE WITNESS: I think it depends what you want to do with the information. If you want to use that information, I don't know. I mean nobody uses that information to define patient care. And so if you are not going to use it for patient care, then how are you justified in coming in as an expert and describing this as reality and true?

And I'd hasten to say -- because you will read this in my other depos when you get them -- I've never used doubling times as an argument either for the defense or the plaintiff; so it's not a matter of because I'm working for a plaintiff I'm not willing to look at it as an option.

The way I do it is I think

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intellectually and internally both ethically and honest. You look at the amount of cancer that you can define. You talk about the cure rate for that amount of cancer. Then you look at the cancer that they had at a later time.

Q. Let's go to your opinions with regard to survivability and treatment had a diagnosis been made in 2001.

What opinions are you going to be rendering with regard to Mrs. Richnafsky in this case had a diagnosis of cancer been made in November 2001?

A. I think what I would say is that standard appropriate care at that time would have rendered her cured, and whether that would have more likely than not required some form of surgery, which more likely than not would have resected one third of her right lower lobe; so she would have lost a part of her right lung and several lymph nodes would have been removed. Assuming the nodes were negative, no further therapy would be needed, and that would have resulted in her having an 80 percent chance of cure. And that is the

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most likely scenario.

Q. What was the 90 percent figure you gave me before?

A. Whether the nodes would be involved or not.

Q. Okay. When you use the term cured for a patient with lung cancer that undergoes that kind of treatment, what do you mean by the word "cured"?

A. In the most general sense, alive and well in five years with no evidence of disease. I think that the concept of curability has been -- has been modified as a result of the malpractice litigation. And so as long as we use the same parameters all the time, and so five-year cure rates are, I think, a valid number. Most people would say that if you make it five years from a lung cancer, it's unlikely that you will die of that lung cancer going forward. There is still a risk but it's small.

Q. And so the extent of her treatment would have been the resection of the node with -- or it would have resected one-third of right lower lobe?

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A. They take the whole right lower lobe; so she'd have a right lower lobectomy and probably a mediastinal node sampling.

Q. And your opinion as to what the mediastinal findings would be?

A. More than likely than not the nodes would be negative.

Q. Are you able to tell me between November 2001 and June 2003 when she was no longer a surgical candidate to reach being cured?

A. No.

Q. Why are you unable to render an opinion on that?

A. Because we don't have any information to draw upon. There is no objective information. And so I think really -- I mean the issue in this case is if the CAT scan had been followed up on within four to six weeks, she would have had the definitive surgery that would have cured her. Whether a year later or a year and a half later somebody could have intervened, it's sort of -- again, it's one of those inconsequential questions that has no meaning.

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Q. When you talk about the five-year survival rate and survival rate -- and we do know that patients like her, if they do get that treatment in November 2001, they can succumb to the cancer and still die.

A. Absolutely.

Q. Can you explain to me why, then, are there patients under similar circumstances, the same, you know, kind of nodule and -

A. Why doesn't it work 100 percent?

Q. Yes.

MS. PANTAGES: I want to object as to possibilities as opposed to what is more likely than not.

Go ahead.

THE WITNESS: Well, that's one answer -- come back to where we started. My job as an expert is to describe probabilities of what will happen in a population of patients dealing with this situation.

There's none of us who can tell a specific patient what will happen to them. All right? And we manage people based on our experience with large groups of people.

In other words, you can't take

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somebody that you really like because you bond with them, they have kids your age, and you just think they are really lovely people, and so you operate and you give them radiation and you give the chemotherapy because you really want them to be cured. That's doing them a disservice just as much as taking somebody with no insurance who you really hate who never takes a shower and you sort of do a half-assed operation and don't take the whole thing out. We operate on people the same, and we do the same operation based on their tumor burden.

We understand that there is a potential that we won't be successful each and every time. But my job is to tell you what's more likely than not to have happen in a case and extrapolate from the information we have.

Q. And so, I mean, anything's possible, that someone can succumb to the cancer with the best treatment if the diagnosis is made November 2001?

MS. PANTAGES: Objection.

THE WITNESS: They can get hit by

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a bus going home.

BY MR. LEAK:

Q. I'm limiting this to being diagnosed in 2001 and still getting the surgical treatment that you have described, she could still have succumbed to this cancer?

MS. PANTAGES: Objection.

THE WITNESS: The risk of that occurring is between one in ten and one in five.

BY MR. LEAK:

Q. Are you able to -- I think I know the answer -- pinpoint when she went from Stage I, II, III, to IV?

A. No, not given the information we have.

Q. The report of November 21st, 2005, when you do this, is this dictated and like this is the only draft, or are there other drafts of this?

A. Wow. That's the only -- that's the only draft I have. I think certainly they are created in consultation with the attorney to make sure that the terms of art

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are in the appropriate places and things are said correctly. And so there may be reiterations of it, if there is a misspelling or if I don't say something in the right paragraph at the right place, but I -- that's basically my feelings.

Q. Do you know if there was anything that had to be changed that was recommended to you by the attorney's office?

A. I can't remember.

Q. Does the report of November 21st, 2005, contain all of your opinions in this case? I think we've discussed pretty much all of those.

A. You know, I actually read the opinion of the surgeon who is talking about standard of care, and so I offered to -- you know, to offer opinions on standard of care, but they are not covered in my declaration.

Q. Well, we -- we have a rule, and --

MR. LEAK: I'm assuming you are not presenting him as a standard of care expert.

MS. PANTAGES: You can ask him

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questions about that. I mean I -- the first time we chatted about that was today, and so the rule is what it is, but this is your opportunity, I mean the rule is also -- the case law is that he can supplement his opinions by way of his discovery deposition too. He's not necessarily limited to that, but --

Q. The rule is within 30 days of trial, so I'm going to object to any standard of care opinions, and if the court is going to allow it, then I'm going to ask to redepose him, because I'm going to follow the local rules that there's been no supplemental report within 30 days of trial.

THE WITNESS: That's all right. I'm cool with that. I don't care.

MR. LEAK: Plus you also have Devereux deposed on Thursday.

THE WITNESS: But he may not do a good job and then you'll wish that you had come back here.

MS. PANTAGES: Then we'll call you.

THE WITNESS: Right.

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BY MR. LEAK:
Q. Once again, they first thought she was a Stage IIIB?
A. B.
Q. And then the PET scan and biopsy confirmed Stage IV?
MS. PANTAGES: You are talking about 2003, right?
MR. LEAK: Yes, yeah.
THE WITNESS: Yes, yes.
BY MR. LEAK:
Q. Tell me how that played out. Why did they first think it was IIIB? Is it because of the pancreas, they didn't have --
A. Well, there were two lesions, weren't there? There was a pancreas lesion and then there was also a lesion down in the pelvis. And I think they may have been visualized on the CAT scan, but the nature of the abnormality was not clear to the people reading the original films, and so that's why you get a PET scan, because you are trying to define the extent of disease, and so then you go back and interpret the PET scan in the context of the CAT scan.

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Q. Any significance to the fact that she was diagnosed in June 2003 and passed away October 2003, on how quickly that happened?
A. You know, it's my impression that most people with Stage IV lung cancer die within six months to a year of time of diagnosis, and so I think that in fact is consistent with what my understanding of the natural history of the disease is.
So if you had said to me, do I think she could have Stage III or IV disease in 2001 and live -- that was the point I was trying to make before -- and live that long with no symptoms, it's unlikely.
Q. When we are talking about the survival rate, you put a percentage on that earlier in your testimony?
A. 80 percent, right? That's what you are talking about?
Q. Right.
A. Yeah.
Q. But you did not put that in your report. You just said she was a chance of cure which was better than 50 percent.

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A. That's correct.
Q. And now you are saying it's 80 percent?
A. That's correct.
Q. And then why didn't you put that particular number in your report the first time around?
A. I guess that's the report I generated, because I think -- my understanding is, to take a case and to move forward you have to show -- at least in California -- you have to show that the cure rate, if diagnosed appropriately, would be better than 50 percent. And so that's the bar that you have to meet to launch a case. Now -- so based on information I had, I felt it was reasonable to proceed, and I said better than 50 percent. I think I left myself some room in case there was more information that came to light, in case I learned something else that would alter my opinion, I could tighten it up.
Q. Let me explore that. So based on your experience as an expert, you were following the greater than 50 percent rule

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when you issued your report in terms of survivability?
A. I think what I put into the report was a general response that would meet the standard for what I thought was appropriate.
Q. Has anything changed in your review since November 2005 that you can now be more specific and render an opinion that it's 80 percent?
A. Well, I think there's no new information that came to light -- well, no, that's not true.
There's no new obvious information that came to light. I've learned about what the radiologists felt -- he thought they saw when they looked at it. I've reviewed the films in detail again with a radiologist that I've worked with here. And so I'm comfortable saying that it truly looks like a T1 N0 cancer, and the cure rate for that is 80 percent.
Q. I may have asked you this, but I want to pin down exactly where the 80 percent figure comes from. Any particular study? Is it your experience? I mean, are there

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different figures out there?
A. It depends how you arrive at it. I think the T1 N0, the cure rate is 80 percent. There are several studies that talk about operating on coin lesions, isolated little lesions in the lung. The specific reference I've referred you to is Nile Martini from Memorial Sloan-Kettering, so you can go look up his numbers. The question of the staging, though, that's people who are staged surgically T1 N0; so that's the most complete staging.
Q. Is that in the HACC cancer staging manual?
A. No. Their staging is a much more general staging, and so in fact when they talk about Stage I, they are talking about defined by chest x-ray, not by surgery, and II incorporates T2 lesions as well as T1 lesions, and so in fact, if you do that, then you get an overall cure rate that's lower.
Q. We discussed your -- you know, the extent of your opinions. I just want to make sure. You know the terms "causation"

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and "proximate cause." Have we covered all of your opinions relative to the proximate cause issues in this case?
A. I think so, yes.
Q. And of course, if you read anything in Dr. Ettinger's deposition, which I don't know when -- it's next week, the deposition?
MS. PANTAGES: Two weeks.
MR. LEAK: Two weeks.
MS. PANTAGES: Yeah.
MR. LEAK: Or if any issue comes up with the court where they are going to permit standard of care opinions, we may have to redepose you under those two circumstances.
MS. PANTAGES: Under which two circumstances?
MR. LEAK: If he changes his opinions after Dr. Ettinger's deposition if he reviews Dr. Ettinger's deposition and he changes anything, like you mentioned --
MS. PANTAGES: Well, I don't think you get to redepose him after your expert is deposed. I don't think there's anything --
MR. LEAK: No, I'm saying if he

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reads the deposition and tells you he has different opinions, that's what I'm asking.
MS. PANTAGES: Okay --
MR. LEAK: I think I've already --
MS. PANTAGES: You asked him if you and he have discussed the full extent of his proximate cause opinions.
MR. LEAK: Right.
MS. PANTAGES: And if I understand his testimony, his response was as he sits here today he's reserving the right to review Dr. Ettinger's deposition before he testifies at trial, which is clearly the way that it works and what he's entitled to do. I don't think that you are entitled to redepose him after he --
MR. LEAK: Oh, yeah. If he has a change of opinion. I'm sitting here saying if he's going to come into trial with a different opinion or changed opinion, I have every right to depose him again.
MS. PANTAGES: All right. I don't know that we're arguing about different things.
You asked him if you and he have

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discussed all of his opinions relative to proximate causation --
MR. LEAK: Right.
MS. PANTAGES: -- and he said yes.
THE WITNESS: Yes.
MS. PANTAGES: The only other additional information that he will get is he will have an opportunity to review Dr. Ettinger's deposition before trial, so that's the only caveat to his testimony.
MR. LEAK: Right. And I'm reserving my right under the circumstances if he tells you he has a change in his opinions or they are altered in any way, I have a right to rediscover those, because he's reviewing different materials.
THE WITNESS: If I suffer an epiphany.
MS. PANTAGES: Okay. Well, then I think we're splitting hairs but --
MR. LEAK: And then also --
MS. PANTAGES: -- you know, to the extent that they would be called upon --
THE WITNESS: You are done with me? You are going to fight this one out --

Reason for change:

Page No. Line No. Change to:

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Paul Goldfarb, M.D..