D102CV921651

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| **ELIZABETH** ANN DYKES **AND** JOE G. DYKES, JR. | * | IN THE DISTRICT COURT OF |
| VS. | * | BOWIE COUNTY, TEXAS |
| **COLLOM & CARNEY CLINIC, JOHN D. FISHER,** M.D. **AND ERIC HALL,** M.D. | * | 102ND **JUDICIAL DISTRICT** |

Doc. 266

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VIDEO DEPOSITION OF
MONTAGUE LANE, M.D.
**October 18, 1993**
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DEPOSITION OF MONTAGUE LANE, M.D.

taken on the 18th day of October, 1993 between the hours of 2:25 p.m. and 6:25 p.m., before Janet M. Canton, a certified Shorthand Reporter and Notary Public in and for the State of Texas, at the offices of Giessel, Stone, Barker & Lyman, 2700 Two Houston Center, Houston, Texas, pursuant to Notice, the Texas Rules of Civil Procedure and the stipulations of counsel.

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VIDEOGRAPHER:

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MR. TWINING: Would you like to read and sign your depo?
THE WITNESS: Always.
MR. TWINING: According to the Rules.

MONTAGUE LANE, M.D.
having been first duly sworn, testified as follows:

EXAMINATION

BY MR. ONSTAD:

Q. Dr. Lane, my name is Rockne Onstad. We have never met before, have we?

A. No, sir.

Q. How is it that you got involved in this case?

A. A call was received in my office. I believe the call had been made by Ms. Novick. My secretary, received the call -- this is, I don't know, about three weeks ago, two weeks ago -- requesting that -- whether I would be willing to review some records in a particular case. And I indicated yes, I'd be willing to review records.

Q. Were you asked specifically what to do in this case?

A. No. Because -- well, except in the letter, which

was to review the records and come to an opinion one way or another as to the allegations in the petition. That's what I presumed was requested.

Q. Did you bring a copy of that letter with you today?

A. Yes, sir.

Q. Where is it?

A. It's all here. All the letters are here.

MR. TWINING: It was in this first stack of materials we had labeled with the sticky note of No. 1.

Q. (By Mr. Onstad) All right. Let me kind of go through this stack. Lawyers have some legal process called a list of things they want the witness to bring, and did you review the list of things that you were requested to bring?

A. Yes, sir.

Q. And this item one is the materials that you have received for review in this case?

A. Correct.

Q. The stack -- let me go through them and make sure I've got it all right. It appears to be the deposition and exhibits of Dr. 'Alvin Cohn. Did you --

A. Yes, I got to review that yesterday for the first

time.
Q. You reviewed it all?
A. Yes, sir.
Q. You looked at the original mammograms?
A. Yes, sir.
Q. You looked at the report of Dr. John Martin?
A. I did.
Q. Do you know Dr. John Martin?
A. Not personally.
Q. Do you know who he is?
A. Yes.
Q. Do you know about his reputation?
A. Yes.
Q. Is it good?
A. Fairly good.
Q. Well, did he write a book called the Atlas of Mammography?
A. So they say, but I haven't read it.
Q. You haven't read it?
A. No, sir.
Q. Have you ever read any books on mammography?
A. I looked at some books on mammography.
Q. Can you tell me which ones they are?
A. I can't remember.
Q. The next item here is the deposition and exhibits

of Dr. Schapira. Did you read it?
A. I did.
Q. Do you know Dr. Schapira?
A. No, sir.
Q. Do you know of him?
A. No, sir.
Q. Is he at a major cancer center?
A. I'm sorry?
Q. Do you know if he has a position at a major cancer center?
A. Well, he lists that he's at the, I think, South Florida Cancer Center.
Q. Is that a major cancer center?
A. I'm not familiar with it firsthand.
Q. Do you know its reputation?
A. No.
Q. Are you at a major cancer center?
A. We don't identify ourselves as a cancer center.
Q. Are you at M.D. Anderson?
A. No, sir.
Q. Do you have privileges at M.D. Anderson?
A. No, sir.
Q. Have you ever practiced at M.D. Anderson?
A. No, sir.
Q. Is it a major cancer center --

A. It is.
Q. -- close to where you office?
A. Yes, sir.
Q. The next item I have is the deposition of John Fisher. Did you study it?
A. I did.
Q. The next item here is the CV or resume of Dr. Schapira, David Schapira. Did you study it?
A. I did.
Q. Has he published quiet a few articles in the area of breast cancer?
A. Yes.
Q. Have you published any articles specifically dealing with breast cancer?
A. Some.
Q. Are they listed on your CV?
A. They should be.
Q. And you looked at the deposition of Dr. Hillis?
A. Yes, I have.
Q. The deposition of Rex Thomas?
A. Yes.
Q. What do you --
A. Simmons.
Q. Oh, I'm sorry. I just read the first -- Rex Simmons. Who do you understand him to be?

A. I understand that he is the administrator at the clinic where Dr. Fisher was working at the time of the events.
Q. And you read the deposition of Dr. Eric Hall?
A. Yes, I have.
Q. Read the deposition of Tom Hillis?
A. Yes, sir.
Q. The report of Dr. Charles Hollingsworth?
A. Yes, sir. Plastic surgeon. Uh-huh.
Q. Looked at the records from Texas Oncology?
A. I have.
Q. More records from Texas Oncology, Looked at the records from Dr. Eichler?
A. Yes, sir.
Q. Records from Dr. Eichler. Looked at the deposition of John Fisher?
A. Yes, sir.
Q. This stack of paper just appears to be miscellaneous medical records from the Collum & Carney Clinic and medical bills dealing with Ann Dykes. I guess you read that stack of papers.
A. Yes, sir.
Q. And the deposition of Ann Dykes?
A. I did.
Q. And I have the correspondence you talked about.

It appears the earliest letter I see here is dated September 30th. Is that about when you got contacted?

A. I think that's about right. Well, I think the contact to my office was made by telephone earlier than that, but I don't recall the date because it was through my secretary.

Q. Okay. Is the September 30 letter the letter that transmitted to you the first materials to read and asked you to do whatever it was you were asked to do?

A. Correct.

MR. ONSTAD: Mark this correspondence as Exhibit 1, please.

(Deposition Exhibit No. 1 was marked for identification by the reporter.)

Q. (By Mr. Onstad) Now, item 2 here appears to be a fax copy; appears to be six pages and it's entitled Breast. Would you tell us what that is?

A. That's the staging classification of breast cancer of the American Joint Committee on Cancer, both the clinical and the pathological staging of breast cancer. I think this one was prepared in

1992.
Q. Is breast cancer staging pretty standardized?
A. Yes, sir. In this country, certainly.
Q. Do you believe that the item that you're looking at where it says Breast that you just described is a nationally recoqnized standard for staging of breast cancer?
A. I would say so.
Q. Where all is it published?
A. Well, it's a manual that's published by the American Joint Commission on Cancer, and sections of it, I think, appear in many of the standard texts on cancer. It's widely distributed and used by most registries including the registry at the hospital which I work, Methodist Hospital.
Q. Did you rely upon it in the formulation of your opinions?
A. Yes, I do.

MR. ONSTAD: Mark that as Deposition Exhibit 2.

(Deposition Exhibit Nos. 2 and 3 were marked for identification by the reporter.)

Q. (By Mr. Onstad) Deposition Exhibit 3 appears to be an invoice for your services in this case up to this point.
A. Yes, sir.
Q. Did I state that correctly? Is that what it is?
A. That's correct.
Q. Your charges are $400 per hour for reviewing materials?
A. Yes, sir.
Q. Is that what you charge in all instances for reviewing materials?
A. Essentially.
Q. Are there occasions when you charge more?
A. Generally not for materials to review.
Q. Are there occasions when you charge less?
A. In the past.
Q. Who is Mr. Giessel? I see on the 3rd you had a meeting with Mr. Giessel and you charged $800.
A. Yes, sir.
Q. Who is Mr. Giessel?
A. Mr. Giessel is an attorney with this firm.
Q. Do you know him?
A. I didn't know him before I met with him.
Q. Okay. And what did you do at that meeting?
A. I reviewed the case with him. As the initial

letter indicated, it was of great urgency to review this case and prepare -- if I had an opinion as to the facts of the case -- prepare for an early deposition. And there was some materials that I had not had available. I tried to -- I had this material to review over a weekend. They actually indicated an extreme urgency in preparation for this deposition. since they were materials that I needed, I attempted to reach both Mr. Barker and Mr. Twining that weekend and could not. And eventually I did reach Mr. Giessel and he said he would come and meet with me, review what it was, and activate as soon as possible my requests.

Q. Do you know Dr. Alfred Watson?

A. No, sir.

Q. Do you know -- you don't know him to be a radiologist at Baylor with a special emphasis on mammography?

A. No, sir.

Q. Did you meet with any radiologists to go over the mammograms in this case?

A. Yeah. Not to go over them. I just showed them to one radiologist after I had formulated all my opinions. I thought they were interesting and I

wanted to show them to him.
Q. And who was that?
A. That was Dr. Doug Rutherford.
Q. First name?
A. Doug. D-O-U-G.
Q. Rutherford?
A. Yes. Uh-huh.
Q. Where does he work?
A. Methodist Hospital.
Q. Does he have a special emphasis on mammography?
A. He does a lot of mammography. Uh-huh.
Q. Do you read mammograms professionally?
A. Well, as a physician, I read mammograms. When you say professionally, do I report mammograms as part of my activity, the answer to that is no,
Q. Okay. Let me break it on down. I guess when I said professionally, it wasn't a very good word to communicate what I was thinking.
Do you get paid by patients to read their mammograms?
A. No, sir.
Q. Does anybody pay you to read mammograms?
A. No, sir.
Q. Do you report mammograms?
A. No, sir.

Q. Have you had any specialized training in how to report mammograms?
A. No, sir.
Q. Do you know what the American College of Radiology has said in the past five years about reporting mammograms?
A. I have read their recommendations.
Q. Well, I have them here. Which recommendations have you read?
A. I've read the recommendations. I can't tell you exactly which, but I -- for -- that are generally followed, I think, in their approach to the certification of institutions as mammography centers.
Q. Have you ever been involved in certification of institutions as mammography centers?
A. Not personally.
Q. Is your charge for giving deposition testimony $400 an hour?
A. Yes, sir.
Q. So these charses --
A. Oh, I'm sorry. For deposition testimony?
Q. Yes, sir.
A. No, sir. That's 600 an hour.
Q. So right now you're making $600 an hour?

A. That's correct.
Q. So your charges from October the 2nd through October the 17th for reviewing materials in this case and for talking with lawyers has been $9,200?
A. That's correct.
Q. Did the lawyers that hired you in this case tell you that they had had these mammograms reviewed by a radiologist before they retained you?
A. Not that I recall. As far as I know, the only radiologist who looked at these mammograms was Dr. Fisher.
Q. Did they tell you about Dr. War, the radiologist that replaced Dr. Fisher?
A. No, sir.
Q. Did they tell you he gave a deposition in this case?
A. No, sir.
Q. You obviously haven't read what Dr. War said, have you?
A. No, sir.
Q. Did you ask the lawyers that retained you in this case had they provided you with all the deposition testimony in this case?
A. I assume -- No, I did not. I assumed this was

all.

Q. Here's what I'm getting at pointblank without beating around the bush. If you're going to give a professional opinion about a matter, wouldn't you want to know and review all the testimony of everybody that has reviewed the facts and testified about them, or would you just want to have somebody else select it for *you* and then give your opinions based upon selected materials?

A. That's a very generic question. It varies. There may be enough materials for me to make up my mind on my own.

Q. Wouldn't it be interesting to you to know what a radiologist at the Collum & Carney Clinic said about the mammograms and the report?

A. It might be interesting, but it might not be helpful.

Q. Okay. Do you actually treat patients with breast cancer?

A. Yes, sir.

Q. What percent of your time is spent treating breast cancer patients?

A. Well, of my clinical activities, I would say breast cancer probably is the largest single subset of cancer patients that I treat. Probably

breast and lung are the two largest. They'd be pretty close. I think probably a little in favor of breast.

Q. I appreciate that answer, but my question was: What percent of professional time is spent with dealing with breast cancer patients?

A. Professional time has to be defined for me as well, if you don't mind.

Q. Whenever you're functioning as a physician.

A. Well --

Q. In charging fees, professional fees for functioning as a physician.

A. I would guess it's about 20 percent. It's very hard for me to quantitate it off the top of my head.

Q. Are you employed by Baylor College of Medicine?

A. Yes, I am.

Q. Are you paid a salary by Baylor College of Medicine?

A. Yes, I am.

Q. Are you paid $400 an hour by Baylor College of Medicine?

A. No, sir.

Q. I don't mean to be really prying that much, but what I'd like to do is find out how your time is

spent for Baylor, being paid by Baylor, what your hourly rate would be versus when you're reviewing matters for lawyers.

A. Well, I don't know that that's a terribly fair question, because what I get paid by Baylor College of Medicine relates only to my activities as a professor of the Department of Pharmacology. It does not relate to my practice.

Q. All right. So your salary source would be a salary from Baylor --

A. That's correct.

Q. -- out of the Department of Pharmacology?

A. That is correct.

Q. Then you have an additional source of income, and that is from seeing patients?

A. That's correct.

Q. And they're independent?

A. That's correct.

Q. You charge patients $400 per hour?

A. No. Well, again, it depends on the setting. I say the amount of return in an hour can be anywhere from $250 to $400, depending on the setting.

Q. Which setting would precipitate 250 an hour versus 400?

A. Excuse me. I'm sorry, I didn't mean to interrupt. That would be a consultation fee for an hour's consultation.
Q. Under what circumstances would you get $400 an hour for consulting with a patient?
A. That's -- would be derived from multiple patients as a consequence of hospital rounds or seeing patients in the office. And there it's a question of, you know, how many patients are seen over what period of time. That would be a, I think a fair representation of that.
Q. When you read Dr. Fisher's deposition, what did you learn his clinical impression was after he reviewed the mammograms that were taken on July 25, 1989?
A. Well, I'm sorry, that's sort of a mixed question. I learned what his clinical impression was when I read his report. I mean, that portrayed to me what his clinical impression was.
Q. Well, --
A. The -- 1/11 leave it at that.
Q. Let me tell you why I asked this question. Again, I'm not going to come at you from an angle, I'm going to come straight at you. Until we took his deposition, I wasn't sure what his

interpretation was. We only knew what he wrote in the report. And I guess, unless you talked to him or read his deposition testimony, then all you'd be able to say is he must have been thinking what he wrote in the report. Is that what you did?

A. Well, it was not my job to read Dr. Fisher's mind.

Q. Is what?

A. I wasn't trying to read Dr. Fisher's mind. I was trying to read his report. Now, in the deposition, there are several things that Dr. Fisher has said, and I'd be happy to refer to them. But I came away with the eventual impression that -- I had the same impression from his deposition that I had from reading his report; namely, he had made an indeterminate, in my mind, an indeterminate approach to the reading of the mammography. Namely, there was no special suspicion one way or the other as to what the significance was of several, as I recall, patchy densities in both breasts.

Q. Well, don't you know he thought there might be a tumor present?

A. Well, you have to look at the whole deposition in

context. I think you could select a portion out where he says something that sounds like that, but there's another portion where he says it's indeterminate. So that's why what he's saying on the deposition, I'm not sure which of his comments reflect what he was thinking. And I just, therefore, have to evaluate the report on its own merits, what I would think had I received such a report from a radiologist.

Q. Don't you recall that on Page 35 -- in fact, let me get it out because I think we're going to eventually get to it.

Here's Dr. Fisher's deposition, In fact a copy you read. Look at Page 35, beginning on Page 35, Line 15.

MR. ONSTAD: Have you got those mammograms handy, Kent?

MR. TWINING: Originals --

A. Okay. I'm sorry, 35, Line 15.

Q. (By Mr. Onstad) Don't you recall that at that point in time we had just got through talking about the original mammogram, Plaintiff's Exhibit 1 and Plaintiff's Exhibit 2, and he just got through marking red marks around --

A. Uh-huh.

Q. I'm going to hold it up in front of the camera. Marking the red marks around the area that he was referring to when he said --

MR. ONSTAD: Mr. Video Operator, are you awake? Zero in on this.

THE VIDEOGRAPHER: It's on it.

Q. (By Mr. Onstad) I'm holding up Plaintiff's Exhibit No, 2. And these little red marks that Dr. Fisher put around there and said that was the area he was talking to when he said a mass lesion cannot be ruled out, and he did the same thing on Exhibit No. 1?

A. Yeah. Of course, he says he can't rule one either.

Q. Do you remember that? Then I asked him, right there it says, and the word mass lesion means it's another word for saying tumor? And he said, yes, sir.

.I said, so what you're basically saying is there might be a tumor there?

And he says, yes, sir.

Is that pretty clear to you?

A. Is what pretty clear to me?

Q. That he's saying there might be a tumor there.

A. Yeah. He's also saying there may not be a tumor

there.
Q. Where does he say there may not be a tumor there?
A. So you're basically saying that there might be a tumor there?
Yes, sir. But I can't say -- but I can't say there is not. Yes, I can't say a hundred percent yes or a hundred percent no.
So, that's how I interpret it.
And you've got to be careful about the use of the word tumor. Tumor doesn't mean cancer. Tumor just means something.
Q. You were talking so fast that I couldn't catch up with you, so let's go back through there to make sure I understand what you're saying.
What were you just reading from?
A. Well, I'm reading from the page you were on which said -- you said in the first portion of this page, means it's another word for saying tumor?
Yes, sir.
So what you're basically saying is there might be a tumor there?
Yes, sir. But I can't say there's not. Yeah, I can't say a hundred percent yes or a hundred percent no. It is something that needs to be investigated. You agreed.

What I'm saying further is that tumor and cancer are not synonymous words. Just density.

Q. Okay. So you recall what he said on Page 48 of his deposition?

A. 48?

Q. Yes, sir.

A. I have to turn to it, if I may.

Q. Go ahead. It's right in front of you.

Right there on Page 48, Line 6 he says, I was suspicious. I said, I asked him, you weren't suspicious of cancer? He said no, I was suspicious. That's the reason I mentioned in the report that a mass lesion or a mass can't be excluded.

You take that to mean that his clinical impression was he was suspicious for cancer or do you take it to mean something else?

A. Well, he's as suspicious of cancer as he is that it's not cancer, as I recall later in the deposition when he was examined by Mr. --

Q. I'm going to let you do that, but let me just ask you right now, didn't he just say --

MR. TWINING: Let him finish. He needs to finish his answer. Let him finish his answer.

A. I'm sorry, there is a cross in here.
Q. (By Mr. Onstad) I didn't ask you about that. Your answer would be nonresponsive and I will make an objection to that part. But if you want to go ahead and give it at the present time, go ahead.
A. I just want to find it -- or 1/11answer your question at this time.
MR. TWINING: I think it's around Page 80.
THE WITNESS: 80?
MR. TWINING: Yeah.
THE WITNESS: Thank you.
MR. TWINING: That's where I started picking it up.
MR. ONSTAD: Object as nonresponsive.
THE WITNESS: Mr. Polewski, that's who I was looking for.
MR. TWINING: Are you looking for the beginning of his examination?
THE WITNESS: No, I'm -- Yes, I have what I want. Okay. Thank you.
A. Now, I'll try to answer your question. I'm not trying to be evasive. Go ahead, sir.
Q. (By Mr. Onstad) . What I'm really trying to find

out is if you get the same reading from this deposition I did. We're going to show it to the jury, it sounds like, in great detail, and I'm focusing you on those words where he said he was suspicious. And on Page 48 I asked him a negative question. I said, you weren't suspicious of cancer. He says, no, I was suspicious. That's the reason I mentioned in the report a mass can't be excluded.

And I'm just asking you: In your review, did you take that to mean his clinical impression at the time he looked at and studied this mammogram he was suspicious for cancer?

A. Well, sir, to answer that question, if one reads. Page 48 alone and without the rest of the deposition I would say yes, he said he was suspicious. But that doesn't mean -- he doesn't say how strong his suspicion was. He said he was equally suspicious that it wasn't, in my estimation. And the reason I say that relates to his comments later when questioned by the other attorney here, Mr. Polewski, cross examination, where he says he had no -- it was indeterminate, He says he finds these patchy densities and he said they should have raised a red flag. But

then when you get down to what the flag is, the flag is on Page 80; no, I didn't see any definitive evidence of carcinoma or I would have caught it. I saw findings, you know, that are indeterminate and could go either way.

But all you said about that is that a mass lesion cannot be definitely excluded?

Right.

Now, Doctor, it's a fact, isn't it, that mammograms can't catch all cancer?

That's for sure.

So, I mean, his reading and his comments, I think to me, represent the fact that he had what I would call an indeterminate mammogram. He is reading exactly what he said and he is not giving any weight to yes, it's suspicious for cancer and no, it's not suspicious for cancer. Where a cancer doesn't appear, he says a mass lesion cannot be excluded. And he finds lesions in both breasts which, again, doesn't suggest any predominant mass. That's my estimate of this deposition.

MR. ONSTAD: Objection, not responsive.

Q. (By Mr. Onstad) Don't you recall that Dr. Fisher

was of the opinion of whatever it is that he was seeing, it needed to be followed up?

A. Well, I don't know if he has the -- I didn't come away with that. And it wouldn't be, as I indicated here, as I understood it here, he states that his role as a radiologist is to report what he sees. And that is the role in which I hold a radiologist. If he felt that it should have been followed up, he should have said so. I think the question of follow-up based on a report, in this instance, would depend upon the referring clinician. If the referring clinician, based on his clinical impressions of this patient and then his report of the mammogram, thought . . something else ought to be done, then I think he should have considered doing it. But obviously it seems to me that as a radiologist, he was not in the position to say it should be followed up or shouldn't. He said that she had basically some vague densities in both breasts, and there was no mass lesion that could be included or excluded, and that the calcifications were not particularly suggestive of cancer. And he left it at that. I think the decision about how important that reading is or not should lie with

the physician who ordered the tests.

MR. ONSTAD: Objection, not responsive.

Q. (By Mr. Onstad) You know on Page 56 at Line 21, right after talking that the clinician had come down and asked you what you meant, and we went through a dialogue of explanation, I asked him the question: What if the clinician says well, what do you mean? Could it be cancer? And the answer was yes, he thought it could be cancer. Do you take that to be what he thought?

A. You haven't completed the statement, in all fairness. He says, what if the clinician says, well, what do you mean? Could it be cancer?' Answer, yes. And if he says, well, show me what you're talking about that might be cancer. Would you point to those? I would point to all of those that I had marked on the right breast as well as about three or four in the left breast that look similar. And if he says, well, what do you think I ought to do? I mean, if these could be cancer, what should I do, what would you tell me? I'd tell him he needs to go by his clinical exam, and if there's any suspicion, get follow-up mammograms. I mean, that's just the point.

Any one of these nondescript shadows, and that's what you're looking at, you're not looking at masses, you're not looking at cancers, you're looking at shadows of those breasts. And all of them could be equally suspicious or nonsuspicious, because none of them had what is considered to be diagnostic features or strongly suspicious lesions, changes pointing to a breast cancer. And obviously there aren't going to be seven independent cancers in the breast of this asymptomatic woman in my opinion.

MR. ONSTAD: Objection, not responsive.

Q. (By Mr. Onstad) Do you recall that Dr. Fisher was of the opinion that his report in fact sent up a red flag of suspicion for cancer?

A. That's not what he said, sir, as I recall. I read the red flag business. I'm happy to read through it again, which was somewhere around Page 80 when we talked about red flag. The red flag was that it could be something or it couldn't be something. Precisely what he said.

MR. ONSTAD: Objection, not responsive.

Q. (By Mr. Onstad) Why don't you look at Page 63,

Line 19. Question, it reads: Let me go back to the mammogram of July 25, 1989. Is it your position that your report sent up a red flag of suspicion €or cancer?

Answer: Yes, sir.

What does that mean to you?

A. Well, it means in -- what he said there, yes, there is some suspicion. On the other hand, there was extensive discussion about red flags on .Page 79. And if I may read those, some patchy densities are visualized within both breasts which are due in part -- at least in part to the above-mentioned findings. However, a mass lesion cannot be definitely excluded from either breasts on this study.

Now, is that the sentence that you think should have raised the red flag?

Yes, sir.

Is there any other sentence in your report which you think should have raised a red flag?

No. That was a flag raiser there.

That's it though?

Yes, sir.

And you've already testified you didn't have any other discussion or communication with

Dr. Hall concerning your findings on these mammograms?

Not that I recall.

All right. Read for us the last sentence in your report.

No definite abnormal calcifications suggestive of carcinoma are visualized within either breast.

Okay. And you're saying that you don't see anything definite which is even suggestive of carcinoma?

No. All I'm saying is that there's no calcifications in there plus -- calcification or sign of carcinoma, but they're not the only sigh.

Well, at any rate, you didn't see any that were suggestive of carcinoma?

No, I didn't see any definitive evidence of carcinoma or I would have caught it. I saw findings, you know, that are indeterminate and could go either way.

But all you said about this -- that is that a mass lesion cannot be definitely excluded?

Right.

Well, you know, if that's a red flag, the flag is that this is, to me, an indeterminate

mammogram with non-specific changes. And then the clinician has to determine, based on his clinical impressions, as to whether this requires further evaluation or not. That's as red flagging as I get from it.

MR. ONSTAD: Objection, not responsive.

Q. (By Mr. Onstad) What is your understanding of what Dr. Fisher's clinical impression was before he wrote his report?

A. I have no idea what his clinical impression was before he wrote his report. That was in his head.

Q. Maybe I didn't ask my question very clearly. What do you believe Dr. Fisher's clinical impression was after he was finished examining the mammograms and just before he dictated his report?

A. Sorry. I don't have that kind of insight as to what was going on in Dr. Fisher's head. I only have his work product which is his report to evaluate. That's all I have from anybody who writes a report, not what's going on in his head.

Q. Well, do you agree with me that the report should accurately reflect what was going on in his head?

A. I think the report should accurately reflect what his readings or impressions were of what he was doing. I don't know what you mean by going on in his head. He may be thinking about dinner that evening. I don't know what's going on in his head means. All I know is that the report is what he felt he was seeing. That was his professional impression of what he was looking at.

MR. **ONSTAD:** Objection, not responsive.

Q. (By Mr. Onstad) In your experience, is there a commonality between pathologists and radiologists to the extent that both of them examine evidence looking for cancer and that they are required to clearly report to others if they see any evidence of cancer?

A. Well, that's a very complex question and that's not what they do. They report what they see. Basically they report what they see. It may have to do with cancer, it may not have to do with cancer. But each observer in each specialty is supposed to accurately report what he sees or what she sees, whoever is doing it.

Q. In reading mammograms, is it your understanding

that one of the things that the radiologist is looking for is evidence of cancer?

A. No, sir. I don't think so. I think what you're looking for is an interpretation of shadows or radiographic findings that may suggest any number of things depending on their configuration and what experience in mammography has shown to suggest something. But the diagnosis of cancer has to be based on pathological findings, not on mammographic impressions.

MR. ONSTAD: Objection, not responsive.

Q. (By Mr. Onstad) If a radiologist reviews a mammogram, and after the review of the mammogram. is suspicious of cancer in the patient, do you know what the standard of care is for a radiologist in reporting that suspicion?

A. Well, I think the answer to that in general terms is yes. Yes, I'm generally familiar with the standard of care. I couldn't state it the way a radiologist might state it perhaps.

Q. Where did you learn the standard of care for radiologists in reporting suspicion of cancer?

A. First of all, I have a broad knowledge of that through my role as director of the mammography

screening program for female employees at the Methodist Hospital which embraces some 6,000 women employees. And of course in this arena, have conversed repetitively with our radiologists and with what is expected from them in their reporting in these asymptomatic individuals that are being screened. So I have some concept of standard of care.

Q. Is mammography in that program used as a screening tool for the early detection of cancer in women?

A. That's correct. In asymptomatic women; that is, women who have no symptoms or findings.

Q. When you say a screening tool, that means that it's some sort of a machine that images tissue in the breast?

A. In general that's correct. Uh-huh.

Q. And then the radiologist looks at the film that's printed like these mammograms here that we've got marked as Plaintiff's Exhibit 1 and 2, and then he studies them and forms opinions about what they show. Is that true?

A. Well, first he reports his -- he should report his findings objectively. That's his first job. And then secondarily to that he then indicates

what his opinions might be. And of course his opinions will depend on what he has diagnosed as the changes of the breast.

Q. If a radiologist after examining a mammogram and after he reports his findings objectively is of the opinion that there is a suspicion of cancer, do you know what the standard of care calls for in the type of words that are chosen to report the opinion of suspicion of cancer?

A. I think I do.

Q. What is your understanding?

A. Well, he should indicate his degree of suspicion of cancer and on what he bases this opinion. For example, because I see a cluster of microcalcifications, an abnormal cluster, so many, so many microcalcifications in a certain way in association of perhaps some increased density in the area, I would be suspicious of the possibility of a neoplasm in this area. He might also say that there are other calcifications in the breast that appear to be nonmalignant. So he has -- he would indicate his degree of suspicion of cancer based on his findings. And he should not mince the word cancer.

Q. should not what?
A. Should not hesitate, shouldn't hedge on the word cancer if he thinks there may be cancer there, if he feels strongly that there's cancer. You know, if he strongly is of the impression that the findings are sufficiently diagnostic in his mind to suggest a cancer, he should so state.
Q. so what you're saying is if he has a suspicion of cancer, he should use the word cancer?
A. It depends on his degree of suspicion. If he has -- it could be any number of things and he's not thinking that it's a cancer or it isn't a cancer, there's nothing diagnostic or -- the findings have to fit into certain categories that create suspicion. For example, if you look at the report of December the 9th, as I recall, 1990 -- was that the date -- or somewhere in December 1990, by Dr. Fisher where he noted the stellate type of changes or spiculated what he thinks might be mass lesion, that type of finding is sufficiently suspicious for him to use the word, I am suspicious for cancer, because of that particular configuration. I don't mean there's a cancer there, but it's stronger, much stronger as a finding. And the radiologists know how to

interpret each of these findings than saying I see some vague densities in both breasts. So that's how -- in that instance, he uses the word carcinoma and/or cancer. And suspicious for -- and even then he has a disclaimer on the bottom which says, you know, it may or may not be and so forth. You have standard disclaiming language.

So yes, I understand when they use such language that that means -- that means look into it. It doesn't mean there's a cancer. That means they're suggesting you look at this,

MR. ONSTAD: Objection, not responsive.

Q. (By Mr. Onstad) If a radiologist writes in his report any degree of suspicion of cancer, do you believe it should precipitate further investigation by the attending physician?

A. Not necessarily. That's a function of the clinic -- the clinician's expression or. impression of the clinical situation of the breast, the age of the patient, prior breast history, and then perhaps a discussion with the radiologist to see, you know, what is this degree, is this a one percent chance that this might be an abnormal finding or is this a

percent chance. Even with definite mass lesions, definite mass lesions without microcalcifications, only about 70 percent of those turn out to be positive. That's with a definite mass lesion.

So just because he says, you know -- there almost always is a vague suspicion that anything could be cancer. That's what the nature of mammography is. Because you're looking at shadows. It's a question of the degree of suspicion. All of this has to do with the degree of suspicion in the mind of the mammographer, period.

MR. ONSTAD: Objection, not responsive.

THE WITNESS: May we break so I may have a glass of water, sir?

MR. ONSTAD: Sure.

THE WITNESS: Thank you.

(Brief recess)

Q. (By Mr. Onstad) To kind of recap, move on, I just want to make sure my notes are accurate and I have a clear understanding where you are.

At that point in time after Dr. Fisher reviewed these mammograms that were taken on July 25, 1989, and just before he dictated his report that ultimately became his report, you don't have any idea what his mental impressions were on the issue of whether there was any evidence of cancer, do you?

A. That's correct. I do not.

Q. Now, are you here on behalf of Dr. Fisher?

A. No.

Q. Who are you here on behalf of?

A. The truth.

Q. Well, who's retained you? Was it Dr. Fisher's interest that retained you? I mean, I didn't retain you, did I?

A. No. Mr. Barker retained me.

Q. Do you know who he represents?

A. He represents Dr. Fisher.

Q. If you wanted to know the truth, wouldn't you want to talk to Dr. Fisher?

A. Well, Dr. Fisher is only a minor part of the case. I don't know that I have to talk to him. I have his record, you see.

Q. We're talking --

A. What he has to say or what a lot of these people

say has nothing to do with the truth and with what the facts are. And I think the facts and the medical facts determine what the realities of this case are all about. So Dr. Fisher may later say one thing, he may later say another thing. That doesn't mean, you know, what his thinking was when he wrote that report. Now, frankly, I don't think this report is that important in this case.

MR. ONSTAD: Objection, not responsive.

would you read the question back?

(Thereupon, the following question was read by the reporter:

"Question: If *you* wanted to know the truth, wouldn't you want to talk to Dr. Fisher?")

Q. (By Mr. Onstad) If you wanted to know the truth of the matter of what Dr. Fisher was thinking after he studied the mammogram and before he wrote his report, do you agree the only source of that would be talking to Dr. Fisher?

A. I don't know how to answer that question. To me,

the truth of what Dr. Fisher was thinking is what he wrote in his report. As a physician, that's all I can interpret as the truth of any report that I see, unless, of course, the report was erroneous or the study was erroneous. But the report given as a subjective report, if it's typed accurately, it reflects to me what the thinking was of that person, in this case Dr. Fisher, not what he thought before or what he thought later.

Q. Well, would you agree with me on this point: The report should reflect what the radiologist was thinking after the examination of the film?

A. Oh, I agree with that, sir.

Q. All right. Have you ever seen circumstances where the radiologist was thinking suspicion of cancer but failed to say it in the report?

A. Well, I don't know. I wouldn't know that.

Q. Never seen that before?

A. I don't think so. If I have, I wouldn't have recognized it. All I know is what the report says. Everybody has 20/20 hindsight.

Q. Well, on that point, do you agree that Ann Dykes in fact had breast cancer?

MR. TWINING: When?

A. Ever?
Q. (By Mr. Onstad) At any time. Ever.
A. Of course she had breast cancer.
Q. When was the diagnosis made?
A. It was made at the surgery following the mammogram in December of 1990. I don't recall the exact date that it lists Dr. Hillis performed that surgery.
Q. Are mammograms used from time to time to guide the surgeon as to where the tumor's located?
A. Yes, sir, they certainly are.
Q. And have you ever looked at a mammogram for the purpose of determining where within the breast the tumor is located?
A. Yes.
Q. And these mammograms that are done on December 1990, can you see the tumor on Plaintiff's Exhibit No. 6 that I just handed you?
A. No, I can't see a tumor there.
Q. Can you see where the tumor's located?
A. No. I can see some shadows there,
Q. Can you see a shadow that in all probability represents the tumor?
A. Some part of it might.
Q. Can you put your finger on it?

A. Not which part will tell me where the cancer actually is in the shadow, because the abnormality of the shadow is considerably in excess of the size of the tumor.

Q. Doctor, I took the liberty to prepare for this deposition by going and getting this book called Atlas Of Mammography written by Dr. John Martin. I bought it over at Major's Book Store out in the Texas Medical Center. Have you ever seen that book before?

A. Probably I've seen it on the radiology shelf, may have glanced through, but I've never read it.

Q. Do you own it?

A. No, sir.

Q. You see on Page 101 where it shows a good example of a stellate carcinoma? Can you see it?

A. He has it labeled as such. Uh-huh.

Q. Do you recognize it as such?

A. I recognize it as a stellate shadow within a breast on a mammogram which may well contain a carcinoma in it.

Q. Okay. Doesn't it look almost identical to the shadow on Plaintiff's Exhibit 6?

A. Not at all.

Q. You don't --

A. It has some -- it has some vague resemblance to it. You see, we're talking about terms here that are very important. When you say shadow, now I'm agreeing with you. This is what looks like a shadow that suggests the possibility that there may be some abnormality such as a cancer in it. But since this shadow's been measured by several radiologists as two and a half cm, 2 cm, 3 cm by 2 cm, and we know that the cancer that was eventually detected here was 1.2 cm, no one can tell you exactly where in relationship to this configuration the cancer is actually located. So what part of that shadow eventually constituted the cancer is uncertain. So I don't see a cancer there. I see an abnormal configuration in a mammogram highly suspicious that there may be a cancer in that location.

MR. ONSTAD: Objection, not responsive.

Q. (By Mr. Onstad) Did you form an opinion as to when Ann Dykes' cancer first began growing?

A. No, sir.

Q. Did you form an opinion as to how often it divided?

A. I think that's indeterminate, sir. The answer is

no, sir.
Q. You have no opinion?
A. No, sir. I have some opinion in a very general vein.
Q. What are your general vein opinions?
A. Well, see the -- I suspect this had been an extremely slowly evolving cancer, even by Dr. Schapira's estimates of its size in July of 1990, and what we know to be its size in December of -- I'm sorry, July of 1989 and December of 1990. The reason it's difficult to come up with an opinion is that in order to calculate the growth rate of a tumor, you have to know its exact size at two separate points in time. And we only have its exact size in December of 1990. The rest is conjecture.

MR. ONSTAD: Objection, not responsive.

Q. (By Mr. Onstad) What kind of cancer was it histologically?
A. Moderately well differentiated infiltrating ductal carcinoma.
Q. Of what type of tissue?
A. Of the breast.
Q. What does moderately well differentiated mean?

A. That terminology is used as a descripter by pathologists to tell us the degree to which the cancer structurally histologically resembles or does not resemble normal breast tissue so that at the one extreme you have a well differentiated carcinoma, and at the very other end you have an undifferentiated carcinoma, and in between you have various degrees of differentiations such as moderately well differentiated, moderately differentiated, poorly differentiated, undifferentiated.

Q. Does the degree of differentiation usually indicate how rapidly the cells are dividing?.

A. In part. It's just a very indirect index of . . that. It's an index. The issue is not, by the way, how rapidly the cells are dividing, it's how rapidly the tumor is growing. And those are only indirectly related. It depends on the growth factor.

MR. ONSTAD: Objection, not responsive.

A. That's very responsive, sir, if you don't mind my saying so. That's right on the ball.

MR. ONSTAD: Objection, not responsive.

Q. (By Mr. Onstad) What does the literature indicate the range of cell division time is for a moderately well differentiated ductal cell carcinoma of the breast?
A. I'm not sure that the literature subfractionates out moderately well differentiated carcinoma of the breast. It gives a range for it.
Q. What is the range that the literature says?
A. For what?
Q. Cell division time.
A. For what?
Q. For a moderately well differentiated ductal cell carcinoma of the breast.
A. I'm unaware -- I'm responding to that, sir. I told you once. I am unaware of any literature that separates out moderately well differentiated carcinoma of the breast with respect to a range of division times. Now, in general, most of the literature merely refers to adenocarcinoma of the breast and gives a range for all adenocarcinomas of the breast that have been studied. Now, if you want me to tell you what Dr. Schapira's measurements would indicate that the doubling time of this cancer is, I'll be happy to do that for you based on his determinations of tumor

size. As they say, you've got to have two sizes, beginning and end point in between to determine the rate of growth of the tumor. It's hard to do if you only have one point. Like determining the rate of anything. If you know something's going 80 miles an hour, you don't know how long, you know, what distance it covered, unless you knew that that rate was constant or what the beginning point was, how much distance was covered. But if you'd like me to do that with Dr. Schapira's measurements, I would be happy to do that.

MR. ONSTAD: Objection, not responsive.

Q. (By Mr. Onstad) Did you look at Dr. Schapira's reports?

A. I certainly did.

Q. Did you note what Dr. Hall said about them?

A. I'm sorry?

Q. Do you know who Dr. Eric Hall is?

A. Eric Hall?

Q. Right.

A. Was the gynecologist who saw Mrs. Dykes and sent her for initial screening mammogram in July of 1989.

Q. Do you think he'd have some familiarity with the

patient?
A. Sir?
Q. Would you expect him to have some familiarity with the patient?
A. I'm sorry, you lost me. You started with Dr. Schapira then you switched --
Q. Dr. Hall.
A. -- doctors.
Q. Do you think Dr. -- would you expect Dr. Hall to have familiarity with the patient?
A. He examined her. And the answer would be yes, I would expect him to.
Q. Would you expect him to be familiar with the care she had received both before the diagnosis of cancer and after the cancer was diagnosed and treatment commenced?
A. Well, I don't how to answer that, sir. I don't know.
Q. I'm just asking --
A. The degree of familiarity would depend on the degree which he was involved with her care subsequently. So I don't understand your question.
Q. Have you ever given depositions before?
A. Yes, sir.

Q. On approximately how many occasions?
A. I don't recall. It's been a number of times.
Q. What's your best estimate?
A. I don't keep track of them. I don't know. You know, I've been in medicine a long time.
Q. More than ten?
A. Probably. Oh, yes, I would say so.
Q. More than 20?
A. You're going to start with the numbers, and I can't tell you exactly how many over what period of time. You know, I've been doing -- practicing medicine 41 years.
Q. Well, how many did you give in 1993?
A. I have no -- in '93?
Q. Yes, sir.
A. I can't even remember that exactly. I would say probably three or four at most.
Q. Did you make any court appearances?
A. In '93? You mean as an expert in behalf of somebody?
Q. Yes, sir.
A. I'm trying to remember. I think I may -- I don't remember if I appeared at the end of '92 or beginning of '93 one time.
Q. And the three to four depositions you gave in

1993, who were you working for?
A. I don't know what you mean by that, who I was working for.
Q. Who paid you?
A. Attorneys.
Q. What attorneys?
A. Oh, I don't remember the cases exactly. I know the one case we're referring to there was a case of David Livingston.
Q. David Livingston?
A. Was the attorney.
Q. He's the one that hired you?
A. Yes.
Q. What kind of case was it?
A. The case involved a physician who actually had been treating a patient in an adjuvant setting for breast cancer and the patient had a stroke, And the question was, was there any way that this physician could have anticipated the stroke based on what happened in his care of this patient and was there anything that could have been done to prevent it or ameliorate it, so forth.
Q. What about the other two to three cases? Who retained you?
A. I don't remember. I really don't remember.

Q. Were they lawyers that were representing the doctors or were they lawyers who were representing the party bringing the lawsuit?
A. I would say of -- the deposition cases were all representing physicians,
Q. Sir?
A. Representing physicians.
I had several cases that I was evaluating for the plaintiff's attorneys, but they have not come to deposition.
Q. Let me just stay with '93. All of your depositions given were on 'behalf of lawyers., representing doctors. Is that correct?
A. Well, I wouldn't put it that way. I would say I was hired by or paid by attorneys. The attorneys were representing physicians, and I was acting as an expert on the evidence that was presented to me.
Q. Okay. I'm just trying to be clear. You were hired by the lawyers representing doctbrs in all the cases you gave testimony in in 1993. Is that correct?
A. Correct.
Q. How about in 1992?
A. Virtually all the work I do is in behalf of

defendants. I have done some plaintiff's work, but relatively little.

Q. When was the last time you did anything on behalf of a plaintiff?

A. I think in 1989, thereabouts.

Q. Who was the lawyer?

A. His name was Mr. Wynne.

Q. Who?

A. Mr. Wynne, W-Y-N-N-E. He was from Arkansas.

Q. Did you give a deposition?

A. Yes, sir.

Q. What kind of case was it?

A. Failure to diagnose breast cancer.

Q. Is he in Little Rock?

A. No, sir. El Dorado.

Q. When did you give that deposition?

A. Sometime back then.

Q. 1989?

A. I think so.

Q. Do you know Mr. Wynne's first name?

A. I don't recall.

Q. Have there been any other occasions when you gave a deposition on behalf of a plaintiff?

A. Well, the plaintiff happened to be an insurance company. The answer is yes. The plaintiff

happened to be an insurance company, but the deposition related to the physician who was using an unapproved method of therapy. And the plaintiff brought him in as their expert so they could reimburse him, I guess get the insurance company to reimburse him for what he had done.

Q. All right. I'm looking for other cases where you were giving testimony on behalf of an individual who had sued a health care provider contending the health care provider was negligent and that that negligence caused some harm.

Have you ever testified on behalf of a plaintiff except in the instance for Mr. Wynne out of El Dorado, Arkansas?

A. No, sir.

Q. And over how many years have you been making yourself available as an expert for physicians?

A. Well, you know, I have testified in other types of situations here. For example, for the Bureau of Narcotics, against narcotics dealers and things of that sort. I've -- I don't think I started doing any work of this sort until about 1985 or so.

Q. Before that you were testifying on behalf of narcotics dealers?

A. No, sir. The reverse. On behalf of the federal government.
Q. Okay. I just wanted to make sure.
A. Let's make that clear.
Q. You wouldn't want me to leave an unclear point in that --
A, Not in that direction. It would be 180 degrees off course. As a pharmacologist, I don't work for narcotics dealers. I am a law-abiding citizen.
But, you know, I don't like the concept of "your testifying for". I'm testifying to my appraisal of the data.
MR. ONSTAD: Objection, not responsive.
Q. (By Mr. Onstad) If that's the case, why don't you just do it for free?
A. Well, because in doing this, I'm giving up my practice. I'm having to pay physicians to cover me, and I have to pay the bills back home, pay for secretaries, physicians, et cetera.
Q. Who's covering you now?
A. Dr. Frank Smith.
Q. So you're saying you're paying Frank Smith to cover you right now?

A. Uh-huh.
Q. What sort arrangements do you have with him to cover you?
A. Well, that depends on who he's seeing, patients in the office, whatever. I always -- we have a monthly arrangement, which I don't think is essential to the case at hand here.
Q. How much an hour are you paying him while you're here?
A. I don't think that I want to get into that particularly. I think that's between me and Dr. Smith.
Q. Okay.

Do you know any of the lawyers in the Giessel Stone firm?

A. No, sir. I mean I've met them with the case. I never met Mr. Giessel before. I never met Mr. Twining before. And I never met Mr. Barker before.
Q. Did you form an opinion as to what the stage of Ann Dykes' cancer was?
A. At which time, sir?
Q. At the time she had her surgery on 12 -- well, December of 1990.
A. Yes, sir.

Q. What did you determine?
A. You'll have to allow me to give the whole definition though.
Q. I just want to know -- Isn't there a staging?
A. I say -- Yes.
Q. I just want --
A. Based on this classification,
Q. Classification, Exhibit 2?
A. Okay.
Q. Stage and grouping?
A. First of all, I'll tell you she had a T1. I can give you the TNM classification.
Q. She had a T1?
A. T1 lesion. Tumor's stage is one. The node stage was -- pathological stage -- let's go pN1A. And the metastatic level is zero. Now, a pN1A lesion -- I mean an N1 -- a pN -- small p, capital N, 1A lesion, if you just stage it, the stage would be Stage II breast cancer because there was one -- because the patient had involved lymph nodes. She had a T1 lesion. Okay?
However, if *you* look at the bottom of the page, you'll see that anybody who has lymph nodes that have less than 2 millimeters of tumor involvement have the same prognosis as if their

lymph nodes were not involved. And this was the case with this patient So that effectively she had a T1 NO MO which would make her a Stage I. The disease would be Stage I prognostically. And that appears at the bottom of the table qualifying lymph node involvement.

MR. ONSTAD: Objection, not responsive.

Q. (By Mr. Onstad) What stage did her own oncologist stage her at?.

A. As I recall, he called it a Stage 11.

Q. Stage II what?

A. Well, I don't recall that. I don't recall. May I see it?

Q. I just want to know what you can recall.

A. Yeah, 1 -- I don't think --

MR. TWINING: What do you want to see, first of all, before you go on?

THE WITNESS: I want to see what he called it. I don't remember what he called it.

Q. (By Mr. Onstad) That's good enough. He called it what he called it. If you can remember, that's good.

A. Well, I don't remember.

Q. If you can't, you can't remember.
A. Which oncologist are you talking about? Eichler?
Q. Right.
A. I don't recall what Dr. Eichler called it.
Q. Okay.

MR. TWINING: Let me say if you want to look at any of this material in response to his question, you're free to do that at any time. Simply let me know.

A. I don't recall out of my head what he called it. No matter how you call it, it would have to be called a Stage II based on TNM. But again, by TNM, it would be functionally a Stage I.

MR. ONSTAD: Objection. Not responsive.

A. I think it's very responsive.

MR. ONSTAD: Objection, not responsive.

Q. (By Mr. Onstad) What did Dr. Schapira stage it?
A. I would have to look at his material. I don't recall.
Q. You don't recall?
A. I don't recall, sir, but I'll be happy to look at it and see what he called it. But depositions, I can --

Q. What did Dr. Hillis stage it at?
MR. TWINING: Hold on a second. If you want him --
MR. ONSTAD: We can go dig it up. I just want to know what he can recall. I have the right --
A. My recollection vaguely is that -- it's vague -- is that all of these people called it a Stage II breast cancer.
Q. (By Mr. Onstad) Because I have the right to test your recollection.
A. Pardon me?
Q. I have the right to test your recollection on examination.
A. Well, I'll have to look at it then.
Q. I understand.
MR. TWINING:. You want to look at his depo?
THE WITNESS: I'll be happy to look --
Q. (By Mr. Onstad) We'd just be wasting time. I know what -- the depo says whatever it says. My question was: Do you recall it? And the answer is you don't recall it.
A. Pass. 1/11 pass.

Q. I'm not as sophisticated as you are in looking at cancer so I've got this book called Everyone's Guide To Cancer Therapy. Are you familiar with that?
A. No, I haven't read that book, I'm afraid.
Q. Sir?
A. I haven't read that book.
Q. Do you recommend it to your patients?
A. No, sir. I'm not familiar with it.
Q. It has a section that says treatment by stage, and they talk about a stage called Stage 0 or in situ. Are you familiar with carcinoma of the breast in situ?
A. Yes, sir.
Q. And then they have a group they call Stage I, and it substages TNM T1 or NO or MO. Are you familiar with that --
A. T1 NO MO. I'm quite familiar with it. That's Stage I.
Q. All right. They have Stage II, TNM T0 N1 MO or T1 N1 MO and T2. Are you familiar with that terminology?
A. Yes, I am.
Q. And is the treatment --
A. You have to be careful about whether you're

talking about a clinical or pathological staging, because the ultimate staging is pathological staging. So I'd like to know what you're talking about.

Q. Do you do surgery for breast cancer7

A. No, sir.

Q. Do you do any kind of surgery?

A. None at all.

Q. Have you ever done any kind of surgery?

A. Sure. When I was a resident and intern.

Q. When was that?

A. In 1952.

Q. Did you ever do any breast surgery?

A. No. I assisted a surgeon, but I didn't do surgery. I'm not a surgeon. We've defined that.

Q. Do you get involved in needle aspiration biopsy?

A. No, sir.

Q. Have you ever done it?

A. No, sir.

Q. Do you know anything about it?

A. Of course.

Q. Is it a standard way that a suspicion of cancer in a mammogram might be followed up?

A. It's one way, yes.

Q. Is it reliable?

A. Well, as with all techniques, it may or may not be reliable. It depends on when you get into the lesion, whether the lesion's cystic, whether the lesion has cells floating in it. It is a useful technique.
Q. Do you recommend it?
A. I don't know what you mean by that. To whom and in what situation?
Q. Do *you* ever recommend it to your patients who have a reported suspicious mammogram?
A. Those recommendations are made by the surgeon, sir.
Q. So you don't get involved in even recommending whether the needle aspiration biopsy or incisional type biopsy?
A. That is correct, That's made by the surgeon.
Q. Do you have a group of patient's that you follow that are perfectly normal, healthy patients and that you are screening for breast cancer?
A. Not that are my patients.
Q. Is it fair to say that the only time you really get involved with a patient as your patient is after the diagnosis of cancer has been made?
A. That's wrong.
Q. Okay. Well, straighten me out.

A. I see patients in consultation initially where they have a suspicion of problems, and the question is what should be done at that point, before they've ever seen a surgeon and I will make recommendations in that regard.

Q. So would it be fair to say then you might have a patient that would present just like Ann Dykes did after her July 25, 1989 mammogram?

A. Only if Dr. Hall had said gee, I'm concerned about this, Dr. Lane. Would you like to see this patient's mammogram and tell me what you think we ought to do? But otherwise that patient would remain with Dr. Hall. Or he could similarly have decided he wanted the surgeon to see the patient', But I would not otherwise be involved in that setting. I would be involved if somebody felt something, for example, that would be more likely, and they wanted do know what I thought and what else should be done. Or the patient had a mammogram or that there was great concern based on the physical exam and mammogram that the patient might have cancer, that the biopsy may not even have been done at that point, and they would want my thinking about alternatives in therapy were the lesion positive.

Q. If Dr. Fisher had called you up in July of 1989 and said he was suspicious after reviewing the mammogram and was suspicious of a tumor or suspicious of cancer and reported that to you, what would you have recommended?
A. Would I have been the primary care physician in that case, in other words --
Q. Wouldn't matter.
A. I had taken -- I had seen the patient or not? Never seen the patient?
Q. Never seen the patient.
A. The first thing --
Q. She was referred to you with a mammogram that said suspicious for cancer.
A. Wasn't referred -- Is that a hypothetical?
Q. Yes, sir.
A. Referred suspicious for cancer?
Q. Yes, sir.
A. With that wording? Well, first of all, I would like to see the patient. The first thing I would request is that I see the patient and examine her, look at her, see what else I wanted to do; check the mammogram, then talk with Dr. Fisher about it.
Q. I understand from my reading about breast cancer

that one of the nice things about mammography is sometimes it can detect cancer before the mass becomes palpable. Is that true?

A. Absolutely true.

Q. Is that a good thing to detect a tumor before it becomes palpable?

A. You know, that'd be like saying you're against motherhood. Yes. The answer is sure, we'd like to find it before we can feel it. But sometimes that also is rather late. In other words, the breast my not allow you to feel it because of its configuration. But it will show on a mammogram. But it doesn't imply that it's a very, very minute lesion.

MR. ONSTAD: Objection, not responsive.

Q. (By Mr. Onstad) Is there any benefit to detecting cancer early?

A. The answer to that is early is an extremely difficult definition, sir. It depends on where that definition falls. In some instances, by definition -- by early, for example, the earliest change in a Pap smear, yes, it is extremely beneficial. In some instances, in a breast cancer, a minute lesion that has low biological

potential for metastasis detected on a mammogram and not palpable as early, yes, that is very desirable. But the definition of the word early is a very generic term and I think largely misunderstood by a lot of people, particularly laymen, but often by physicians, too. But always better -- this is a fair statement, always a better, and this is a very qualitative statement, early than late.

MR. **ONSTAD**: Objection, not responsive.

**Q.** (By Mr. Onstad) Is it always better to detect cancer early rather than late?

**A.** I just said that, sir. Not -- and the answer is no, I can't say that because there may be no difference in outcome in patients you define or someone may define as early versus late. There may be absolutely no difference in outcome. It depends on how early early is, what the biology of the tumor is, et cetera, and how late late is. So you can't make blanket statements to that effect. They sound very nice and they sound nice when you try and sell screening programs, which we try to sell and I try to sell, but you can't make a blanket statement about early and late.

MR. ONSTAD: Objection, not responsive.

Q. (By Mr. Onstad) Are there some tumors where a lumpectomy is the recommended surgical approach?

MR. POLEWSKI: Today? I going to object as irrelevant if the time is not specified.

Q. (By Mr. Onstad) 1989. 1989, December of 1989 -- Let me start over.

As of July 1989, were you aware that some breast cancer was being treated with a surgical lumpectomy rather than a mastectomy?

A. Yes, I'm aware of that.

Q. Was that occurring in Houston?

A. Yes, sir.

Q. Was it occurring nationwide?

A. Yes, sir. Some cities more than others. More in California, more in New York, more in Chicago than in Texas.

Q. Are there reasons for doing a lumpectomy instead of a radical mastectomy?

A. Yes.

Q. Do you know what they are?

A. Yes.

Q. What are they?

A. The primary reason is cosmetic.
Q. Cosmetics. Does that affect how a woman sees herself?
A. It affects how everybody sees the patient. But yes, it involves how the patient sees herself. A cosmesis.
Q. I noted in some of the papers you've written they focus upon the psychosocial aspects of breast cancer. Is that true?
A. That's true.
Q. And have you come to learn that women don't like to have their breasts disfigured?
A. Well, I think we've all known that for some time. I didn't have to come to learn that, anymore than men like being disfigured.
Q. I understand. But as far as the cosmetics go, it's just more than cosmetic, it affects self-esteem very greatly, doesn't it?
A. It depends on the patient.
Q. Most patients are devastated by a radical mastectomy psychologically, aren't they?
A. Well, that's a generalization that you can't make. You have to take this all into some -- you can't generalize about any of these things. Some people would be more devastated by the idea that

you've removed a small portion of the breast and have left their breasts there as a harbinger of future cancer and they insist on mastectomy. So you can't generalize about this.

You have to remember that lumpectomy, which is not in itself, is never a procedure the surgeon recommends, it's a procedure the patient may ask about and inquire about, because it has to do with cosmesis and the patient's desire for herself. And it is not in itself a cancer operation, not a good cancer operation. It requires a lot more to go with it like radiation therapy and lymph node dissection. So it's not an either or situation. Some women want it. Some women don't want it. In some women who want it, it's a procedure that *you* can do. And there are indications and contraindications. And some women who want it, you can't do it. In some women who don't want it, you could have done it. So it's not a very simple subject, sir, is what I'm saying. You can't -- but it is one alternative in the management of breast cancer for some women.

MR. ONSTAD: Objection, not responsive.

Q. (By Mr. Onstad) Did you form an opinion as to what stage Ann Dykes' cancer would have been in July of 1989?
A. Well, sir, you weren't happy with my opinion in December, which was that effectively she had a Stage I breast cancer. And that's my opinion. And my opinion is she would have had the same stage in July of 1989; namely, Stage I breast cancer.
MR. ONSTAD:. Objection, not responsive.
A. I'm sorry, sir. I don't understand what you mean by not responsive. You asked me what my opinion is. I've given you my opinion and you tell me -- it's not responsive. I don't know.
MR. TWINING: He's required --
MR. ONSTAD: Objection, not responsive.
MR. TWINING: He has to do that. He has to do that for the record. You need to answer his questions as best you can.
THE WITNESS: Just so I understand.
A. I'm sorry. Forgive me. I have -- just didn't capture that nuance.
Q. (By Mr. Onstad) Is it possible that in July of

1989 the stage of her cancer was in situ?
A. I have no way of knowing that. Possibly is -- I would say was highly improbable.
Q. Is it possible?
A. Anything is possible, sir. I would say it is highly medically improbable. Because I think, as I've indicated before, that this lady had an extreme, my guess is, my educated guess, which is not really a guess, she had a very slowly evolving breast cancer.
MR. ONSTAD: Objection, not responsive.
Q. (By Mr. Onstad) Do you agree that the standardized treatments given for Stage I carcinoma of five-year survival rate is 90 percent?
A. Well, that varies from series to series. It depends on the size of the T1 lesions. And you'll see anything from 78 or so percent to above 90 percent based on many characteristics of the tumor. The problem with just using stage is that it does not take into account all of the prognostic factors in that group. So that in a series compared to another series, you may have a large variety of patients with Stage I breast

cancer, and the population may be skewed in a certain way in one group than another and that accounts for the wide range of five year or so-called five-year survivals that are reported. So you can't just say 90 percent T1 or Stage I. But it's not unreasonable in some series.

MR. ONSTAD: Objection, not responsive.

Q. (By Mr. Onstad) Exhibit 2 here, does it come out of a book?

A. It came out of a staging manual. Uh-huh.

Q. Is there more to that book than just a staging manual?

A. Well, it's called that.

Q. Sir?

A. I think it's called the Manual for Staging by the American Joint Committee on Staging. This is the thing of the American College of Surgeons. It is pretty universally used in this country.

Q. Is there another corresponding type book that talks about prognosis depending on the stage if the standardized protocols are followed?

A. I don't know what you're talking about.

Q. Sir?

A. I'm not sure I know to what you have reference

because there are no standardized protocols in managing breast cancer.

Q. I'm asking these questions.-- I've got this Everyone's Guide to Cancer here. I know it's kind of like a Reader's Digest or a National Inquirer to an oncologist, but it says Stage II, it says, the five-year survival is 66 percent. Is that a statement that you agree with or disagree with?

A. No, I don't agree with anything in a lay text that I can't read that is generalized, that doesn't have all the specifics, all the qualifications that are needed in an extremely complex area which is management to breast cancer. So just to, you know, pluck this out of your Reader's Digest or even out of a text, and a good text, one has to be very careful about making these types of general statements. There are too many factors that go into the prognostication of breast cancer, including the therapy that's employed, the age group of the patients. I mean there's lots of features here.

But as I told you, I don't think it would have been prognostically any different if this patient had been diagnosed in July or if this

patient had been diagnosed in December of '90.

MR. ONSTAD: Objection, not responsive.

MR. TWINING: Let's take a five minute break.

(Brief recess)

Q. (By Mr. Onstad) Do you agree that at the present time mammography is the only screening method available to detect subclinical or occult breast cancer?

A. I would have to say in general clinical use. There is some work going on now with MRI, but it is not generally clinically available or sufficiently refined for that purpose.

Q. Can mammography detect cancer before it has spread to the lymph nodes?

A. Mammography doesn't detect cancer. Mammography detects abnormal shadows in the breasts. And at any time if a lesion is detected in the breast and proven to be cancer, it may have occurred before or following a tumor in the lymph nodes.

MR. ONSTAD: Objection, not responsive.

Q. (By Mr. Onstad) Does mammography routinely depict shadows which, if followed up, lead to a diagnosis of cancer before the cancer has spread to the lymph nodes?
A. I'm sorry, I don't understand that question... Say it again please.
Q. Can mammography be used to image a shadow --
A. Yes.
Q. -- which if followed up, leads to the diagnosis of cancer before the cancer has spread to the lymph nodes?
A. It may.
Q. Is that one of the benefits of mammography?
A. If that happens to be the case in that patient at that time, that it is a subclinical lesion detected in a mammogram, and it has not yet spread to the lymph nodes, then I would say that would be a benefit in that patient.
Q. Let me hand you Dr. Martin's report. You don't know Dr. Martin personally, do you?
A. No, sir.
Q. Do you know what his position is over at the University of Texas?
A. Well, it says he's a professor of radiology.
Q. Did you take his report and compare it to

Plaintiff's Exhibit 1 and 2 to see if you could either confirm what he said or challenge it?
A. Yes, sir, I have.
Q. Do you agree with Dr. Martin that Plaintiff's Exhibit 1, the original mammogram before you, does show a poorly defined mass near the centrum of the breast?
A. Well, I don't agree with him completely because -- well, do you want me to dilate on that? The answer is I don't agree with him, with Dr. Martin, as simply as that.
Q. Have you ever had any courses in mammography?
A. No, sir. But --
Q. Have you ever taught residents in mammography?
A. I wanted to finish that statement.
Q. I'm sorry.

MR. TWINING: Let him finish his answer.

A. I have not taken a course, but I have read literally thousands of mammograms with radiologists.
Q. (By Mr. Onstad) Do you see any kind of a mass on Plaintiff's Exhibit 1?
A. I see multiple ill-defined lesions in the breasts.

Q. Are they within the areas where the red dots appear?
A. Yes, there are in the -- the answer is yes. You need me to expand on that?
Q. Do you see a dilated duct running to the areola?
A. I see something that could so be construed.
Q. Are masses on mammograms consistent with cancer?
A. I don't like to answer the question the way you asked it because they're consistent with a lot of things.
Q. Is one of the things they're consistent with is cancer?
A. Yes.
Q. They could be consistent with a bullet. Right?..
A. With -- Sir?
Q. With a bullet.
A. It wouldn't appear as a mass, it would appear as a foreign body.
Q. Okay. How would it look on a mammogram?
A. Would be a solid metallic-looking structure. I mean, it doesn't look like normal tissue. You can always see a difference. Extremely homogeneous and dense and with geometric outlines.
Q. Do you think Dr. Martin is qualified to review

and study those mammograms?
A. Oh, of course.
Q. Do you know of anybody more qualified than Dr. Martin?
A. Oh, I -- I know that there are same highly qualified people at our institution. I don't know how you would compare with more qualified or less qualified. But that doesn't mean that I agree with the wording he's used here, and there's implications here that I disagree with.
Q. Let me turn you to his book. I thought this was kind of interesting from a lawyer's viewpoint. I'll be curious as to what you think from a doctor's viewpoint.

He wrote a chapter on writing mammography reports. And he has some examples of good reports and bad reports. And down here on Page 35 he says, for example, an obvious stellate mass as seen that has all the characteristics of cancer, this is a good report, which say there is a 2 centimeter stellate carcinoma in the outer quadrant of the left breast, no axillary nodes are visible, A bad report, there is in the left breast a suggested 2 centimeter mass that may have spiculations and biopsy would seem to be

indicated.
You want to take a look at that?
A. Uh-huh.
Q. I'm not a very good audible person. I have to see it in order to pull it in.
A. Uh-huh.
Q. Do you agree with that?
A. Do I agree that one is a bad report? Well, yeah. I don't know that the first report is one that all radiologists would read in that fashion. This is his opinion. When he says 2 centimeter stellate carcinoma, I think many people would say there is a 2 centimeter stellate lesion strongly suggestive of carcinoma in the upper outer quadrant of the left breast, because you don't know it's cancer until you know it's cancer by biopsy.
The bad report, yes -- well, the bad report is just vague. I mean, that is a bad report. If we're talking about the same lesion being observed, I would say there are too many degrees of uncertainty in that report.
Q. All right. So you're saying --
A. You don't say may have or et cetera. I agree that is not as -- obviously that is -- wishy

washy would be the word I'd use for it.
Q. So what you're saying a vague report is a bad report?
A. No. It depends on -- if the findings are vague, then the report is vague. If the finding are clear-cut, then you have to have a clear-cut report. That's what I'm saying.
Q. I'm going to ask you another question about another sentence.
Do you believe in order for the report to be a good report it should not leave the slightest doubt of the radiologist's opinion?
A. I would say that's correct.
Q. Do you agree that if a radiologist establishes a pattern of indecisive reports, the referring physicians tend to regard those reports with skepticism?
A. I have no opinion on that because I'm not familiar with that circumstance. We don't have -- I've never dealt with such radiologists.
Q. Do you agree that the important aspect of reporting mammograms is the delivery of a meaningful report that referring physicians can easily understand?
A. I'd say that's correct for mammograms and €or all

reports.

Q. Do you know how many physicians at the Collum & Carney Clinic were relying upon Dr. Fisher for the interpretation of mammograms?

A. I don't recall that, sir. I don't know how many of them order mammograms.

Q. What is your understanding of the size of the Collum & Carney clinic?

A. I don't recall that either. I think it's -- I've forgotten what I read about that. Perhaps maybe 30, 40 doctors, but I don't remember exactly.

Q. You didn't read Dr. McCuvin's deposition. He's one of the gynecologists there at the clinic. On his deposition, it was given on September 15th, he made a statement, he said, any time there's a new radiologist, there's a matter of learning how they speak, how they communicate. There's -- takes a time period to learn what those reports mean.

Then that precipitated a question. And the question was: Dr. McCuvin, this learning process that you and the other OB-GYN's had to go through since Dr. Fisher was hired, did this learning process have anything to do with you and Dr. Fisher having meetings, having policies

formulated, having words that were needed to be in black and white said on these mammogram reports so you would understand what he was doing? And the answer was no.

Now with that, what I'm asking you: Do you agree that any time you get a new radiologist, there's ordinarily some time period that has to go by where everybody learns how they communicate?

A. I have never experienced that, We deal with many radiologists. Most of the radiologists at our institution have been there €or a long period of time. There has been some turnover. Whenever I get a report that suggests anything to me that -- well, even when it's a normal report, I have some questions about it, I always go down to the radiologist and go over with them. I'm in the radiology department several times a day seeking out each radiologist. And these are for the most part patients with advanced cancers. So I don't have any communication problem with radiologists in that regard. I don't know their situation there

Q. Well, is there any kind of policy in the program that you supervise where a common lexicon is used

so that whenever the radiologist suspects that there's a lesion present, they use clear words so that everybody will understand it?

MR. TWINING: What point in time? Currently?

MR. ONSTAD: Yeah, currently.

MR. TWINING: '89?

Q. (By Mr. Onstad) Well, let's take it today and let's work back how long that's been.

A. Okay. My answer to that is I know of no such common lexicon. I do know that these are all very skilled radiologists. They abide by -- there have been several types of approaches to grading mammograms, several different schemes that have been used in the past whereby -- and I don't claim to be expert in any of them, okay -- whereby they attach certain weight and significance to certain things like, for example -- I'm just pulling this out of a hat. It's my understanding that if a radiologist saw two microcalcifications, according to most mammographers, they would not report this as being very suspicious of anything. But if they were to see three or four or any increase over a period of time in the number of

microcalcifications, then that would be designated as a suspicious microcalcification. But -- and I think these radiologists all pretty well follow the same approach to evaluating the changes in mammograms. But I'm unaware of any standard language. But they all have the standard disclaimer on the bottom of every mammogram report. That's as close as I can come to that.

MR. ONSTAD: Objection, not responsive.

Q. (By Mr. Onstad) Are you familiar with this article put out by Dr. Sue -- Katherine Remp in the American Journal of Radiology, November of 1987, that deals with -- in fact, the title is A Simple Classification System For Mammographic Reporting. And her classification involved four basic classes: Class 1, normal findings; Class 2, mass or masses present, probably benign; Class 3, indeterminate lesion found, suggestive of possible malignancy; Class 4, probable malignancy. Then there's an elaboration on each class.

A. I'm generally familiar with the existence of that article, and I know that that type of class

reporting is in use in some institutions. But it is not in use at either Methodist Hospital, that I'm aware, or St. Luke's Hospital or the Harris County Hospital District, Ben Taub Hospital. So it is one such approach.

Q. Well, is there a classification system that's used at the mammography center that you have supervisory responsibility with?

A. No, sir. They do not use that type of classification that I'm aware of. They will report the mammograms as they see them, indicating each in his own terms what they consider to be -- I mean, a normal mammogram or one without any suspicious areas or one that shows fibrocystic or proliferative breast disease as it's more properly called. Or they will speak to the degree of change that is more or less suggestive of a cancer and will render that report to the referring physician, but not in any categorized classification of that sort.

Q. Is there any kind of written policy, procedure or protocol that gives them any guidelines on what to say if in their minds after'reading a report they suspect cancer?

A. None that I'm aware of.

Q. Now, if I understand your previous testimony, if the radiologists you work with after reviewing a mammogram have any suspicion of cancer, you don't want them to mince words, you want them to say -- use the cancer word and then state their level of suspicion. Is that correct?

A. I would say if he has a definite significant suspicion of cancer. When you say any, again, you know, is that a one in a thousand suspicion of cancer? If we're talking about that, no, I don't -- those words should be minced. But if he has a significant concern about abnormality'; in general what will happen at my institution, if I may say that, if the radiologist has significant concern, usually several things happen. One is -- and this is available today, it was not available before -- he might suggest getting a magnified view of the lesion. We did not have that available, say, in 1989 on a mammography. Secondly, they may suggest an ultrasound. Thirdly, if they're in this arena where they're strongly suspicious, they will call us. There will be a direct verbal contact between the radiologist and us telling us what's happening. And of course, whenever possible, all of these

readings will be based on examinations and comparison to prior mammograms; That's about how they operate.

MR. ONSTAD: Objection, not responsive.

Q. (By Mr. Onstad) Do you know what Dr. Fisher would have told any of the clinicians had they called him up and wanted to question him further about the mammogram?

A. As best I can determine from reading his deposition, he didn't know if there were mass lesions in there or not. That's my understanding of it.

Q. Did you learn he would have told them that the lesions he was trying to document needed to be followed up?

A. I don't recall that.

Q. Do you remember what Dr. Eric Hall said on whether or not the report was clear to him, that being the report of Dr. Fisher dated July 25, 1989?

A. I think I do.

Q. Do you remember him saying the report was unclear?

A. That was my recollection, that it was unclear to

him.
Q. When a report's unclear to you, do *you* recommend calling the radiologist to talk about it?
A. I go see him.
Q. Do you think that's prudent?
A. I think that is prudent.
Q. Do ***you*** think that's the standard of care for any kind of physician who is referring patients for mammograms, and when the reports comes back unclear?
A. If he is unclear about the report, that doesn't mean **the** report is unclear. But if he is unclear about the report, I think it behooves him to find out what the radiologist had in mind.
Q. Do you think that the words in the report should be consistent with the mental **impression** that the radiologist has?
A. It **should** be consistent with what he -- what he sees, what he thinks he saw. That's correct.
Q. What he sees is a brain interpretation **of** light that comes in through our eyeball. Isn't that true?
A. This is a visual interpretation.
Q. When we say what we see, what we really mean is what *our* brain thinks after we've looked at

something.
A. That is correct. I agree it's an integrated process. I agree with that, sir.
Q. Now, you've stated opinions here about what you think a reasonably prudent radiologist ought to do or not do. Correct?
A. Based -- yes, that's correct.
Q. What medical organizations do you belong to?
A. I belong to the Americal Medical Association, American College of Physicians, the Harris County Medical Society, American Society of Clinical Oncology, American Society of Hematology, American Society of Clinical Pharmacology and Therapeutics, American Society of Experimental Pharmacology, Pharmacology and Experimental Therapeutics. There's several more. Let me see my CV to make sure I haven't left any important ones out.

MR. TWINING: Sure.
THE WITNESS: Can we take a short break? I want to call my office before the girls leave.
MR. TWINING: Sure.

(Brief recess)

Q. (By Mr. Onstad) Let me hand you Dr. Fisher's report dated 7-25-89. You've examined that, haven't you?
A. Yes, sir.
Q. Does that raise any suspicion in your mind that the radiologist was of the opinion there might be cancer present?
A. To me the answer is that I can't tell one way or the other from this report whether he is suspicious or not, because he says he cannot definitely exclude from either breast a mass iesion.
Q. Would it cause you any alarm to do any further follow-up?
A. What I would have done is I would have gone to look at the mammograms with him if I had seen this report, because, you know, no matter how careful you attempt to be with words, they may not convey exactly what your intent is. And you know the old saying, one picture is worth a thousand words? I don't know what a small patchy density is until I look at it. Then they're in both breasts, that's another question. So I would have gone to look at them.

Q. If he told you he thought there might be a tumor present and that he was suspicious for cancer, what would you do?
A. I would have asked him what additional studies would he have recommended in this setting, if he was that suspicious.
Q. If he was trying to imply suspicion of cancer in that report, do you think he did so?
A. I don't think so. I don't think this report implies cancer or noncancer.
Q. Does that report send up any red flags to you that there might be cancer present?
A. Not in any specific way.
Q. Aren't these mammogram reports kind of like dialing 911, if you see cancer, I mean?
Well, let me tell you what I'm trying to say. If you see cancer, you need to put out the word in a real clear and positive way. Isn't that true?
A. If you think you see a specific suspicious lesion, you have to make that clear,
Q. Kind of like walking down the street at 6:00 o'clock in the morning and seeing smoke and fire coming out someone's bedroom window, you've got to set out the alarm?

A. If that's what you think you see. Something -- then you have to say that. If you don't see it, you don't say it.
Q. It's not the kind of thing you mince words with and it's not the kind of thing you keep to yourself?
A. Not if he thought that there was cancer present. This report does not suggest that.
Q. Do you think the report should suggest to a reasonably prudent referring physician a necessity to follow up by going down and talking to the radiologist?
A. It may. As I've indicated, it's hard to -- there's nothing in this report that says I see a lesion that is suspicious for cancer, because there are a lot of patchy densities reported in both breasts. All he says is that there is a mass lesion there. He can't exclude it based on this study. And I think that's a very accurate representation.
Q. Okay. Let me show you Page 423 out of the Harris County Medical Directory, and I've circled Dr. Watson. Maybe if you see his picture and you see a little blurb on him, you will recognize him. Do you know that Dr. Alfred Watson?

A. No, sir. I don't know where at Baylor he works. He does not work -- I see he's listed as One Baylor Plaza. He may be at the Ben Taub. He's not at the Methodist.
Q. Do you have the same address he does?
A. Yeah. That's out Baylor academic address.
Q. Well, I note -- €or example, here's the copy of the page that's got you. It shows you both at One Baylor Plaza and it shows you both working for Baylor. Right?
A. It shows that I'm in the Department of Pharmacology, and we're both located, our academic offices are at One Baylor Plaza. That's correct.
Q. And what kind of a doctor does it reflect he is?
A. He's in diagnostic radiology.
Q. Is that the area that deals with interpreting mammograms?
A. Yes, sir. Well, it may not. Depends on what he does in diagnostic radiology.
Q. Do you know?
A. I don't know.
Q. Do you know --
A. It could embrace that.
Q. Do you know that the same people that retained

you retained him to examine the mammograms?
A. No, sir.
Q. Now that you know that, wouldn't you want to know what he found?
A. Wouldn't hurt to listen.
Q. Do you agree that if you're going to review a case and be an expert witness, that you need to review all the facts thoroughly and fairly and not exclude any relevant information?
A. The facts are what has happened in the case. Everything after that is interpretative, in my opinion.
Q. Well, being that you're not a radiologist, wouldn't you be interested to know what a Baylor radiologist found on reading these mammograms? You think that would be relevant?
A. It may or may not be, I'd be happy to hear what he said.
Q. In fact, you're really not even qualified to be giving opinions about the standard of care for radiologists because you're not a radiologist. Isn't that true?
A. Well, not really. I'm not giving opinions about the total capability of the radiologist, but whether this report, based on what I've seen, all

the mammograms I've seen, whether this report conforms at least to what I would expect a radiologist to say about them. And I am an oncologist and I see an awful lot of breast cancer and have for 40 years.

MR. ONSTAD: Well, objection, not responsive.

Q. (By Mr. Onstad) You prepared a report dated October 15th, 1993, didn't you?

A. Yes, sir.

Q. In the first page of your report, you stated it was your expert opinion arrived at after careful review and analysis of the materials in this case, that Dr. Fisher, his conduct was well within the standard of care for reasonably prudent radiologists. Do you recall that language?

A. Yes, sir. I said that.

Q. Well, don't you agree with me that the ethics of your profession require you to limit your giving standard of care opinions into the specialties in which you're qualified?

A. I don't know that that's necessarily true. I've never seen that written. It may be, but I've never seen that written. And I would think I

could have some opinion in there. For example, just to take an example, a surgeon went in to do a varicose vein stripping on one of my patients and said he stripped out the femoral artery and the woman lost a leg, I could tell you without being a professor of surgery, that that was not within the standard of care of practicing surgeons.

Q. Well, what is the standard of care for radiologists in articulating their mental impressions on a mammogram?

A. That the mental impression should convey their interpretations of what they see in the mammogram.

Q. You think the report should reflect what was in their mind?

A. Again, we're back to that. I think the report should reflect their interpretation of the mammographic findings that they see.

Q. Well, I'm couching it in terms of your knowledge about the standard of care for board certified radiologists.

A. Again, what I'm saying, they should reflect their interpretation of the information conveyed to them by the mammogram as they perceive it.

Q. Where is this standard of care written for radiologists and what they should write in their reports?

A. Well, to my knowledge, in terms of mammography, there has been no standard of care, so to speak, written. Most of the concepts of standard of care really are -- if you'll let me finish this -- are concepts of physicians practicing and common physician practices. Now, there has been an effort recently on the part of the, I think the American Society of Radiology to codify some of this in terms of what radiologists doing mammograms should do, the kind of physics that goes into the center, you know, make sure that the quality control is maintained in that regard, And now they are going about trying to, I think -- I don't know if the word is licensed, but basically give a seal of approval to mammography organizations that set themselves up to do screening or other mammographic studies that would be considered high quality.

MR. **ONSTAD**: Objection, not responsive.

Q. (By Mr. Onstad) I'm asking you to tell me where it's published. Are there any places where this

is published?
A. I'm not sure of the answer to 'that question. I don't know.
Q. Have you ever studied the radiology literature for articles that talk about how to write a good report on a mammogram?
A. I've not studied that. I've seen reports. I've seen recommendations, but I have not made a study of that literature.

MR. ONSTAD: I'm going to pass the witness. I understand Mr. Twining is going to ask you some questions. If I have any more, I'll ask them when he's finished.

EXAMINATION

BY MR. TWINING:
Q. Dr. Lane, Kent Twining here representing Dr. Fisher, for the record.
Will you tell us how long you've practiced medicine?
A. A little over 41 years.
Q. And is there a specific area that you practice primarily in?
A. Yes, sir.
Q. What area is that?

A. Medical oncology.
Q. What is medical oncology?
A. Medical oncology is a subspecialty of the specialty of internal medicine which deals with aspects of the prevention, diagnosis and treatment by nonsurgical means and nonradiotherapeutic means of patients with cancer.
Q. Does that area of specialty involve seeing patients and examining patients who have breast cancer?
A. Yes, sir.
Q. Does that area of specialty include working with mammograms?
A. Yes.
Q. Are you affiliated with any of the medical schools here in the State of Texas?
A. I am.
Q. How are you affiliated -- well, first of all, who are you affiliated with and how?
A. I'm affiliated with the Baylor College of Medicine. I am a professor of pharmacology and -- which is the subject that deals with drugs, and a professor of medicine at that institution. And I am head of the division of

clinical oncology at Baylor College of Medicine. clinical oncology is the subspecialty of cancer or medical oncology.

Q. How long have you been affiliated with Baylor Medical School?

A. For over 33 years.

Q. Are you board certified in any area?

A. Yes, sir.

Q. What area are you boared certified in?

A. I'm board certified in internal medicine, and I am board certified in medical oncology; and I am board certified in clinical attrition.

Q. What does board certification represent in medical circles?

A. Well, it is an indication that someone has gone through a certain requisite program of training and experience followed by the successful completion of an examination that is prepared by that particular specialty organization. So that in my own case, the first board examination that had to be passed was that of the American Board of Internal Medicine. In order to do that, I had to complete a year of internship, three years of residency training and two years of clinical practice, and then took a written examination

prepared by the members of the board. And once that was successfully completed, I had to take an oral examination which patients were presented to me and then I was quizzed about the patients and -- by various examiners. Then I had to pass that.

That has been simplified today so that current trainees take three years of medical residency, the first year really being an internship, and then two years residency. And they just take a board examination. Then having passed that -- that is a prerequisite to being able to take the certifying examination of medical oncology.

In order to take the subspecialty examination of medical oncology, one has to complete at least two years of what we call fellowship training in oncology beyond the medical residency level; that is, in which your training is devoted completely to the field of medical oncology. And having done that, one then has to take a qualifying examination in medical oncology and pass it to be certified as a diplomate of that board.

Q. How many years of professional experience as a

board certified oncologist: do you have with regards to the review of mammograms and the interpretation of mammograms in patients who are suspected to have some type of breast cancer or screening them for potential breast cancer?

A. Well, to answer your question, the certification in medical oncology was not possible prior to the year 1973 because there was no board until 1973. So that's when I took the board and passed it. On that basis, I have been a certified medical oncologist reviewing -- seeing patients with breast cancer and reviewing mammograms for 20 years. In terms of medical oncology contact, I have performed medical oncology services for 38 years.

Q. All right. The hospitals that you're affiliated with were again what please?

A. Well, I'm a senior attending physician at the Methodist Hospital, Houston, Texas. I'm a senior attending physician at the Ben Taub General Hospital which is part of the Harris County Hospital District. And I am a consulting and attending physician at the Veterans Administration Hospital, Houston, Texas. And I have courtesy privileges, I rarely go there, at

the St. Luke's Hospital.
Q. All right. With regards to all of the opinions that you've been asked by -- to express by Mr. Onstad thus far, have those been based on reasonable medical probability?
A. Yes, sir.
Q. Can I likewise ask you to express any additional opinions that you might be called upon to give during the rest of *your* deposition based on reasonable medical probability as opposed to speculation or guessing?
A. Yes, sir.
Q. If you're called upon by any attorney asking you questions at this deposition that fall below; that call you to guess or speculate, would you please indicate so?
A. Yes, sir.
Q. All right, Do you have an opinion as to whether or not Dr. John Fisher was negligent in his interpretation of the mammogram -- mammograms of Ann Dykes taken in July of 1989?

MR. ONSTAD: Objection, form of the question, failure to lay a proper predicate.

Q. (By Mr. Twining) Do you have such an opinion?

A. Yes, sir.
Q. What is your opinion?
MR. ONSTAD: Objection, form of the question, failure to lay a proper predicate.
A. I do not believe that Dr. Fisher was negligent in his reading of those mammograms, his interpretation of those mammograms.
Q. (By Mr. Twining) Have you reviewed in forming that opinion and in forming other opinions I'll ask you about all of the medical records that you file are pertinent to Ann Dykes case?
A. Yes, I have.
Q. You have learned in discussing the case with Mr. Onstad that there have been certain depositions that you may not have reviewed. Do you feel like you need to review those before expressing any opinions regarding this case?
A. No, sir.
Q. Is there anything that was not provided to you originally by my offices which you felt that you needed to review or see before you formed any final opinion?
A. Well, there were some things and then I obtained them from you subsequently.

Q. What things did you want to look at and review before forming any final opinions in this case which were not originally provided to you?
A. Well, I did not have the original mammograms to review. And I wanted those. Initially, as I recall, I did not have Dr. Martin's review letter. And I subsequently got that. As I recall, I did not have Dr. Hillis' records. I got that, his deposition. And I had not had an opportunity to review the slides with myself and with a pathologist.
Q. What slides are you referring to?
A. I'm referring to the slides which are the histologic slides or tissue slides that were prepared from the breast cancer and breast tissues and lymph nodes removed during Mrs. Dykes' modified radical mastectomy.
Q. All right. Have you reviewed all of those materials?
A. Yes, sir.
Q. Do you have an opinion, Dr. Lane, as to whether or not Dr. John Fisher in his report, his written report of July of 1989 accurately interpreted what is seen in the mammograms of July of 1989?
MR. ONSTAD: Objection, leading.

Objection, failure to lay a proper predicate.

Q. (By Mr. Twining) Based on reasonable medical probability.

A. I do.

MR. ONSTAD: Okay.

Q. What is that opinion?

MR. ONSTAD: Objection, failure to lay a proper predicate.

Q. (By Mr. Twining) Based on reasonable medical probability.

MR. ONSTAD: Objection, failure to lay a proper predicate.

A. It is my opinion that he fairly represented and reported and interpreted what he saw in those mammograms.

Q. (By Mr. Twining) All right. In reaching that opinion about the interpretation -- in his reporting of his interpretation from the July of 1989 mammograms, did you find it helpful to compare those to mammograms taken of Ann Dykes later in December of 1990?

A. Yes, sir.

Q. Would it be helpful to you in explaining to us here today what you reviewed and looked at in

comparing the two sets of mammograms?
A. I think it would.
Q. Okay. Let me hand you what has previously been marked as Exhibits No. P1 and P2. And if you would, hold those up to the camera and explain to the jury what those are.
A. This is what is called a craniocaudad view of -- mammography view of Mrs. Dykes' right breast. And that picture is taken through the breast this way from the cranial and to the caudal line and recorded on a photographic plate or the mammography plate. And that's what we see here.

And this view is a medial lateral, lateral medial view which is going across the patient's breast horizontally in this fashion. The patient is standing this way with her arm out and the picture is being taken this way and the plate is on the other side of the breast. And what's being recorded is a soft tissue x-ray or a mammogram.

The difference between conventional x-rays and so-called xeromammography is that in a conventional x-ray, one has a film that you're mostly familiar with that you can hold up and look through, and it's due to the deposition of

grains of silver; whereas this process of xeromammography uses a solid sheet of paper and the picture takes on this blue characteristic. Both of these are acceptable techniques of mammography. They have certain advantages and disadvantages. But xeromammography is very commonly used, perhaps more commonly .used than film mammography in this period of '89 to '90.

So this is the so-called lateral view, if you wish. Or medial lateral view. And the breast is seen hanging down. The picture is taken this way. And the other, again, is a view taken this way through the breast.

MR. ONSTAD: Objection, not responsive.

MR. TWINING: Can I ask you to mark this, Janet?

(Deposition Exhibit No. 4 was marked for identification by the reporter.)

Q. (By Mr. Twining) Now, the xeromammograms taken of Ann Dykes in July of 1969 that you just held up and showed us and explained to us about, are those the mammograms that were reviewed by Dr.

Fisher, and are the things that we can see in these two mammograms, the things that he reports to us in his report dated July 25, 1989, which our court reporter has marked as Exhibit No. 4?

A. Yes, sir, with the exception that the red dots were not on there. They were added later. But other than that, that's what he examined.

Q. Okay. To make sure the record's clear, when were the red dots added, to your understanding, in reference to this case?

A. My best recollection, they were placed there -- I may be wrong, but my best recollection was during Dr. Schapira's deposition, that he was asked to put some dots there. But may be it was during Dr. Fisher's deposition.

Q. Only --

A. One of them. It was during deposition, but it was -- I think it was Dr. Fisher. I think it was Dr. Fisher.

Q. I just want to make sure the record's clear that the red dots were added during one of the procedures here in this lawsuit as opposed to care and treatment she received at collum & Carney Clinic.

A. Correct.

MR. ONSTAD: Let's take a break. I need to call Dr. Longley because he's going to be leaving one place and going to another and expecting us.

(Short recess)

Q. (By Mr. Twining) Dr. Lane, let me ask you to take the July of 1989 mammograms and take the report drafted by Dr. Fisher regarding what he views in those July of 1989 mammograms, and ask you if you can hold the mammogram up for the camera, and as you read the report of Dr. Fisher, point to the pertinent areas that he refers to for us, if you would please, in the July of 1989 report.

MR. ONSTAD: Objection, failure to lay a proper predicate.

A. I'll try. I don't know if this will --

Q. (By Mr. Twining) Try not to jiggle it around too much.

A. Let me set it down. It will be jumping all over the place.

Well, briefly --

MR. TWINING: Can you see that

okay? Let me move this up. Maybe you can --

MR. ONSTAD: Looks like a bigger fire ant bed.

A. It's just too difficult to define.

Q. (By Mr. Twining) All right.

A. Why -- may I make a suggestion? Because it is so difficult to define, let me just address the question of the patchy densities and the statement that follows that.

Q. Fair enough.

MR. ONSTAD: Objection, nonresponsive.

Q. (By Mr. Twining) Let me see the report so I can read the verbiage exactly.

A. You can read it.

Q. This portion of the report dated July of 1989 wherein Dr. Fisher refers to small patchy densities being visualized within both .breasts, do you see those in the mammograms that you have in front of you labeled Plaintiff's Exhibit 2 and 1?

MR. ONSTAD: Objection, form of the question and failure to lay a proper predicate.

A. I do see them in the right breast mammograms which I have here and -- yes, I see them.

Q. (By Mr. Twining) Are they noted with any markings on the exhibit?

A. Yes.

MR. ONSTAD: Excuse me. I object to the form of the question as failure to lay a proper predicate.

Q. (By Mr. Twining) Can you describe for us how they're so marked on the exhibit?

MR. ONSTAD: Kent, I don't want to keep interrupting you, but every time you ask him to give any kind of interpretation on the mammogram, I want to have a running objection on failure to lay a proper predicate and failure to show he's qualified to read and interpret mammograms. If you'll spot me that objection, I'll quit making these objections.

MR. TWINING: You want a running objection on failure to what?

MR. ONSTAD: On failure to lay a proper predicate that he's not qualified to interpret these mammograms and render opinions as to what the things on them

show.
MR. TWINING: And what were your other objections you wanted a running objection on?
MR. ONSTAD: I want to object on that point to all your questions that deal with what does the mammogram show or what does it mean or what is this as it relates to the mammograms. What I'm trying not to do is delay your taking the deposition, but I want to preserve the objection.
MR. TWINING: I don't have a problem with that and I understand that you're going to be objecting to the doctor's testimony and you're going to be taking the position he's not qualified, so on and so forth, and I don't have any problem with that.
MR. ONSTAD: or interpreting the mammograms?
MR. TWINING: Yeah.
MR. ONSTAD: So you'll give me a running objection on that point?
MR. TWINING: I will.
A. All right, sir. Yes, there are some red marks

that have been scattered over several areas on both mammograms.

Q. (By Mr. Twining) All right.

A. Both mammographic views of the right breast.

Q. Okay. Earlier counsel, Mr. Onstad was asking you whether or not these types of small patchy densities would be consistent with cancer or carcinoma, and I recalled your response being that that would be perhaps one thing it could be consistent with but there would be others as well. Is that --

A. That's correct.

Q. What other types of things would small patchy densities such as the things we observe in Plaintiff's Exhibit 2 be consistent with?

A. They could be consistent with areas of fat necrosis. They could be consistent with benign tumors within the breast. They could be consistent with fibrotic changes due to previous trauma, previous hemorrhage. They could be consistent with artifact created while taking the picture. The picture doesn't always, depending on how it was taken, demonstrate anything that really represents any pathological finding within the breast so that there are a whole variety of

shadows. And that's why I believe that Dr. Fisher called them small patchy densities. Certainly there are a minimum, as outlined even by the red marks, three such areas in the medial lateral view of the breast. And he's indicated perhaps three, not necessarily corresponding to these three, in the craniocaudad view so that they are fairly nondescript as I see them.

Q. Okay.

A. They have no special characteristics.

And then in the left breast, if you have that, this is 12. Here's the left breast of July '89, there are at least one, two, possibly three patchy densities, small densities in the medial lateral view. And there are perhaps one or two that I would think would conform to that definition, namely, a patchy density in the craniocaudad view of the left breast on July 1989.

Q. All right.

MR. ONSTAD: Objection, not responsive.

Q. (By Mr. Twining) Let me show you what our court reporter had in another deposition, and I recall it being Dr. Fisher's, quite frankly, marked as

exhibit -- Plaintiff's Exhibit No. 6, and ask you to identify that for the record.

A. This is the mammogram taken on Elizabeth Ann Dykes on December 6, 1990 of her right breast, and this is a medial lateral view.

Q. What is Exhibit 5, Plaintiff's Exhibit 5?

A. Exhibit 5 is a craniocaudal view of the patient's right breast taken on December 6, 1990.

Q. You see the area that has been demarcated with the four red hash marks in each of those two views?

A. Yes, I do.

Q. Do you recall, again generally, when and how those red hash marks were placed there?

A. As I recall, they were placed during deposition, and I thought they were Dr. Fisher's is my best recollection, but --

Q. Okay.

A. -- may have been one of the other doctors' depositions.

Q. Assume with me if you will that the testimony has been thus far that the area suspicious of carcinoma in December of 1990 was that area demarcated with these red hash marks. Is that consistent with your recollection of the

testimony?

MR. ONSTAD: Objection, leading.

A. Yes, sir.

Q. (By Mr. Twining) When you take the mammograms of December of 1990 and take this area that was suspicious in 1990, December of 1990, is there any way for you or any other physician reviewing this case to correlate that area to any suspicious area viewed in the July of 1989 mammogram?

A. Well, first of all, I don't know what you mean by suspicious area in the July mammogram. I mean, there's nothing to me that is particularly suspicious. There are some patchy ill-defined densities.

Q. This is my question, I guess: The area that is marked in December of 1990 --

A. Excuse me, let me --

Q. Sure.

A. I don't want to confuse -- I have too many mammograms. This is left. It doesn't belong here. And this is left.

Okay. Now, we have these right.

Q. Okay. Is there any way that we can take the area identified as suspicious for carcinoma in

December of 1990 from the two mammograms we have before us marked as Exhibits 5 and 6 and correlate that to any area that we see in the July of 1989 mammograms which are marked as Exhibits 1 and 2?

A. In my opinion, one cannot do that with any degree of assurance because, first of all, the breasts are not in the same position. The area that appears here is underlined, is out in the middle of the breast in this craniocaudad view. And here there are two areas that are sort of marked. And there's a third one. But they're not up in the middle of the fatty portion of the breast. So I can't find an area that exactly anatomically corresponds to this.

Now, in the medial lateral view, there were these three areas here. Looking backward, two of them have disappeared sort of and sort of blended into all of this. So it's possible. It's possible, again, the views not being comparable, that this area here might correspond to this area here. But I can't say that with certainty.

MR. ONSTAD: Objection, not responsive.

Q. (By Mr. Twining) Do you have an opinion whether

or not there are any findings available either clinically or by way of mammography which would enable you or any other physician reviewing this case to tell us whether or not Ann Dykes had breast cancer in July of 1989?

MR. ONSTAD: Objection, fails to lay a proper predicate and calls for speculation.

A. The answer to that is not with certainty.

Q. (By Mr. Twining) Okay. If, if Ann Dykes had breast cancer in July of 1989, do you have an opinion after having reviewed all the mammographic studies done both in July of 1989 and afterwards in December of '90 and reviewing all of the medical records, do you have an opinion that if she had breast cancer, it was detectable or undetectable in July of 1989 mammographically?

A. I do.

Q. What's that opinion?

A. It was not detectable based on these mammograms.

Q. If Ann Dykes had breast cancer in July of 1989, undetectable or otherwise, do you have an opinion as to whether or not the rate of growth of any cancer she may or may not have had was a

fast-growth type cancer or a slow-growth type cancer or otherwise?
A. I do.
Q. What is that opinion?
A. It is my opinion it was an extremely slowly growing cancer.
Q. Do you have an opinion based on your review of the records in this case whether or not the cancer, if she had any cancer in July of 1989, would have been an aggressive type or a nonaggressive type?
A. I do.
Q. What is that opinion?
A. A nonaggressive type,
Q. Can you explain for us briefly why it's your opinion that if Ann Dykes had breast cancer in July of 1989 it would have been of a slow growing type and a nonaggressive type?
A. Yes, sir.
Q. Would you explain that, please?
A. Yes. Well, first of all, the tumor or cancer -- let's call it a cancer -- was only 1.2 centimeters pathologically when it was removed.
Q. When was that?
A. And that was in December of 1990.

Q. All right.
A. At that time, histologically it was described as either moderately or moderately well differentiated carcinoma, which in general is a -- tends to be a nonaggressive tumor. In addition, studies were performed on the tumor to assess what we call the estrogen receptor and the progesterone receptor. These are measurements that if elevated and -- if elevated, correlate with less aggressive rather than more aggressive. So the higher these receptor levels are in general, the less aggressive the tumor is.

Now, receptors are present in a smaller proportion of premenopausal women, which Mrs. Dykes was at the time and still is, I believe. And in general in premenopausal women, these receptors are of lower magnitude or value as compared to postmenopausal women. In postmenopausal women, receptors occur in a higher percentage of patients or present in a higher percentage and the values tend to be considerably higher when they are present than in premenopausal women.

The values of receptors in Mrs. Dykes' case were extremely high. Her progesterone receptor

was about 350 femtomoles per milligram of protein. And the estrogen receptor, as I recall, was about 120. These are very high values. And there is a proportionate prognostic indication which is actually given on the report that was rendered on these receptors which correlates the level of the progesterone receptor with survival, And hers would have put her tumor at the highest opportunity for survival which would be consistent with or consonant with a relatively nonaggressive tumor.

In addition, the pathology indicated that she had only two micrometastases in her lymph nodes. And micrometastases which volume wise are less than a volume of the two millimeter lesion, which is a tiny, tiny lesion, have been found not to indicate prognosis -- have been found not to influence prognosis adversely. It's as if those lymph nodes were not involved. So that means that if indeed cancer was present back in July of 1989, which is 17 months earlier, and if -- then the patient had obvious cancer diagnosed 17 months later, then that cancer had only achieved in itself a size of 1.2 centimeters, which is a very small lesion, a T1 lesion, and had not

produced lymph node involvement that is clinically significant in terms of influencing prognosis. Both of these facts, plus the high receptor, plus the histological moderately well differentiated neoplasm to me mean that this is a nonaggressive type of breast cancer.

MR. ONSTAD: Objection, not responsive.

Q. (By Mr. Twining) One factor which you considered in expressing the opinion that we have a slow growing nonaggressive type cancer, if such is present in July of 1989, as I understand your testimony, was the shape of the lesion removed in December of 1990?

MR. ONSTAD: Objection.

Q. (By Mr. Twining) Would that be one such factor? Is that true?

MR. ONSTAD: Objection, leading.

Q. (By Mr. Twining) Or did I misunderstand?

MR. ONSTAD: Objection, leading.

A. I don't understand that question. It does not ring a bell with me.

Q. Let me talk to you --

A. You mean that it was a round lesion rather than an infiltrating lesion?

Q. Yes, sir.
A. In that sense, yes, it indicates a low degree of invasiveness, which is sort of interesting because the mammogram is interpreted as showing spiculation or stellate change, and the implication of that often is that the cancer is infiltrating like a crab. That's where the word cancer came from, crab. But this was a well-defined lesion which did not infiltrate into the areas around it. And, therefore, it would appear to have a very low level of invasiveness.
Q. Another factor, as I understand your testimony in opining on this cancer if present in July of 1989 being a slow growth nonaggressive type, was the high level of estrogen and progesterone receptors in Mrs. Dykes?
MR. ONSTAD: Objection, leading.
Q. (By Mr. Twining) Is that so?
A. Well, that's what I commented on earlier. Yes, sir.
Q. And then the third factor, if I understood you correctly, had to do with the size of micrometastases found in the two lymph nodes that are referenced in this case being involved when they were examined pathologically in December of

1990?

MR. ONSTAD: Objection, leading.

A. That is correct.

Q. (By Mr. Twining) Will you explain briefly for us the process of metastases and micrometastases in the lymph node system and why it's significant in Ann Dykes' case? I'm not sure that I followed you on that explanation.

MR. ONSTAD: Objection, multiple questions; form of the question.

A. The process of metastases is the process of spread. Cancers vary in their capacity to mestastasize. Mestastasis does not always -- or the mestastasizing capacity does not always correlate with growth rate. But in general, slow growing tumors are less likely to mestastasize than very rapidly proliferating tumors.

Metastases take place in three ways generally. The first is direct local spread or invasion. And that had to do with the shape of this -- Mrs. Dykes' tumor, which was one that tended to remain sort of balled up and did not send out invasive strands of tumor into the surrounding tissue so that it appeared as a well-defined nodule when it was removed by Dr.

Hillis and as examined subsequently by pathologists.

The second form of invasion is through the lymphatics in the breast to the draining lymph nodes, which are the lymph nodes in general under the arm. But there are lymph nodes in other areas which may be involved. Tumors that have a higher tendency to invade lymphatics and multiply in lymph nodes are tumors which in general have a poor prognosis; that is, the more lymph nodes that are involved at the time of diagnosis, the greater the likelihood that the cancer would recur in the future. Now, it doesn't mean that the recurrence is out of those lymph nodes.

That is merely a predictor for poor survival because it correlates eventually with the third way in which cancer is spread, and that is by direct entry into the bloodstream. And that is what is commonly referred to by most people as metastases, but they are distant metastases.

Q. What did you find --

MR. ONSTAD: Wait a minute, a second. Objection, not responsive.

Q. (By Mr. Twining) What did you find in reviewing

the pathological slides of the two lymph nodes in Mrs. Dykes' case as it pertains to the metastases or the spread, if you will, of cancer from her breast tissue to the two lymph nodes reviewed?

A. I reviewed these lymph nodes with the chief of anatomical pathology at Methodist Hospital, Dr. Thomas Wheeler. And we used a microscope that has two separate sets of eyepieces so we could both look at the same fields at the same time and with a pointer so various areas could be pointed out. And we found that, as was noted by the original pathologist, that of 23 lymph nodes that were removed, and all of these, I'd say, were very small lymph nodes, there were only two that contained any metastatic cancer. And these were two very small lymph nodes. In each of these we measured using a micrometer, which is in the eyepiece, the millimeter micrometer, the diameters, the two largest diameters of each of the tumors. And I independently determined the micrometer size in each of these two directions, and Dr. Wheeler determined this independently, and recorded our findings which were within a -- fractions of a millimeter in each case.

The two lesions diameters were recorded and

I measured them out and he did, and then calculated the average diameter, which in each case was under two millimeters, and calculated further the volume which was smaller than the volume that would have been occupied by the two millimeter focus or sphere. And it has been well established that the finding of lesions that are less than two millimeters is of no prognostic clinical significance in an adverse way. And this is documented throughout the medical literature. There have been numerous studies to that effect and they're reported in DeVita, in the book that I cited, and is so stated also by the committee on stagings when these lesions are under two millimeters, it is prognostically as though the lymph nodes are not involved at all.

MR. **ONSTAD:** Objection, not responsive.

**Q.** (By Mr. Twining) Is that finding that you made in reviewing the pathological slides of these lymph nodes significant to you in classifying the cancer found in Ms. Dykes in December of 1990?

**A.** Yes, sir.

Q. Is it significant to you in formulating some prognosis for Mrs. Dykes after her cancer was

found and removed in December of 1990?
A. Yes, sir.
Q. I want to ask you about those opinions in a second, but let me first have you explain to us what the system of classification of breast cancers is and why oncologists and physicians classify breast cancers in examining patients.
MR. ONSTAD: Objection, form of the question, multiple questions.
A. The system of breast cancer classification in general is similar to the systems that are used for classifying many human tumors at different sites in that conventions have been established to first determine a tumor size range, and that is given as a T value, T1, T2, T3, T4 for different sites. T1 may have a different size because prognostically it might be different, say for a tumor of the colon to have a T1 that's 1 cm. That might be 1 cm in the colon, and in the breast it could be under 2 cm. It varies with what happens to the patient. In other words, the staging systems are evolved based on studies of thousands of patients in the past and what different size tumors, what different degrees of node involvment and what metastases have to do

with the ultimate prognosis of the patient.

Q. In theory --

MR. ONSTAD: Objection, not responsive.

Q. (By Mr. Twining) In theory, what does classifying a patient's cancer, breast cancer let's say in this case, enable a physician or oncologist to do with regards to that patient?

A. Okay. In general, the first thing, and that's which we think is very important, is to allow oncologists throughout the country to describe their patients' disease in similar fashions so that they can then, when evaluating forms of therapy, see if their results are Comparable; better or worse than those of other physicians. So you have to have some common descriptor of what the extent of the disease is.

Secondly, based on those classifications, studies are carried out, actually studies are carried out comparing different forms of therapy. But it would be pointless to compare therapy, for example, in a patient who had a very tiny tumor with no lymph node involvment and no metastasis to the therapy of a patient with a large tumor, lots of lymph nodes and distant metastasis.

There would be no point to such a comparison. So, therefore, the patient's entered into treatment programs, if you're going to study the effects of the treatment, should have diseases that are comparably staged. So we use T to designate the size of the tumor. N to indicate the lymph node involvment. And N is broken down into various subletters so that describing the number of lymph nodes, the size of involvement, the degree of involvment, and whether the nodes are stuck together or not. So there are a lot of subclassifications there. And M means any distant metastasis, for example, in the lungs or the liver or the bones or other than lymph nodes.

Q. Okay.

MR. ONSTAD: Objection, not responsive.

Q. (By Mr. Twining) Do you have an opinion based on your view of the records in this case and based on your years of experience as a board certified oncologist about what classification or what staging Mrs. Dykes' cancer as detected in December of 1990 was?

A. Yes, sir. But in order to do that I have to carry that TNM system one step further which is

into staging or stage grouping --
Q. Okay.
A. -- if I may.
Because these are each separate variables, although they may be interdependent, it is possible, for example, to have a tumor, say, of size which we'll just say T3, okay, which would be larger than five centimeters, depending on whether nodes are involved or not, in the absence of any distant metastasis, to be in the same stage grouping as somebody who had a smaller tumor with lymph nodes.
So the stages then represent groupings together of patients with various tumor sizes; degree of lymph node involvement and metastases so that you can have similar prognostic outcomes even though the tumor sizes may not be the same. So that a patient who may have a T1 tumor and positive lymph nodes, okay, may have the same staging as a patient who has a T2 tumor, which is a bigger tumor, but no lymph nodes. And these are called stage groupings. And they're based on the experience with these types of degrees of involvement. Okay?
So based on that, in general, we would say

that patients who were to have a tumor of a T1 size, okay, which was Mrs. Dykes' tumor, and just -- and no lymph node involvment and no distant metastasis, that cancer would be classified as a Stage I.

MR. **ONSTAD:** Objection, not responsive.

Q. (By Mr. Twining) Is that classification in lay terms sort of the best classification from the patient's perspective?

A. Yes, sir. Yes, sir. That would be the best classification you could be in.

Q. Do you have an opinion based on your review of the materials and your review of the pathological slides what classification you would put Mrs. Dykes' cancer as it was ultimately found and removed in December of '90?

A, Okay. Yes. Yes, I do. And I have to say that based on just classification without the modifications that is listed there, her tumor would -- her disease would have fallen into the class of Stage II because if you just take that she had tumor of a size under 2 centimeters and lymph node involvement, okay, lymph node involvment automatically would throw that into

Stage II disease. However, as the staging indicates, if that lymph node involvment is less than 2 millimeters, then that is functionally or effectively the same as an NO. So that while you have to say Stage II, it would have to be modified because P, which is pathological, N1A which means lymph node involvement, 1A meaning less than 2 millimeters, is the same as NO. So if you throw that back to NO, then the patient has Stage I disease. It's not effectively different.

MR. ONSTAD: Objection, not responsive.

Q. (By Mr. Twining) Do you have an opinion as to whether effectively Ann Dykes' cancer as classified in stage and found in December of 1990 would be consistent with the best type of classification that we referenced earlier --

MR. ONSTAD: Objection, leading.

Q. (By Mr. Twining) -- or inconsistent?

A. I would put her in the best prognostic category, namely Stage I disease.

Q. Even if Ann Dykes had breast cancer in July of 1989, do you have an opinion whether or not it would effectively then have been the same type of

cancer that was ultimately found in December of 1990?

MR. ONSTAD: Objection, leading.

A. Yes. We would not expect the cancer to become very different in that period of time. I mean, it would have the same histologic characteristics. If anything, a cancer with time might -- well, it's over such a short period of growth, I would have to say I would anticipate that had one been found, it would have looked the same under the microscope and have the same receptors and other characteristics.

Q. Would her prognosis have been any --

MR. ONSTAD: Excuse me. Objection;. not responsive.

Q. (By Mr. Twining) Would her prognosis have been any different in December July of 1989 if she had cancer and if such a cancer were detectable and found?

A. In my opinion, no, because she was already in the best prognostic category in 1990 so that -- since the only variable then would have been the size of the tumor, since lymph nodes were of no significance. Then the question is what was the precise size of her tumor and would it have made

a heck of a lot of difference if her tumor was 1.1 cm or 1 cm or .9 cm. And it's very hard to say that that would have created a major distinction, particularly in the face of those very high estrogen receptors.

MR. ONSTAD: Objection, not responsive.

Q. (By Mr. Twining) I want to switch gears with you a little bit here and talk to you about the type of therapy or the type of surgical intervention that Ann Dykes received ultimately in December of 1990.

Do you have an opinion based on your review of these records and mammograms and your review of the depositions you've referenced before, do you have an opinion -- if Ann Dykes had breast cancer in July of 1989 and if it had been detectable and if it had been detected, do you have an opinion about whether or not the medical intervention, the type of therapy received would have been any different from what she ultimately received in December of 1990?

A. Yes, I do.

Q. What's that opinion?

A. Well, in the short, my opinion is it would have

been the same. And now I'd like to turn to the December therapy first --

Q. Let me ask you why you feel that way.

A. All right, sir. I feel that way because in December '90, Dr. Hillis performed a biopsy. He knew at that time from the mammogram he could not feel the tumor distinctly. And he said he couldn't feel the lesion. But based on some sense of fullness or whatever, he knew this lesion was very close to the nipple, areola complex. It was under it. And between the mammogram and his feeling, he knew where to go. So he made an incision above the areola, just around it, and then he dug deeply under the areola and came up with a piece of tissue which contained the tumor mass. That went to the pathologist who did a frozen section and confirmed that this was cancer of the breast.

Dr. Hillis immediately proceeded to do a modified radical mastectomy. There was no discussion about how big that tumor was. There was no discussion as to what it looked like in terms of differentiation since you can't really tell this from a frozen section, just know that you've got a breast cancer. And Dr. Hillis

proceeded then to do what he considered to be the appropriate procedure for her, which was a modified radical mastectomy. At that time there was no knowledge as to whether there were other lesions in the breast. There was no knowledge as to whether there were lymph nodes involved. That only could be determined later after all the tissues were examined finally by the pathologist, which was days later.

Now, if Dr. Hillis had been the surgeon in July '89, which is not unreasonable since he was referred by Dr. Hall -- the patient was referred by Dr. Hall to Dr. Hillis. If Dr. Hillis had done the surgery, he would have done the same surgical procedure because it did not matter to him, he indicated, that -- that he -- Let's say he was not of a mind of doing lumpectomy to begin with in any patient and he so indicated in his deposition. He did not feel that the cosmetic advantages of lumpectomy were such that he would do lumpectomies in people. And he stand -- on a standard bases he did not do them. So he didn't even consider it in the patient. Now, --

MR. ONSTAD: Object --

A. Excuse me. May I --

MR. **ONSTAD:** Objection, not responsive.

A. -- finish my answer, if I may.

It would have of, in my mind, have been a very, I would say, a strong relative contraindication to do a lumpectomy in this patient either in December of 1990 or in July of 1989 because of the location of the tumor. The tumor was located under the nipple and under the areola complex. One cannot do as Dr. Schapira suggested a quadradectomy. I mean, which quadrant would you take out? This is right in the middle of the breast. So **you** had to do a coring out of the entire nipple and areola complex which would leave a big Concavity in the breast. Most surgeons that I've spoken to and most books indicate and authorities that this is a relative contraindication to a lumpectomy.

Similarly, even if the tumor was a little smaller when detected, if detected in July, and it would still have been under the areola complex, so that again, a wide excision of the whole nipple and areola complex would have been required as the lumpectomy. And this is not a

cosmetically satisfying procedure. So most surgeons tend to avoid it. And I have spoken with surgeons who do a fair number of lumpectomies, they will never do a lumpectomy in a patient who has a tumor under the areola.

So in summary, I think the location of this lesion which would have been the same, it may have been a little smaller, but would have been at the same location, would have necessitated a large removal of the entire nipple-areola complex leaving a cosmetically unsatisfactory breast.

Secondly, this would have had to be discussed with the patient in advance. And evidently there was no discussion of lumpectomy in advance.

Thirdly, Dr. Hillis, had he done the procedure, has already stated in his deposition he wouldn't have done a lumpectomy in the first place. So I think for all these reasons the therapy would not have changed. The primary surgical therapy, which in my opinion was the optimum therapy for this patient, was a modified radical mastectomy.

MR. ONSTAD: Objection, not responsive.

MR. TWINING: That's all I have for you right now. I'll reserve the rest of my questions. Thank you.

THE WITNESS: Thank you,

MR. TWINING: Can we take a short break?

(Short recess)

EXAMINATION

BY MR. POLEWSKI:

Q. Doctor, my name is John Polewski. I represent Dr. Hall and the clinic. My first question to you is: Are you planning on appearing live at the trial of this case?

A. If asked, I intend to be there.

Q. Have you been asked?

A. Not directly yet.

Q. Doctor, when you were testifying earlier, as I understand your testimony, you believe that a radiologist who is giving you reports should give clear reports of what he sees. Is that correct?

A. Yes, sir,

Q. And if he definitely sees cancer, he should definitely say that?

A. If he definitely sees something that he believes to be highly suggestive of cancer or suspicious of cancer, yes, sir.
Q. And if what he sees on the film is inconclusive, then he shouldn't be scaring people by saying cancer is there when he doesn't see it. Isn't that also true?
A. Well, he should say what he sees and interpret what he means. And if he thinks that there is nothing suggestive of cancer, he shouldn't say that there is something suggestive of cancer. I would agree with that.
Q. And as I understand your testimony, you feel that Dr. Fisher's report in July of 1989 was a proper and appropriate report given what was on the mammograms themselves.
MR. ONSTAD: Objection, leading.
A. In my opinion, that is correct.
Q. (By Mr. Polewski) Doctor, do you have an opinion one way or the other as to whether or not Dr. Hall did something wrong in this case?
MR. ONSTAD: Objection, failure to lay a proper predicate.
Q. (By Mr. Polewski) First, do you have an opinion?
A. Yes, I do.

Q. All right. And, Doctor, let me ask you to assume that the definition of negligence in the State of Texas is, with respect to a physician, the failure to do that which a physician of ordinary prudence would have done under the same or similar circumstances or doing that which a physician would not have done under the same or similar circumstances. Can you assume that definition with me?

A. Yes, sir.

Q. Assuming that definition, Doctor, do you have an opinion as to whether Dr. Hall's conduct with respect to reading the report from Dr. Fisher and his subsequent conduct was negligent?

MR. ONSTAD: Objection, failure to lay a proper predicate.

A. I have an opinion.

Q. (By Mr. Polewski) And what is that opinion, sir?

MR. ONSTAD: Objection, failure to lay a proper predicate.

A. In my opinion, Dr. Hall was not negligent in his behavior.

MR. POLEWSKI: Doctor, I will reserve the rest of my questions until the time of trial. Thank you.

THE WITNESS: Thank you, sir.

FURTHER EXAMINATION

**BY MR. ONSTAD:**

Q. What is your understanding of the clarity Dr. Hall had in his mind after reading the July '89 mammogram?

A. It's my understanding that Dr. Hall was -- did not find anything in this reading to suggest the presence of a cancer and, therefore, told the patient to return in one year for a repeat mammogram and examination.

MR. ONSTAD: Objection, not responsive.

Q. (By Mr. Onstad) What did Dr. Hall testify about whether the report was clear or unclear to him?

A. He subsequently testified, he said it was unclear to him, as I recall.

Q. But it's your understanding --

A. I have that page.

Q. -- that in Dr. Hall's mind, after reading the report, the report was unclear to him. Is that your understanding of Dr. Hall's testimony?

A. It's my understanding that's what he said in his deposition.

Q. Do you understand --
A. I don't have his -- May I see the deposition please, sir?
Q. Do you understand he was under oath when he gave that testimony?
MR. TWINING: What's the page you're looking at?
MR. BARKER: You're being very unfair at this.
MR. ONSTAD: I'm just asking him if he recalls, if his recall is correct.
Q. (By Mr. Onstad) Do you recall if Dr. Hall was unclear when he read the report?
A. Would you mind -- would you mind, sir, referring to that page so I can find it again?
Q. Do you understand when Dr. Fisher --
A. Excuse me, what page are you on?
MR. TWINING: If you're going to ask him to testify about testimony Dr. Hall has given, and you're sitting there looking at a transcript, I only think it's fair that you refer him to whatever part of the deposition you're referring to.
MR. ONSTAD: I don't have to do that.
MR. TWINING: If you're saying that

you may not be reading from the transcript, then fine. But if you're reading something from the transcript, I think you need to inform him where you're reading from.

Q. (By Mr. Onstad) You're the one that's getting paid $400 an hour to read this stuff and remember it, aren't you?

A. I'm getting -- I'm getting paid to read it and analyze the case. But I'm not being paid to remember every word of testimony.

Q. Whatever you're doing, you're getting paid --

A. I'm not a camera, you know.

Q. You understand that Dr. Fisher was of the position that his report of July 25, '89 sent up a red flag of suspicion for cancer?

A. That is not my understanding.

Q. Well, did you read his deposition?

A. We're talking about Dr. Fisher? Didn't we go over this earlier? And which I said I thought he said red flag and this being an indeterminate reading.

Q. I've got a different question now. Look at Page 63.

A. Of which?

Q. Dr. Fisher. The question beginning on Line 19.

A. 63. Yes, sir.
Q. It says, let me go back to the mammogram in July 25, 1989. Is it your position that your report sent up a red flag of suspicion for cancer?
What was his testimony?
A. His testimony there was yes, sir. But subsequently his testimony was that it's -- that it was indeterminate.
MR. ONSTAD: Objection, not responsive.
Q. (By Mr. Onstad) Let's try it again. Let's see if we can get the complete answer and the complete question.
This is the complete question. Okay. Let me go back to the mammogram in July 25, 1989. Is it your position that your report sent up a red flag of suspicion for cancer?
Would you read the complete answer?
A. Yes, sir.
Q. Thank you.
MR. TWINING: You don't want to read any more of his deposition?
MR. ONSTAD: If you want to read his whole deposition, you can.
Q. (By Mr. Onstad) You studied that deposition and

prepared to come in here and give your opinions, did you not?

A. I did. And I gave you my opinion based on the entire deposition, which included his response to questions asked by Mr. Polewski that indicated that it was an indeterminate report.

MR. ONSTAD: Objection, not responsive.

Q. (By Mr. Onstad) Do you think it's prudent to wait 15 months to treat an adenocarcinoma of the breast?

A. That's a question out of context. The assumption here is that somebody had an adenocarcinoma of the breast that was diagnosed and left untreated for 15 months. If there was such a case where the patient had a known carcinoma of anything, no, it would not be prudent to wait 15 months to treat it.

Q. Why would it not be prudent to wait 15 months to treat an adenocarcinoma of the breast?

A. Again, with the predicate that one knows that you have a carcinoma of anything, including the breast, it is not prudent to wait to treat it because the opportunities for effective therapy are greater shortly after diagnosis than after 15

months in most cases.
Q. Does the majority of medical literature on cancer of the breast indicate that if a Stage I cancer is properly treated in a timely fashion, the chances of disease pre-survival are five -- excuse me. I'm going to start this question all over.

Do you agree that the majority of medical literature on breast cancer stands for the proposition that if a Stage I adenocarcinoma of the breast is timely and properly treated,. there's only a 5 to 10 percent recurrence chance?
A. At what time point?
Q. Over ten years.
A. At ten years it usually is. It's variable between 74 to -- 78 to 94 percent, depending on many other characteristics of the tumor.
Q. And on Stage II, how does it compare?
A. Stage II, again if it's a Stage II of the sort we're talking about, the figures fall down at ten years to about 55 percent. This is without anything other than the general information that it's Stage II and the general information that all you're doing is surgery and you're not doing any additional therapy.

Q. Have you ever seen any protocols that recommend chemotherapy for Stage I cancer of the breast?
A. Absolutely.
Q. What type of chemotherapy?
A. CMF is generally what's been recommended.
Q. And what's CMF?
A. Cytoxan and methotrexate and fluorouracils usually according to the program developed by Bonnadonna (phonetic) and his colleagues in Milan. But that's not the only form of chemotherapy. Many people use what we call FAC or F-A-C, which is fluorouracil, adriamycin and cytoxan. Those are two fairly commonly employed programs.
Q. Now, your charges since you've been involved in this case have been $9,200. That's before you got here today. Right?
A. That's correct.
Q. And what are your times today?
A. I don't know. Until we're over.
Q. Well, how many hours have you been involved so far today devoted to this case?
A. Well, I'd say it looks like four hours.
Q. And is that at the $600 per hour rate?
A. That's correct.

Q. You didn't have any prep time today beyond your testifying time?
A. That's correct.
Q. What is your charge to come to Texarkana and testify?
A. $600 an hour.
Q. When does that time start?
A. That's time and testimony. Time to get there is $400 an hour. And back.
Q. Okay. So you charge $400 an hour to travel?
A. Yes, sir.

MR. ONSTAD: That's all the questions I have.

FURTHER EXAMINATION

BY MR. POLEWSRI:
Q. Doctor, just so we don't get confused in this deposition, the ten-year survival rates that Mr. Onstad was talking about are ten-year survival rates for Stage I cancers of all types and Stage II cancers of all types. Is that correct?

MR. ONSTAD: Excuse me. Object to the side bar remark and object to the question as leading.

A. Yes. It includes all -- the whole range of Stage

I tumors with all characteristics of the tumors histopathologically, receptor wise, et cetera. Anything in that heading so long as it's a T1 NO MO.

Q. (By Mr. Polewski) And, Doctor, with respect to this case, we know the particular type of cancer which Ann Dykes had, do we not?

A. Yes, sir.

Q. And so with respect to this case, do you have an opinion as to whether or not the gross ten-year survival rates for Stage I cancers of all types is even relevant to this case?

MR. ONSTAD: Objection, leading.

Q. (By Mr. Polewski) First, do you have an opinion?

A. I have an opinion.

Q. And what is it, sir?

A. Well, it's relevant as a general guide, but when one factors in all the other prognostic things we talked about, this patient in my mind has probably at this time a 95 plus percent chance of surviving ten years.

MR. ONSTAD: Objection, not responsive.

MR. POLEWSKI: Thank you, Doctor, that's all I have.

MR. TWINING: Reserve the rest of ours. Thank you, sir.