IN THE COURT OF COMMON PLEAS

PHILADELPHIA COUNTY

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REBECCA BISH DEVINE, et al.,
Plaintiffs,
-vs-
BLANCHARD VALLEY MEDICAL ASSOCIATES, et al.,
Defendants.

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Oral deposition of HARVEY J. LERNER, M.D., held in the doctor's offices at 907 Pine Street, Philadelphia, Pennsylvania 19107, on Wednesday, September 15, 1999, beginning at approximately 11:00 a.m., before Patricia Crudo, Court Reporter and Notary Public.

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EXHIBITS

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(It is hereby stipulated and agreed by and among counsel for the respective parties that certification, sealing and filing are waived; and that all objections, except as to the form of the question, are reserved until the time of trial.)

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HARVEY J. LERNER, M.D., having been duly sworn, was examined and testified as follows:

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EXAMINATION

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BY MR. MADDEN:

Q. Good morning, sir. Would you just as a formality state your full name?

A. Harvey Lerner, L-E-R-N-E-R.

Q. What is your occupation, sir?

A. I'm a physician.

Q. And I will address you as Dr. Lerner; is that okay?

A. That's fine.

Q. Dr. Lerner, tell us the address where we are for this deposition.

A. 907 Pine Street, Philadelphia.
Q. And is that a professional address of yours?
A. Yes; it's a medical office.
Q. Is that your primary address for professional contact, or do you have other offices?
A. I have other offices but this is the primary address for professional contact.
Q. Without getting into the street names and so forth, what are your other addresses at the hospital?
A. I have an office in Germantown Hospital. This office is across from Pennsylvania Hospital. And I have an office directly across the street from Northeastern Hospital.

MR. MADDEN: Okay. Just to be on the safe side, let me digress for one moment. I'm simply going to put on the record that counsel for Dr. Cosiano is not here, but it has been represented to all counsel in the room that we are authorized to go ahead in counsel's absence and that there won't be any objection raised to that. Is that right?

MS. MOODY: He telephoned me and said that he wasn't coming.

BY MR. MADDEN:

Q. Doctor, we met a few moments earlier. My name is Justin Madden, and you and I have had a chance to talk here informally about the Philadelphia area and the homes and so forth. I think you can see that I'm not down here to trick you or trap you or argue with you. I'm simply here to discover your impressions and opinions in this case. And if you will be completely forthcoming with what it is you're going to be testifying about, I would appreciate that. Is that fair?

A. No problem. I fully understand and I intend to be just as friendly as you have been.

Q. All right. In your medical occupation, Doctor, what is your field of specialty?

A. I do surgery, surgical oncology and cancer chemotherapy.

Q. When were you first contacted in this case?

A. I couldn't tell you the exact date. You probably could tell from the letters. There was probably a phone call sometime before May twenty-fourth, 1999, and there were three similar letters with patient information or information about the case.

Q. Okay. In your file, and I'm going to go

through that momentarily, you have some letters of correspondence from counsel, Nancy Moody; correct?
A. Correct.
Q. And are you sending your bills for your time in this case to counsel, Mrs. Moody?
A. Yes.
Q. There was a phone call that preceded the first letter that you have which is dated May twenty-fourth, 1999. Tell me again approximately how much earlier was the phone call.
A. I couldn't tell you if she spoke with me or more likely my secretary, Maria. I couldn't tell you that.
Q. Do you have any idea how much earlier than May of 1999 you were first contacted to serve as an expert in this case?
A. I couldn't tell you. It would probably most likely be less than a month, but I couldn't tell you that.
Q. That's fine. So your involvement in this case dates back, at the most, to April of 1999; is that fair?
A. More likely than not, but I could not tell you that exact date.

Q. What have you been asked to do in this case, Doctor?
A. Review the records and give my opinion whether this alleged delay affected outcome.
Q. Okay. Without giving me all the factual bases for your opinions, we are in a court in Ohio that does not require the expert to provide a report or summary in writing of his opinions. What I would simply ask you to do is just tell me what your opinions are going to be and then we can cover them one at a time. I just don't need all the factual bases at this point.
A. My opinions are that this lady had a probable cancer of the lung adenocarcinoma which was biopsied, and there was subsequent metastases to bones and liver, and she subsequently expired. And her tumor was refractory to the chemotherapy, and she received some radiation therapy to the central portion of her lung, the left main stem bronchus.
Q. Tell me that last opinion again. She received some --
A. She received radiation therapy to her chest, her left main stem bronchus, and that her tumor was essentially refractory to chemotherapy.

Q. And you mentioned something about the left main stem bronchus?
A. There was an adenocarcinoma biopsied.
Q. Doctor, we will get into more detail on this question in a moment, but do you have an opinion whether the tumor in the left main stem bronchus was the primary tumor for this lady?
A. My opinion is that it most likely was. And I could tell you about why I think that is, but there is no question that's the only tissue diagnosis that exists to the best of my knowledge. And that was visualized and gross biopsied. And looking at the report, the endoscopist reported that it was about an eighty percent occluded bronchus. The slides were reviewed by the local pathologist and subsequently by the Armed Forces Institute of Pathology in which they did special stains, and their opinion was this was an adenocarcinoma, most likely lung.
Q. There was an adenocarcinoma most likely originated in the lung. We know it metastasized to the pubic bone and to the liver?
A. We have evidence that there are lesions in the bone and the liver that are compatible with metastases and it enlarged over time, correct.

Q. I think you would agree with me that the metastases to the areas of her body outside of the lung field all occurred after April of '97; is that fair?
A. I don't know that that's fair. They were recognized after that time, but they occurred at some point before that.
Q. All right. That's a fair clarification. That's when they were first recognized.
A. Right.
Q. Now I think you told me summarily, Dr. Lerner, that your opinion in this case is that the delay in diagnosis of this lung cancer was not significant to the outcome. Did I state that correctly?
A. That's very correct.

MR. MADDEN: Let me go ahead and mark a few items here, if I can. First of all, Doctor, you have been good enough to give us a copy of your CV which is last dated May of 1998; is that correct?

THE WITNESS: Yes.

(Whereupon, a curriculum vitae was marked Deposition Plaintiffs' Exhibit "Lerner

1" for identification.)
BY MR. MADDEN:
Q. Doctor, I'm marking Plaintiff's Exhibit One with your last name and today's date. Can you identify what the object is I have handed you?
A. My CV.
Q. Is that the most current copy of your CV, Doctor?
A. Yes.
Q. Are there any honors, publications, memberships that have either expired or you would add to that that don't appear there?
A. Yes.
Q. Would you just tell me what those are, please?
A. In February of 1996 I stepped down as the chairman of the department of surgery at Germantown, and this year also as head of the section of surgical oncology and cancer chemotherapy at the Pennsylvania Hospital.
Q. So I understand, you are no longer the chairman of the department of surgery at Germantown Hospital?
A. Correct.

Q. And that's been the case since 1996?
A. No, since February of 1999.
Q. I apologize. And secondly --
A. This year.
Q. -- what was the other change?
A. This year I am no longer the head of the section of surgical oncology and cancer chemotherapy at the Pennsylvania Hospital.
Q. All right. Were those the only two hospitals where you held privileges in the last ten years?
A. No. I still have privileges every place, including Northeastern Hospital, and at some time in the past I was chairman at Northeastern also.
Q. May I have your handwritten notes which I believe are the notes you have made about the radiology reports in the case?
A. Right.

(Whereupon, hand-written notes were marked Deposition Plaintiffs' Exhibit "Lerner 2" for identification.)

(Whereupon, hand-written notes were marked Deposition Plaintiffs' Exhibit "Lerner 3" for identification.)

BY MR. MADDEN:

Q. Doctor, I'm handing you Plaintiffs' Exhibits Two and Three with your last name and today's date on them. Those are two separate pages of notes that you have made in your own hand; is that correct?
A. Correct.
Q. What are the notes addressing on Exhibit Two?
A. O'Grady at the top -- oh, Exhibit Two. I'm sorry. I wrote a chronology essentially of Rebecca Bish Devine regarding many of the x-rays. The first chest x-ray that I had a report on was 10/3/94, and it continued on down to 5/2/97.
Q. And that's just the radiology report points, aren't they?
A. Well, it's basically radiology reports, and I wrote down at the end she had chemotherapy and radiation to the chest; basically a chronology regarding her chest findings.
Q. All right. And Exhibit Three?
A. I wrote down something about O'Grady, Dr. O'Grady thinks it's a primary left main stem bronchus and, in his opinion, caused the wheezing, which was unilateral, and he thought there were metastases to the left upper lobe. The next note says bronchoscopy '97, Watson, and beneath that are some measurements

performed by Dr. -- I think Michael --
Q. Potchen.
A. -- Potchen. And they are the measurements of the lesion in the pubic ramus, from 5/1/97 to 9/15/98.
(Whereupon, a two-page letter, dated May 24, 1999, to Harvey J. Lerner, M.D., from Nancy D. Moody, Esquire, was marked Deposition Plaintiffs' Exhibit "Lerner 4" for identification.)
BY MR. MADDEN:
Q. Okay. And then Exhibit Four with your last name and today's date on is it a two-page letter to you from counsel, Ms. Moody, with what appears to be a factual summary and a request for you to review materials --
A. Right.
Q. -- and get back to her; correct?
A. Correct.
Q. As for the rest of your file, do you want to just go ahead and make a record of what you have? First of all, you have four volumes of medical records in this case; correct?
MS. MOODY: Off the record for a

minute.

(Discussion off the record.)

(Whereupon, four volumes of medical records, first page entitled Expert Book, Index, was marked Deposition Plaintiffs' Exhibit "Lerner 5" for identification.)

BY MR. MADDEN:

Q. All right. Dr. Lerner, I'm handing you Exhibit Five as we were talking about the contents of your file. We have marked the cover page of one of the four volumes of medical records that you have; is that correct?

A. That's correct.

Q. And so books one through four are sort of summarized as to their contents by Exhibit Five; right?

A. Correct.

Q. Have you had an opportunity to review all of the medical records in this case?

A. I have gone through all of them at one point or another.

Q. Have you requested any other information that has not yet been sent to you?

A. There is one piece of information that I

would like but not required.
Q. What is it that you would like?
A. If there is any way we could measure the size of the tumor in the main stem bronchus I would like that measurement, but it's not absolutely essential.
Q. You have also had an opportunity to review radiology films in this case, or not?
A. I have not directly seen the films that I could recall.
Q. Were they ever sent to you?
A. I don't think I have ever gotten those films.
Q. Have you asked to see any of the films or the pathology slides from Rebecca Bish?
A. I have looked at the slides.
Q. Why don't we pull the object in your file? I think you made a Xerox of the slides?
A. I don't think I made a Xerox of the slides.
Q. You know what I mean.
A. This is something that was reviewed or sent. Somebody else made that; I didn't make that.
Q. Okay. That's not your Xerox?
A. No.
Q. You have had an opportunity to review the pathology slides?

A. Right.
Q. Are they significant to your opinions in any way?
A. No. I just like making sure that it was an adeno, and I would not testify against another specialist as far as changing their diagnosis. If there was something that I could measure on there, I would have measured it, but I do like looking at all the pathology slides.
Q. If you were to measure this object on the left main stem bronchus that you mentioned, how would you go about doing that? What would you need and how would you do it?
A. I would need either an opinion from whoever looked down there as to size. But apparently it was so occluded, they couldn't see the full length; or if it was measurable on one of the CAT scans, I would like that. But I'm not sure it was recognized and measurable on the CAT scan.
Q. Which date would you want to see the left main stem bronchus, from the CT scan that Dr. Watson had back in October 1994?
A. If they could see it on both, I would like to know the measurements on both.

Q. There were CAT scans that were taken in April and May of '97, true?
A. Correct.
Q. Are you also interested in looking at the left main stem bronchus in those CT scans?
A. I would prefer having a radiologist measure. When things get very compact and dense, I would prefer deferring to an expert in that field and I would prefer an expert do that. I can read films fairly well, but I don't want to be the expert in radiology or the expert in CAT scan or the expert in some things that I'm really not a thousand percent trained in. I could read fairly well pathology slides. When I had my training, pathology was a required rotation which you were a pathology resident for a fixed period of time, and I feel very comfortable reading the slides but I would not pretend to be a pathologist.
Q. I think your training would have been back in 1958 or *so?*
A. I started in '58; finished in '63.
Q. And in fairness to you, the technology has changed substantially in the radiology field?
A. Absolutely. Technology has changed in every

field, including surgical technique and instruments we use and everything else. But if you keep current, you get fairly good at reading some of these things, but you're not as slick as somebody who does it primarily.

Q. Okay. If a radiologist was to measure the object that you're concerned with in the left main stem bronchus, say from the April or May 1997 CT scans, what conclusions would you come to from that? What are you looking for?

A. Well, you would have some idea of size and probably duration.

Q. Would it tell you anything about the 1.6 by 1.9 centimeter lesion that was observed as early as February of 1994 in Rebecca's left upper lung?

A. I'm not sure I follow the question. If we could measure the size of the lesion in the bronchus, would it tell me anything more about the left upper lobe lesion?

Q. Right.

A. No, it would not tell me anything more.

Q. What would it tell you then about the object of the left main stem bronchus?

A. If it changed in size that we could measure

over time that we could visualize on these, we would have some estimate as to the tumor growth during that time frame.

Q. Would it change in any way what diagnostic response Drs. Watson, Echavarre or Cosiano should have taken in response to the appearance of this lesion that the radiologist wrote about?

A. The lesion in the left upper lobe?

MS. MOODY: I want to enter an objection here. I don't believe the doctor is testifying as to the standard of care.

THE WITNESS: I'm not sure I understood the question.

MR. MADDEN: Do you want to read the question back?

(Whereupon, the court reporter read the following:

"Question: Would it change in any way what diagnostic response Drs. Watson, Echavarre or Cosiano should have taken in response to the appearance of this lesion that the radiologist wrote about?")

THE WITNESS: You're talking about the left upper lobe lesion?

MR. MADDEN: Right, the 1.6 by 1.9 centimeter lesion observable back in the fall of 1994.

THE WITNESS: I probably would refer it to the pulmonary people. Had I seen this in my patient at that point in time, and I were in an endemic area of granulomatous disease such as cystopapulosis or something in a twenty-eight year old female, lung cancer would not have been my primary thought. And I'm not sure all the diagnostic tests that I would or would not have done at that time. I may have discussed them with the patient, but more likely than not, if you had to pick a percent, it would be more likely than not a granulomatous disease for somebody that age group.

BY MR. MADDEN:

Q. Let's go ahead and finish up the contents of your file. You have two other transmittal letters from Ms. Moody which are just cover letters for a deposition that was sent to you. I think two different depositions were sent to you; right?

A. Right.

Q. And you also have some depositions that are loose. What are the depositions that you have reviewed in this case?
A. I thought I read Dr. Ettinger's. I thought I read Dr. Kanarek's and I just read Dr. O'Grady's.
Q. Have you read Dr. Ettinger's deposition?
A. I thought I did.
Q. You have read Dr. Echavarre's deposition?
A. Yes.
Q. You have read Dr. Kanarek's deposition?
A. I don't recall the name but I probably did.
Q. He is the pulmonologist from Mass General.
A. I don't recall if I read that. I probably did but I can't tell you for certain.
Q. You read the deposition of Dr. David Ettinger?
A. Yes.
Q. Can you recall anything -- and it's a broad question -- can you recall anything in specific that Dr. Ettinger testified to that you don't agree with?
MS. MOODY: Objection.
THE WITNESS: In general, I believe that this was a primary main stem bronchus cancer. I certainly agree with Dr. Ettinger

about the statistical analysis. I think Dr. Ettinger is a very good, very bright medical oncologist. I agree with Dr. Ettinger when he said it takes the average lung cancer about eight to ten years to be recognized. And so I agree with all those statements.

BY MR. MADDEN:

Q. Was there anything else in your file that you have in your possession or that you reviewed that we haven't addressed for the purposes of making a record about it?

A. Not offhand that I could think of.

Q. The Xerox-copied medical records that you have loose from the binders, those are copies of what's contained in there; correct?

A. Yes.

Q. Just itemize what it is that you have copied and loose?

A. I have a copy of the bronchoscopy report. I have a copy of the pathology report from the pericardial biopsy. And I have copies of the other pathology reports of the bronchoscopy with the washings and brushings, and the review of the reports from -- I think that was the Armed Forces Institute

of Pathology, AFIP, including their additional staining or addendum.

Q. Did you finish your answer?

A. Yes.

Q. Doctor, as I went through your CV I observed three articles or abstracts that you were involved in which dealt with the subject of lung cancer. Does it strike you that I'm missing some or does that sound right?

A. That could absolutely be correct. I haven't paid attention.

Q. In 1967 you had an article or an original paper on giant cell carcinoma of the lung?

A. Correct.

Q. That was back in 1967. This particular adenocarcinoma was not a giant cell carcinoma, was it?

A. No.

Q. The second original paper that I came across in your CV was on the phase II protocol for new chemotheraputic regimens in patients with inoperable non-small cell lung carcinoma; correct?

A. Where is that?

Q. It's my page nine. It's a 1981 article, if

that helps you.
A. Okay. That's correct. That was a chemotherapy article.
Q. Okay. That was a chemotherapy article back in 1981. And the third one that I saw was an abstract that you were involved in in 1978 addressing BCNU effect in primary lung cancer?
A. Okay.
Q. Colsky and Lurie. Do you see that?
A. Yes.
Q. First of all, what was BCNU effect about? What's that?
A. That's a chemotherapy drug.
Q. So that's another chemotherapy paper?
A. Right.
Q. Can you think of any other articles or abstracts that you have been involved in that I haven't picked up?
A. I don't know if it's in here or not, but I thought we wrote a paper once on non-operable breast cancer that we treated with hydroxyurea radiation and then followed by surgery, and I don't see it right offhand.
Q. I was looking for any other publications that

you have on the subject of lung cancer.
A. There may be one or two other chemotherapy reports in here. I'm not sure.
Q. But they would be in chemotherapy and not in diagnosing or staging or anything like that?
A. That is absolutely correct. I don't know that I have written any articles about diagnosing lung cancer or staging, so we are not looking -- overlooking anything.
Q. All right. From what I have seen in your CV, Dr. Lerner, and the many articles and abstracts that you have written, I have the impression that lung cancer is not a specific concentration of yours; is that fair?
A. It's something I didn't write about a lot, that's fair. We see a fair number of lung cancers. And up until this year, my partner did all the lung surgery. He went out on his own this past year, January first, but we certainly treated a lot of lung cancers with chemotherapy and he operated on a great number of lung cancers.
Q. And your role in the oncology field is chemotherapy?
A. I do surgery. At that point in time, the

number of patients who came to surgery for lung cancer has basically been continually declining, because staging makes many people non-surgically treatable. And I thought it best that only one of us really be skilled in that, and he was the one.

Q. You're also involved in treatment of gastric cancers?

A. We do treatment, most solid tumors. I have treated most solid tumors, participated in clinical trials, cooperative groups.

Q. Okay. So lung cancer is just one of many types of cancers that you have treated or --

A. Right.

Q. -- or worked in over the years?

A. But most of them have been -- the majority have been breast, lung and colon, which are the most common cancers that I have been involved with.

Q. If you can't break it down to percentages, I understand, but is there a way to approximate the amount of time you spend in lung cancer as opposed to other cancers?

A. I couldn't give you an exact percent.

Q. In other words, you don't spend more than half your time in lung cancer?

A. Oh, absolutely not, absolutely not. I will say that.
Q. More than one third of your time in lung cancer?
A. Probably not.
Q. More than twenty-five percent of your time in lung cancer?
A. I don't think so either.
Q. Okay. Dr. Lerner, have you ever practiced medicine in the private sector?
A. I have only practiced medicine in the private sector.
Q. And the reason I asked is I just saw that you were involved with the University of Pennsylvania School of Medicine.
A. I have always been involved in training programs. When I was at the Pennsylvania Hospital, I was at one point appointed to go over the university and give some courses and I thought some things there. Then I was just with the students here. And at Germantown I was responsible for the surgical training program for the residents and the interns and the students. Currently, I still have students that come with me wherever I go.

Q. Okay. Why don't you just tell me today how do you divide your professional time? First of all, do you still perform oncology surgery?
A. As often as I can.
Q. How much time are you spending in surgery as opposed to teaching as opposed to administrative matters?
A. On Monday I operated from eight in the morning to eight in the evening, did some office hours. I had residents and students with me. Tuesday I operated in the morning, had students with me. I had office on hours in the afternoon; I had students with me. Today I'm spending the day with you. Tomorrow I have surgery again, and Friday I have surgery again and office hours in the afternoon. That's a fairly typical week.
Q. And the type of surgeries you're performing lately, are they a wide variety or a particular area?
A. I still see a great deal of breast cancer, colon cancer, and other cancers that I might biopsy. I biopsied some lymph nodes that were lymphoma just recently, melanomas. I do a lot of oncological surgery.
Q. When was the last time you performed a

bronchoscopy of a lung cancer?
A. As I mentioned, I haven't done that in years and years and years because my associate would do that.
Q. Okay. Same question with regard to needle biopsy?
A. I have never done needle biopsy of lung cancer. Whenever I have ordered it or wanted it or my associate wanted it, in this area most of it has been done by the CT-guided x-ray department.
Q. When was the last time you surgically resected a lung cancer?
A. A lot of years. While I have not been in the operating room for lung cancer as the primary surgeon, I might have assisted my associate at that time. But I have, as I stated earlier, I have not personally done the lung cancer surgery because the number of cases that come to surgery have continued to drop.
Q. And then just for completeness, mediastinoscopies?
A. I have done some, but I haven't done one in years with that also, mediastinoscopies.
Q. Doctor, I'm inferring that you have given

depositions in the past?
A. Correct.
Q. Not to be offensive, have you ever been sued before?
A. Absolutely. Philadelphia, it's hard to practice and not be sued.
Q. How many times have you been sued, if you can --

MS. MOODY: Objection.

MR. MADDEN: Fine. We will continue that.

THE WITNESS: Probably ten times or so. I have been to court twice.

BY MR. MADDEN:
Q. Have any of the actions against you alleged that you or one of your co-defendants delayed or failed to diagnose lung cancer?
A. No.
Q. You have also given depositions before as an expert?
A. Yes.
Q. Have you testified as a treating physician on behalf of a patient to explain their injuries?
A. I probably have. I can't recall. I used to

be a mesothelioma study chairman for the Eastern Cooperative Oncology Group and I know I have testified regarding that, and usually it was for the plaintiff, but I can't give you specific instances or --

Q. Was that the whole asbestos field?

A. It was asbestos.

Q. Let's put aside depositions or testimony you have given as a defendant in a lawsuit because none of it involved lung cancer, okay?

A. That's correct.

Q. Let's talk about depositions where you have served in the capacity as an expert. How many times have you been an expert on a case where you were defending a physician?

A. The majority of cases that I have reviewed have been primarily for the defendant.

Q. Okay.

A. The majority, without question, the high percent majority, probably ninety plus. And what was the second part of your question?

Q. The second part of the question is, have you ever testified as an expert on behalf of a plaintiff against a physician where you were alleging that the

physician failed to meet the minimum standard of care?

A. I have rarely, if ever, testified to standard of care. I would only testify basically to the standard of care to a peer which I would consider somebody that does what I do. And I can't recall being asked to testify to that. I may have but I certainly don't recall it.

Q. So if I may summarize, and you tell me if I do it incorrectly, okay?

A. Okay.

Q. When you have served as an expert in a case, more than ninety percent of the time you have been an expert in the defense of a defendant who was accused of not meeting the standard of care but not testifying on standard of care?

A. It's usually been whether a delay affected outcome.

Q. Okay. So my question was so bad earlier. When you testified as an expert in a case, more than ninety percent of the time you're talking about whether the delay made any significant difference in the outcome?

A. That's correct.

Q. Is there any approximate number of cases, is there a number that you can tell me you have been involved in as a defendant in that capacity?
A. As a defendant?
Q. As an expert for the defendant.
A. I couldn't give you an exact number. I don't keep any records. And I would ballpark for you that since I have been out in practice over the last thirty, thirty-five years or more, I have probably reviewed about two hundred, two hundred twenty-five, two hundred fifty cases. I have no idea of the exact number. Some have been for plaintiffs; some have been for defense. Infrequently I have written a letter for a plaintiff. Most plaintiffs have said thank you and please don't write a letter. And that's been it over that course of time.
Q. When you were identified as an expert on proximate cause whether the delay had any significant impact on the outcome, and you told me that ninety percent of the time you testified in that capacity at the request of the lawyer who was representing a doctor who was being sued; correct?
A. Usually.
Q. How are you charging for your time in this

case, Doctor? Are you --
A. On an hourly basis.
Q. And what is that basis?
A. Five hundred dollars an hour.
Q. And is that five hundred dollars per hour to review medical records and depositions?
A. Everything.
Q. Your time for testifying in a deposition is five hundred an hour?
A. Same, yes.
Q. Your time for testifying at trial will be five hundred an hour?
A. Yes.
Q. And will you bill for your time in traveling to and from the trial?
A. Most likely.
Q. At the rate of five hundred an hour?
A. Yes.
Q. Do you have any idea how many hours you have in this case thus far?
A. Probably about four, possibly five.
Q. You have a letter from the attorney who has retained you that gives you a factual summary from her point of view. Have you had any other

conversations with Ms. Moody as to what the facts of the case are or any representations that have been made to you?

A. I called and asked if I could get some measurements and asked if I could have those measurements of the metastases, or if there have been any changes on any of the x-rays, the report, particularly if there are measurements available on the CAT scan.

Q. And that was a request to Ms. Moody to get those measurement?

A. Correct.

Q. Have any facts or representations been made to you by counsel in this case, anything as to what they view the evidence is going to be in this case or anything of that nature?

A. I'm not sure I really understand that question at all.

Q. In other words, are your opinions based in any way on representations that have been made to you by counsel, or are they based on your review of the records and depositions?

A. Oh, my records.

Q. Are there any texts, articles, publications

that you're relying on in coming to your opinions in this case, anything you can direct me to?

A. Specifically?

Q. Right.

A. There are a lot of very good reviews out there, good references and good reference books, but right offhand I can't give you a specific one.

Q. Right. As you were coming to your opinions in this case, you didn't go to a particular text or book that you could think of to confirm something?

A. Absolutely not.

Q. Are there treatises that you consider to be authoritative on the field of diagnosing or staging lung cancer?

A. Again, there are a lot of good reference things.

Q. Such as?

A. Well, DeVida is a good reference book. There are a lot of good texts on lung cancer, and there are a lot of very good clinical trials that have been performed in lung cancer. There has been a trial from Hopkins, as you probably know, and a trial from the Memorial and a trial from the Mayo. There was a trial in Philadelphia by Catherine Bucco lots and

lots and lots of years ago. So there have been a lot of clinical trials with very important biological information.

I was the cancer fellow for the last two years of my surgical training and it really got me involved in trying to find out about cancer. So when I finished, I did some chemotherapy training. And at one point, by association with some of the other physicians who are interested in tumor growth and doubling, probably mainly Dr. John Spratt, I joined the cell kinetics group to try to understand the biology of cancer. And periodically I take a course in the biology of cancer. It used to be at Carnegie Mellon. Now it's at Harvard. It's a week-long course trying to understand the biology of cancer, which is very complicated. And I spend a lot of time tying to understand the biology of cancer.

The clinical trials with tumors have helped to understand a great deal about the biology of cancer. The things that have changed most in the last twenty, twenty-five years is not the outcome of lung cancer or some of these tumors, but understanding the biology and the new modalities that we will try to attack some of these tumor systems.

But for lung cancer little, if anything, has changed for across-the-board lung cancer in the last thirty years.

Q. Aside from the trials or clinics that have been done that you mentioned, are there textbooks that you consider to be fairly well respected?

A. DeVida is a well-respected book. It's a good reference book. There are some things in there that are great; some things in there I'm not sure that I agree with. I'm sure that is true with most physicians for most very good texts.

I know one super author of a text and he says he doesn't even consider his own textbook authoritative because some of the authors who co-authored things in there he personally has some differences about. And I have a world of respect for that author.

Q. Who is that, by the way?

A. Dr. John Spratt. He is probably an expert's expert in tumor growth.

Q. Is he an oncologist?

A. Surgical oncologist.

Q. Have you discussed anything in this particular case with any of your colleagues or anyone

outside of counsel?
A. No.
Q. I think I know the answers to these questions but let me just go ahead and ask, okay. Do you know Dr. Frank or Cosiano?
A. No.
Q. Do you know Dr. Watson?
A. No.
Q. Do you know Dr. Echavarre?
A. No.
Q. We talked about Dr. Kanarek or Dr. O'Grady. You don't know those fellows?
A. No.
Q. And you have not talked with any of them?
A. No. The only name I know in that file, and I knew him fairly one well at one time, was Roland Skeel. I was very active at that time in the Eastern Cooperative Oncology Group. He may or may not remember me but that probably goes back twenty years. And I thought he was an excellent physician, very bright person, very good, genuine, all-around person.
Q. And he assumed Rebecca's care following the stage IV diagnosis?

A. Yes.
Q. How about Dr. David Ettinger at Johns Hopkins?
A. I know him, but -- we would speak or something, and he probably would say, oh, yeah, I know Lerner, at least I would hope he would say that. But I have a lot of respect for Dr. Ettinger. He is a very good medical oncologist.
Q. Is he considered to be a front-runner or a forefront person in the field of lung cancer to your knowledge?
A. I think he is a very well-respected medical oncologist and knows about the medical treatment of lung cancer very well.
Q. Thank you, Doctor. Do you have any criticism of any kind, understanding you're not here on standard of care; right?
A. I understand that.
Q. Right. Okay. Although you're not giving opinions on standard of care issues, as you sit here today do you have any criticism at all that you would offer on Dr. Watson's care and treatment of this patient?
A. No, I have not.

Q. How about Dr. Echavarre?
A. None.
Q. Or Dr. Cosiano?
A. None.
Q. Are you critical of any of the other physicians who provided care to this woman at or about the time that she had the cancer, starting with Affordable Chiropractic?
A. I'm not critical of any of the care. I'm not sure if she was seeing a chiropractor because she just didn't feel well or she usually goes to them. And I'm not -- I'm not knocking anything about any care. But it's always a possibility that she was having some symptoms in her bones, since we don't know when this metastases occurred, that might not be recognizable on x-rays, or it may have been recognized if they had been studied at that point. But you and I have had aches and pains, and I know a lot of people who are physicians who go to chiropractors and get relief for their aches and pains, and they think that for what they go get treated for, those guys are wonderful. So I have no complaints about any of the care.
Q. And understand again, this is my opportunity

to find out what you're going to be saying at trial So do you have any intention of testifying that the chiropractors missed a sign or symptoms that might have led to the diagnosis *cf* her cancer earlier?

A. I have no plans to testify to any of that, if that's your question.

Q. That is. Okay. The radiologists who were involved in taking or interpreting the chest x-rays in October, November and December of '94 and January *of* '96, the CT scans in October of '94 for Dr. Watson, do you have any quarrel or disagreement with the impressions or conclusions that the radiologists came to?

A. I have no quarrels or disagreements. Again, I don't practice in that area and so -- you know, in my mind's eye, my primarily diagnosis would have been granuloma, but I'm not -- I don't want to upstage or downstage anybody. I have no discrete qualms with anybody's reports.

Q. To finish up this topic, you're not going to get up and criticize any of the care that was provided by Dr. Skeel or his colleagues at Medical College of Ohio; correct?

A. Absolutely; correct.

Q. When you said you might have come to a conclusion as you looked at these films regarding granuloma, these radiologists said there was no evidence of calcification on the chest x-rays. Is that something you agree with?
A. I couldn't agree or disagree. I have not looked at the films. But as far as I'm concerned, I would not try to upstage a radiologist who is trained in that and looks at them every day. I wouldn't want them to make a comment about how 1 operate.
Q. Let me see if we are on the same page with a few general matters. There is no question that Rebecca died from lung cancer; correct?
A. There is no question she died from an adenocarcinoma of the lung which most likely, without an autopsy, was the primary lung. We know she had a tumor in her main stem bronchus.
Q. So even without the autopsy we can agree --
A. We can assume that it most likely was the cause of death.
Q. Would you agree -- I'm sorry. Go ahead.
A. Let me add a little caveat. I gathered by my reading between the lines that some of these physicians were still concerned that it might not be

a primary lung cancer because they were searching other body parts, other areas to see if there was another cancer, such as a breast cancer, which statistically would have been more common than a lung cancer causing all of this in a young woman.

And so reading from the AFIP report, they were uncomfortable, in my opinion, saying it was a lung cancer without doing some of these other sophisticated studies to make sure it was not a germ cell tumor or another tumor from another body part. And they could not, with the studies they performed, say that it came more likely than not from another area other than lung. There is no question everybody agrees it's an adenocarcinoma. And since the biopsy came from the main stem bronchus, it probably was lung since we have no other evidence that it was something else.

Q. And as you recall from reading the records, Dr. Skeel had that same question in his mind initially and ultimately concluded this was a primary lung cancer?

A. Yeah. You have a tissue diagnosis out of the lung. Although it is possible for something to metastasize like that, it doesn't happen that often.

But the age group of the patient is such that it's not very common to have an adenocarcinoma of the lung in a twenty-eight year old female. I mean, I have never seen one in somebody that young.

MS. MOODY: Just for the record, I'm going to object to the characterization of Dr. Skeel's, I will call it research into what was the primary. I think that his records indicate that he never really was convinced where the primary was.

MS. YOUNG: I just want to clarify that the doctor is talking about the hilar region and not the other nodule, and that's what you're talking about as well.

THE WITNESS: I think we are all on the same page here.

MR. MADDEN: I do, too.

BY MR. MADDEN:

Q. When you talk about -- I'm going to get to that, so I will just keep going. Lung cancer is the leading cause of cancer death in males and females in the United States; is that still true?

A. Still true.

Q. And early detection of lung cancer is

essential to the patient's chances of survival?

A. Early is a word that lights my firecracker. I mean, I don't know what early means. I don't mean to be glib about this, but I had to give a talk once after we did the lumpectomy protocol about the early treatment of breast cancer, and they meant early stage rather than early. And I spent fifteen minutes of my twenty-five minutes reviewing the word early. If you read the definitions in the book, it says it's at the beginning, you know. And so I don't know what early means.

And when I give a lecture, and I'm going to give one next week, and if I have to talk about something early, I usually get on to me and I say if I live to be a hundred, when am I early in my life. And I'm planning to be a hundred. And I would say if I'm past age fifty, I'm certainly not in the early part of my life. It's somewhere before the halfway point is an arbitrary definition of early, because there even could be premalignant changes in cells that you can't detect on our current testing system. So I don't know what early means.

As far as lung cancer goes, people try to make synonymous the word stage I with early, or

stage I breast cancer with early, the early stage. They don't necessarily mean they have been there a shorter period of time. Living and dying, when I get on my soapbox, is a biologic phenomenon and it's not simple time/size.

And so early stage lung cancer has the best survivors. And it's been that way for as long as I can remember about lung cancer. And if you're talking about data, the SER data -- are you familiar with the SER data -- surveillance, epidemiology and result. That basically states what localized disease is in lung cancer, and it's been somewhere between sixteen and twenty percent reported for as long as I can remember reading those reports. They issue them every so often. So somewhere in that localized sixteen to twenty percent are most of the survivors who prove to be stage I. So it's not simple time/size.

So the answer is, if you're biologically fortunate and they find a stage I lung cancer, you're more likely to survive than if you had a higher stage. You're not likely to survive very long if you have stage IV.

Q. Clarify this another way. There isn't any

benefit to a patient who presents with signs or symptoms of lung cancer to delay in making a diagnosis?

A. To intentionally delay, no.

Q. It behooves the patient's chance of recovery --

A. Survival.

Q. Chance of survival. Thank you. It behooves the patient's chance of survival to affirmatively diagnose whether a symptom of lung cancer is in fact a lung cancer?

A. It behooves the survival to find a stage I if you're going to find a stage I. And we should also say we are talking about non-small cell lung cancer, so that we don't get caught up in some semantics between each other.

Q. That's right. We have that agreement.

A. All right. And the biology of all these tumor systems are really very fascinating when you get into them because, you know, there are some people, they follow these lesions for long periods of time. Finally they say let's take it out, and, for whatever reason, it's still stage I. And for some people, they find something small first go-around and

it may still be stage I but their survival statistics are different than those who have had it growing slower and imperceptibly over a period of time or a difficulty in recognizing it. And they can say in lung cancer, only I see it here now or a year later or two years earlier or something like that. And those people, if they are still stage I, are biologically far better than the people who they find it the first time they get a chest x-ray.

Q. We talked earlier about Dr. Ettinger's citation of the chances of survival for a female like Rebecca who was diagnosed with stage 11, stage III A or a stage IV lung cancer. In terms of the chances of survival as he recited those statistics, you're in agreement with them?

A. I'm not in disagreement. If you look at different statistical reports, they vary, but basically, the higher the stage, the less well you do. I agree with that.

Q. He indicated that if Rebecca was at stage II at a particular part of October, November or December of 1994, that her chance of survival was twenty to forty percent with a chance of you cure. You would agree with that?

A. It depends on which series you're looking at. I have no qualm with any of his statistics. I would not want to have a stage II lung cancer compared to a stage I. I mean, he is clearly saying she is more likely going to die than survive with those numbers.

Q. But her chances of survival were greater at stage II than they were at stage III A or stage IV?

A. In general, that's correct.

Q. And if she was a stage III A patient by January of '96, he indicated an opinion that her chances of survival would be between fifteen and thirty percent and, again, I take it you have no qualm with that?

A. I have no qualms with if they are all staged pathologically. And we are talking about pathologic staging and not clinical staging. That has to be really very clear.

Q. Right. And pathological staging would be accomplished through either a bronchoscopy or a biopsy -- or a needle biopsy?

A. Pathologic staging is usually a surgical staging, but if she had a mediastinoscopy and they took a positive node out of her mediastinal, I would

accept that as a pathologic staging. But just doing -- looking at the x-rays or things like that, it doesn't count. If you can demonstrate this was metastases that would be by a needle, that would be fine and I would accept that as a pathologic staging.

Q. Incidently, there is no indication of mediastinal involvement in this case before April or May of '97; is that true?

A. That's my understanding.

Q. Do you agree that non-small cell lung cancer such as the kind that Rebecca Bish had typically begin in the periphery of the lung and work their way to the side wall of the lung lining in a typical progression?

A. Maybe single nodules sometimes are adeno, but clearly this is a cancer that's a primarily enter. As far as we can tell, it's a primary in her main stem bronchus. And in my opinion, I don't think they start in the periphery of the lung and kind of leak down the bronchus and leak down the bronchus and eventually occlude our main stem bronchus. I don't believe that. If that's the question you're trying to get me to answer, no, I don't believe that at all.

Q. All right. Let's go back to adenocarcinoma typically originate in the periphery of the lung?
A. It can very often be a peripheral nodule; correct.
Q. And the opinion has been made in this case that as of the CT scan that Dr. Watson had in October of 1994, the CT film showed hilar adenopathy in the left upper lung field.
A. The CT scan showed a nodule in the left upper lobe with enlarged hilar nodes.
Q. What, if anything, does that tell us about this lesion that was one and a half by 1.9 centimeters?
A. That it was there, that was where it was located, and that somewhere in her left hilar area she had enlarged nodes.
Q. Does that indicate to us whether this lesion that I have described was a primary or metastatic cancer?
A. It doesn't indicate either. It just means there is a nodule there. And I'm -- when you peek at cards, you know what cards are out there. And so when I look at her future, I can see what's coming. And so I have a different distorted perspective than

if I'm seeing her primarily at the time and trying to think a future. But, you know, I look at the next CAT scan which is '97, and that lesion on this particular day as I saw the measurement was 1.8 times 2.3, which conceivably could be just variations in technique or things like that. So it didn't change very much.

I have difficulty believing that a primary lung cancer or a metastases as such would say, okay, I'm not going to grow over the next several years. If we didn't know anything else about this lady, that she had a lung cancer and didn't die, and that's the only thing we had over time, you and I would be saying, yeah, she probably has cystopapulosis or granulomatous disease. This well may be a granulomatous disease that we have been looking at. It's essentially not changed over time. And following it with serial x-rays would have been the right thing to do rather than cracking her chest.

So I can't tell you what this is because we don't have a tissue diagnosis. I feel uncomfortable saying, yeah, that cancer just sat around and didn't do a thing for years, it stayed

:hat size. Most of us believe lung cancer and other cancers continue to grow, at different rates maybe, some are faster growing, some are slower growing, but they grow. So I feel uncomfortable about classifying that either as a metastases or primarily lung cancer, because I don't know.

Q. To confirm that I'm clear on your testimony, Doctor, the 1.6 by 1.9 centimeter lesion that is referenced as early as October of 1994, you can't say whether that was a primary or metastatic lesion; is that correct?

A. From my understanding of these right now, I can't say that it is, and clinically in my mind better fits a granuloma, a benign lesion and a malignant lesion essentially that has not changed in those three years or whatever that time frame is, two and a half years, three years. And I feel uncomfortable saying the rest of her cancer continued to grow and it grew in her bones and it grew everywhere else but it didn't grow where we were saying there is a primary or metastases that we can visualize. I feel more comfortable in an area that is endemic with that disease to turn out to be that disease, but I can't tell you and I don't think

anybody could absolutely tell you without a tissue liagnosis or an autopsy. I --

Q. Whether it was primary or metastatic?

A. -- don't have a report of her chest x-ray following the radiation therapy to her chest. And I don't think that peripheral lesion was treated, as I recall, to see if it changed ever. If it didn't change ever or over two and a half, three years, I would be very hard pressed to consider that a malignant lesion.

Q. So to go back, you cannot offer an opinion to a reasonable medical probability whether that particular lesion was a primary or a metastatic lesion --

MS. MOODY: Objection.

MR. MADDEN: -- in this case?

THE WITNESS: I think I'm offering an opinion that it was neither.

BY MR. MADDEN:

Q. It was neither. Okay.

A. If I had to pick to a reasonable degree of medical certainty, if that's the words you want me to use, I think clinically this fits a lesion that has never changed in size over time. I feel more

comfortable at this age group and this area that this was a granulomatous disease.

Q. Is that -- putting comfort aside, Doctor, is that going to be an opinion that you're going to offer, that this was a granulomatous disease?

A. If I am asked that opinion, I would say that the lesion in the left upper lobe was benign and has not changed over time. If I'm asked that question, that's what I will offer.

Q. You had indicated that based on how this lesion appeared, you would have been comfortable following it with serial x-rays and would not see fit to crack her chest, I think were your words?

A. I said after we see what happened over three years, that having -- if it were followed with serial x-rays, that would have been correct, if there was no other problem associated with it. At least, I hope I said that. It's just that, unfortunately, she had a malignant tumor I think in addition to whatever this lesion is.

Q. Well, she had the lesion in her lung field. We can agree to that?

A. We agree.

Q. And following it with serial x-rays was not

the only alternative available to a physician; correct?

A. Absolutely. There are many options. They could have needle biopsied it. They could have opened her chest and removed it. I'm not arguing about different options. What I'm saying is it didn't change over the time frame, and so I feel uncomfortable saying this was a primary metastatic disease when the rest of her cancer that we know about progressed.

Q. So stopping short of cracking her chest, there were other mildly-invasive procedures like bronchoscopy or needle biopsy that could have been performed to determine what this thing was or wasn't?

MS. YOUNG: I believe asked and answered.

MR. MADDEN: I can ask it six times.

THE WITNESS: I will be glad to answer that. Bronchoscopy would not have reached this lesion. Now they could needle it with a transbronchoscopic needle where under x-ray guidance the needle is directed to the bronchoscope to that area, or they could have done it transcutaneous through the chest

wall. Those are diagnostic options that I'm aware of.

BY MR. MADDEN:

Q. And they fall far short of cracking a person's chest, obviously?

A. That's true. They are diagnostic options.

Q. And they are performed all across the country, are they not?

A. They are fairly often performed.

Q. The complication rates from a bronchoscopy are relatively minor, aren't they?

A. Relatively minor.

Q. Same true with needle biopsy?

A. A small percentage get a pneumothorax. It's rare that we get a problem with it when I send people for them. We occasionally admit somebody where we put a Heimlich valve in and that takes care of it for most people.

Q. A complication concerned with needle biopsy being a pneumothorax -- and pneumothorax is a hole in the lung?

A. It's a leaking of the air out of the lung, which in a closed space will cause the lung to collapse a little bit.

Q. But often times a pneumothorax will resolve spontaneously?
A. Most of them usually resolve without having to do anything.
Q. So taking the trade-offs of a bronchoscopy or a needle biopsy against delaying and diagnosing what ultimately proved to be lung cancer, the trade-off really points to bronchoscopy or biopsy; doesn't it?
MS. MOODY: Objection.
MS. YOUNG: Objection.
THE WITNESS: You will have to say the question to me again.
BY MR. MADDEN:
Q. If one was confronted with the option of having a bronchoscopy or a needle biopsy, for the relatively minor complication risk that you and I have just talked about as compared to having cancer develop to the point where it's stage IV, the patient's option is relatively clear, is it not?
A. If you're referring if this were a primary or a secondary lesion in her lung, sure. If that left upper lobe lesion were a potential cancer, sure. I understand everything you're saying. I'm not disagreeing with you. We have no quarrel.

Q. No, we don't.

Would you agree that surgical resection of this lesion was Rebecca's only opportunity to survive the cancer?

A. We are on different pages, I think.

Q. Let's back up. Let's back up. Let's assume the lesion was a primary cancer, if you will assume that for the purpose of this question.

A. If I assume that, then the treatment of choice in my opinion is surgery.

Q. And that's her best chance to survive cancer?

A. I believe that for most lung cancers.

Q. Can you tell me what you believe the sequence of events were in this case? Do you just want to take me through what you think was going on here?

A. I think this lady was found to have a lesion in her left upper lobe. She was seeing several physicians for whatever reason, the chiropractor for body manipulation of discomfort. It was reported as a lesion. She was seen by a pulmonary physician who reviewed it and discussed things with her. And it is my understanding that she opted to have a follow-up chest x-ray -- be followed with chest x-rays, and declined the opportunity to be bronchoscoped at that

time. And that was an option. I'm not sure when she -- I don't recall the exact date when she returned.

Her CAT scan on 9/4 demonstrated the lesion to be almost the same size as the chest x-ray and showed the lesion, that it was called highly suggestive of a primary lung cancer or possible TB, or granulomas infection. Her next chest x-ray in '96 said no integral change. She was hospitalized in March of '97 with what was thought to be a pneumonia in the right lung and a small pleural effusion. I don't have the date in front of me when she had her bronchoscopy, but let me look at that.

Q. I'm pretty sure it's April twenty-fourth, '97, in the lower right corner.

A. Okay. Just before that there was another CAT scan of the chest which reported almost a similar size of the left upper lobe lesion. On this occasion there was a right hilar mass, significant aortopulmonic and precarinal adenopathy descending from the left hilar mass. She had a bronchoscopy, biopsied with a brush, a lesion in the left main stem bronchus, and was unable to pass the scope essentially to the left upper lobe.

These proved to be positive, the review

of the slides by the various people that we discussed earlier. She then had some further staging with a CAT scan of the head, bone scan, which demonstrated metastases to her pubic area and her right femur, and a CAT scan suggestive of hepatic metastases. And she subsequently received radiation therapy to her chest and chemotherapy among other potential diagnostic workups for another primary, and apparently succumbed from her tumor.

Q. In September of '98. All right. You indicated that it's your understanding of the sequence of events that this patient declined to have a bronchoscopy?

A. It was my understanding that she was offered that or serial x-rays, and it's my understanding she chose serial x-rays, and I don't have the numbers of the dates in front of me, but didn't return or returned unsequentially to be followed by that physician.

Q. I have asked you probably a couple times if you're going to have any opinions that are critical of other physicians and you have told me you don't. Are you of the opinion or do you have an impression that is critical of this patient?

A. I'm not angry at anybody.
Q. Or critical?
A. Or critical of anybody. I mean, we all have the right to do whatever we want to do, and patients make choices and patients have to accept some responsibility for their own care, just like you accept responsibility for you. And people make the decisions based on their judgments and best interests.
Q. And certainly --
A. I do not think the outcome would have changed had they done the bronchoscopy and done everything else.
Q. And when patients make judgments or decisions, they look to their physician to give them the setting or the surrounding for the decisions that they are being asked to make?
A. Most people look for some guidance for appropriate direction. I agree with you. And some people, and I will be the first to tell you, that we have biopsied some people, given them the pathology report, they have refused to accept it. I have given a diagnosis of cancer. They just -- some people just will not accept that.

But I think she possibly felt she knew what was going go on, made appropriate decisions for her. I do not -- you know, I voiced my opinion that I don't think she had a lung cancer. And if she didn't demonstrate that lung cancer, that lesion would still be there. And I think the judgment that she made and her physicians said we could probably follow this with serial x-rays would probably be true, because it didn't change in size over significant time frame. It wasn't a month or three months. It was years that it didn't change in size. So if she didn't have a lung cancer and didn't succumb to it, I would estimate that she would still have that same lesion in her left upper lobe.

Now I can't prove that without tissue diagnosis. We don't have any further outgoing studies, except for a possible chest x-ray that might have been performed at some time after her radiation treatment to see if there is any additional change.

Q. We don't have any tissue studies or pathologies back in October or the fall of 1994 because none were done; right?

A. Correct.

Q. And none were done in January of '96?

A. Correct
Q. So we don't know at that time what a bronchoscopy or needle biopsy would have shown because they weren't done?
A. I agree, absolutely agree.
Q. Now I just asked earlier in the deposition what you had reviewed in this case and you told me about the charts and the medical records. You read Dr. Watson's chart, I assume?
A. Yes.
Q. Did you read his deposition?
A. I read it. I don't recall much about it. If you want me to go over some parts together, I would be glad to go over them with you.
Q. Okay. Do you remember during the time that I took his deposition, I asked him whether he told Rebecca what his thoughts or beliefs were as to whether that lesion was cancer. Do you remember my asking him those questions?
A. I don't recall exactly.
Q. I'm going to represent to you that Dr. Watson admitted in his deposition that during the time he was seeing Rebecca in October and November and December of '94, he admitted in his deposition he

told her he did not think it was cancer.
A. I think that's a fair assessment of what he believed.
Q. So when Rebecca allegedly declined this bronchoscopy, as he has noted in his chart, if she was told that her doctor did not think it was cancer, would it have been a prudent decision on her part to elect not to have a bronchoscopy?
A. I don't disagree if she elected to have serial x-rays. I'm not faulting the patient; I'm not faulting the doctor. I think I have made my position really very clear.
Q. It was also indicated in a letter to you from Ms. Moody, and you mentioned in your sequence of events, that at the end of December of 1994 Rebecca Bish did not return to Dr. Watson. Do you see that on the first page?
A. I didn't write any of the dates down so I couldn't tell you how correct or incorrect that is. I wrote down the dates of all the x-rays for my chronology.
Q. Assume that I'm correct that the last visit she had with Dr. Watson is December of '94. And it's been represented to you in this letter from counsel

Watson. Do you see that there?
A. Correct; did not follow up with Dr. Watson as anticipated after 12/12/94.
Q. Now there is nothing in Dr. Watson's chart, and you're more than welcome to go and review it, there is nothing listed in Dr. Watson's chart that she was scheduled for another visit following December of '94, is there?
MS. MOODY: Objection.
THE WITNESS: I don't recall, but I have no problem with that if that's correct.
BY MR. MADDEN:
Q. The same is true with the representation about Dr. Echavarre, and that Rebecca did not follow up or return to Dr. Echavarre. It's been represented to you in the letter; correct?
A. That may be correct. I have no qualm with that. I'm not going to argue with you.
Q. And there is no indication in Dr. Echavarre's chart that another appointment was scheduled for Rebecca and she failed to show; is that correct?
A. If you say it's not there, I believe it's not there.

Q. And if you would be more comfortable looking, I will happily show you the chart.
A. I have no problem that you would misrepresent anything. I think you are very honest and forthright.
Q. Thank you. And I share that with you.
MR. MADDEN: Doctor, let's go off the record a second.
(Discussion off the record.)
THE WITNESS: The one thing that we should say, though, is that the patient clearly knew she had a lesion in her left upper lobe that was nondiagnosed and probably believed that it was a granulomatous lesion in that lung field, but she did know she had something there that was not tissue diagnosed.
BY MR. MADDEN:
Q. What do you believe this patient knew about that lesion?
MS. MOODY: Objection.
MS. YOUNG: I'm going to object. Calls for speculation.
MR. MADDEN: Okay.

BY MR. MADDEN:
Q. And you can go on the depositions you have read or the chart or anything else.
A. I can't say for sure. I believe she believed that she had probably, more likely than not, probably had a granulomatous lesion her left upper lobe which --
Q. And her basis for that belief would be what, what was told to her by her physician?
A. I can't tell you exactly what was told to her by her physicians, but I'm just summarizing in my mind by what I read that her physicians more likely than not said you probably have a granulomatous disease. It is probably safe to follow this. That's what I think occurred. I have no way of knowing absclutely what was stated. That's the feeling I came away with reviewing all these records.
Q. Now you have also had the opportunity to review Derrick Devine's deposition; correct?
A. Yes, but I don't recall very much about that right offhand.
Q. He is her surviving spouse and he testified.
A. I don't recall much about that. I really paid more attention to chronology of what really

occurred rather than what I said, you said, he said, because I'm not sure that changed the outcome one way or another.

Q. Well, in terms of --

A. And, you have been there, I have been there. What I hear and what I say and what somebody repeats are frequently very different. And it's not a fault of anybody in particular, it's just that under the stress of the moment and the mind's eye of everything, things really can blur a little bit.

Q. In terms of whether this patient knew what the lesion was or what it wasn't, do you remember any of Mr. Devine's testimony on that point?

A. I don't recall.

Q. I'm going to represent to you that the testimony has been and will be that she didn't know what it was but she wanted to know.

A. I think it's fair to say she didn't know what it was. But my reading of the records implied to me, without hearing directly from somebody or another -- and whether I read a deposition that a doctor told her exactly this is what I thought or not -- it's my feelings from reviewing the records that it was believed to be a granulomatous lesion.

Q. And this patient, although being told by Dr. Watson, and Dr. Echavarre testifying in his deposition he, too, did not think that this was cancer, aside from being told those things by her physicians, would you agree with me or from the testimony of Derrick Devine that she didn't know what this thing was.

MS. MOODY: Objection.

MS. YOUNG: Objection.

THE WITNESS: I believe that nobody knew what it was and she didn't either.

MR. MADDEN: Okay.

THE WITNESS: I will tell you in my practice -- I will just give you an example with the breast, because there is a lot of anxiety with women who have breast lesions where I referred women who have an x-ray finding of a lesion that is more likely benign than anything. My gut reaction is it's benign. I think it's okay to repeat your mammogram in six months, which is often done. And the women say, I feel so uncomfortable about that. I really want you to biopsy it. And I would say, I don't think

you really need it. And they would say, I'm not going to sleep. If I want to know, I want to know, in which case we do a biopsy.

So if she felt that strongly she wanted to know what it was, if she didn't get it from Lerner, the biopsy, she would have seen Dr. Smith and gotten a biopsy. Because people sometimes have that kind of an anxiety about something that they really want to know what's wrong, even if it's benign, I have to know because I can't sleep. It's reasonable to do the biopsy. And if this patient were so distraught that she would have sought somebody to obtain a biopsy.

BY MR. MADDEN:

Q. There is nothing unreasonable about a patient who knows that they have a lesion and they don't know what it is but they want to find out, asking you to do a biopsy even if you don't think it's cancer?

A. That's correct. And unless I think I'm going to do some harm to them, I would do the biopsy. If I think there is a possibility of potential harm, I might not do the biopsy.

Q. And if a patient -- I'm sorry. Go ahead.

A. There are some rare exceptions, but -- and I could go through some, but otherwise the answer stands.
Q. And in this particular type of cancer, to do a biopsy through bronchoscopy and needle biopsy, we have already been over the fact that they don't pose a great risk of harm?
A. This lesion we are talking about in the left upper lobe, I think the tissue diagnosis is obtainable without undo risk.
Q. In the lesion in the left upper lobe, we are talking about, the 1.6 by 1.9 centimeter lesion?
A. Right. And I believe that had they done that, they would have not found a cancer.
Q. Now if you had a patient who you believed was aware that she had a lesion, she didn't know what it was, she was told that it was not believed to be cancer, but that she was concerned enough about it that she went home and discussed her options with her family and decided that she needed to find out what it was, and came back and asked to have this lesion biopsied through needle biopsy or bronchoscopy, there would be nothing unreasonable about that patient's request, would there?

A. If she had come back and requested that, would I think that would be usual? No, I don't think that would be an usual request.
Q. Or an unreasonable request?
A. Nor do I think it would be unreasonable. It's a patient's desire to know. I can't find fault with a patient wanting to know. Even if I thought it was benign, I can think of some areas that I would not do a biopsy, but this particular instance, the left upper lobe, if the patient truly said I need to know, we would have done most -- almost anything to find out.
Q. And as long as you weren't doing more harm to the patient in finding out, a good, prudent physician should go ahead and do that biopsy, true?
MS. MOODY: Objection.
THE WITNESS: If the patient really wanted to do that, even if you believed it were benign and it would not do any harm, I have no problem with going ahead with that biopsy.
BY MR. MADDEN:
Q. Now an opinion has been offered in this case, Dr. Lerner, that this lesion, we keep referring to

its dimensions, the 1.6 by 1.9 centimeter, that seemed as early as October '94 was a stage IV, metastatic lesion, which meant that Rebecca had a zero to two percent chance of survival even before she saw Dr. Watson. Do you agree with that?

A. I agree that she probably had stage IV cancer, but I don't believe the lesion in her left upper lobe was metastases.

Q. Is there any lesion outside of what you believe was in the left main stem bronchus that was a metastatic lesion?

A. Well, we know that at some point down the line that she has a measurement of a lesion in the pubic bone and she has a lesion in her liver. And those lesions have to grow up to be big enough to be recognized, just like a primary tumor does. And most tumors grow at a similar rate as the primary tumor. And so we know that on May first there is a sizeable metastases in her pubic bone, and just like Dr. Ettinger agrees, it takes a while for the primary tumor to be recognizable. It takes a significant period of time for the metastases to be recognizable. So I believe that primary tumor -- or not the -- excuse me, the metastases was present in

ier pubic bone a long time before it was recognizable.

Q. And obviously, the same is true with any zancer that was in her lung, that would have been there eight to nine years prior as well?

A. Correct. You know, a lot of people undergo lung surgery for cure. And all the scans are normal and everything is normal, and yet they succumb to their metastases which were present prior to the surgery but hadn't grown up big enough to be recognized.

Q. I'm going to come right to the point on the question I asked you earlier, Doctor. You have had a chance to read the partial deposition of Dr. O'Grady; correct?

A. Yes.

Q. Now Dr. O'Grady has testified that he sees two lesions in that lung. One is the one that you and I have been referencing. What's the other one to your understanding that he is talking about?

A. I think you better talk to Dr. O'Grady to be specific. I assume he is talking about the left main stem bronchus, but I couldn't tell you. And I didn't read it specifically when I read it and I read it

rapidly. That he was talking about another lesion other than the left main stem bronchus, he may have, and that's a question best answered by Dr. O'Grady.

Q. Well, you have had a chance to read the radiology reports, although you haven't seen any of the films yourself; correct?

A. Correct.

Q. Can you recall any reference by any radiologist up through January of '96 that identified or commented on the lesion in the left main stem bronchus?

A. There are no references that I reviewed.

Q. Now to clarify the question I asked earlier, this 1.6 by 1.9 centimeter lesion that you saw, you do not believe it was a metastatic cancer or a stage IV cancer, do you?

MS. YOUNG: I don't think the doctor saw any lesion.

MR. MADDEN: You can answer, Doctor.

THE WITNESS: I do not believe the lesion in the left upper lobe was a metastases, but I did say I believe she had stage IV cancer because she had a tumor in her pubic bone.

BY MR. MADDEN:

Q. But that particular lesion that you're talking about, the 1.6 by 1.9 centimeter lesion, that was not in your opinion a cancerous lesion?

A. In my opinion; that's correct.

Q. It was not in your opinion a metastatic lesion?

A. That's still correct.

Q. It was not in your opinion a metastatic lesion from a primary cancer site in the left main stem bronchus; is that correct?

A. That's my opinion. I believe that had not changed in size over time and that remains whatever it was, and I think it's more likely than not in my opinion to be a granuloma. I don't think that myself or Dr. O'Grady even under torture could tell you exactly what this is because we don't have a tissue diagnosis. So he sees a pattern of metastases one way, and I see the pattern of metastases slightly different, because I don't think this lesion changed. And it is my belief if it didn't change in size and over a significant period of time, it wasn't a cancer just sitting around saying one day you will make a diagnosis of me. And I don't believe that

that lesion in her left upper lobe was the primary and spread to her main stem bronchus. I don't believe that either.

Q. It didn't go that way; it didn't go this way? It didn't go either way?

A. No.

Q. It wasn't a metastatic lesion?

A. No. If she does indeed have a primary cancer in her lung, I believe it was primary in her main stem bronchus. And I don't know what Dr. Watson said, but I think if he is asked directly when he looked at that lesion did he think that was a primary lung cancer, my guess would be he would say yes, that left main stem bronchus was a primary cancer.

Q. Let's talk about this granuloma. Again, when you say granuloma, you're referencing the lesion with the one and a half to 1.9 centimeter dimensions?

A. Yes. I do not know exactly what it is.

Q. When I say lesion, I just want to make sure we are talking about the same thing.

A. We are talking I think consistently about the same thing.

Q. Is it the same thing as -- you had earlier mentioned a nodule. Can you use them

interchangeably?
A. You can use it nodule. I have no problem referring to it that way. We will use them interchangeably.
Q. And the radiologists call it a mass density. I just want to make sure we are talking about the same thing.
A. As long as we are talking about whatever it is in her left upper lung field, we are talking about the same thing.
Q. Now you feel it's a granuloma. Was it a calcified granuloma?
A. To the best of my knowledge I don't think there was any calcification reported.
Q. A granuloma would be described otherwise as a benign lesion; right?
A. Most granulomas are thought to be benign lesions.
Q. And a classic presentation of a benign lesion is with evidence of calcification?
A. Correct. And that classic presentation is usually in somebody who is fifty years old, sixty years old.
Q. But without evidence of calcification, we

don't have the classic presentation of a benign lesion?
A. You don't have any evidence that it's calcified. I think if we had a hundred physicians look at that chest x-ray in a twenty-eight year old female, the overwhelming majority would say I don't think it's cancer or a primary lung cancer, because it doesn't happen very often in a twenty-eight year old female.
Q. If this lesion does not -- does not have evidence of calcification as the radiologist indicated throughout the reports, you cannot safely conclude that it was a benign lesion; is that right?
A. You can't conclude it no matter what unless you have a tissue diagnosis. Let me give you the reverse. We get a lot of mammograms on women to see if they have microcalcification and we are concerned, we do the biopsy. I biopsy a lot of cancers that have no calcifications in it and they are malignant. If there is a lesion there, the only way to know what it is have a tissue diagnosis. We get a lot of x-ray reports and it says a microadenoma. It usually is. But you never know unless you have a tissue diagnosis.

Q. And that's critical, isn't it?
A. Well, if you want to know what something is, you have to have a tissue diagnosis. Without a tissue diagnosis, you can make a supposition and you can go by statistical odds. And statistical odds would tell you in this young woman that this is not a primary lung cancer. You know, of all the lung cancers I have seen in a lot of years now, I have never seen one in a twenty-eight year old female.
Q. Now statistically, there are at least some cases where that has happened outside of this one, whether or not you have actually seen it?
A. I'm sure. And I'm sure there may be some reported younger. But the average physician who takes care of people with lung cancer, and they see a peripheral lesion in a young, otherwise vital, healthy person, that's not their primary diagnosis.
Q. Now you would never treat a patient who presented with some lesion as to which the diagnosis was not yet made based solely on the statistics for cancer?
A. Would I treat them as a cancer?
Q. No. Let me ask it another way. If the patient came to you with a lesion that had not been

diagnosed, you wouldn't rule out cancer based solely upon the American Cancer statistics?

A. No, you can't do that. I mean, you can't say that it's absolutely not. I can tell you before we had some of the sophisticated needle biopsies and everything else, and where bronchoscopy was nondiagnostic, and we were convinced it was malignant that we have gone ahead and treated people without a tissue diagnosis because they had what appeared to be an advanced nonresectable cancer, but we don't have a diagnosis. We don't do that very much anymore because we can usually get some kind of invasive study that will give you a diagnosis.

Q. So we can agree then that you would not rule out cancer in this patient based solely upon the cancer statistics?

A. No, you cannot guarantee that it is not a malignant lesion without a tissue diagnosis. I agree with that.

Q. Now this lesion did not present as a benign lesion if there was no evidence of calcification.

A. I don't want to get involved in the argument what the x-ray doctor would primary call something, or a pulmonologist. I think that is probably best

left, your question, to a pulmonary doctor or an x-ray doctor for their statistical, however they want to come out. My whole discussion revolves about the time -- about the argument, I should say, rather than time -- the argument that this didn't change over a period of time, and so I peeked at the cards and say, well, I think statistically now this was not a cancer. I couldn't guarantee that prospectively looking at it at the time of the first diagnosis.

But if you show those, that just the left upper lobe x-ray to a series of x-ray doctors or a series of pulmonary doctors and just show that lesion and say this is the time frame, I would venture to say the overwhelming majority would say it hasn't changed and it's probably not a lung cancer. And you have got to tell them it's a twenty-eight year old female.

Q. But again, with this lesion, taking your testimony that it didn't change in size or appearance?

A Correct

Q. There were no indications that it was calcified?

A. I am not going and arguing against anything

I'm not arguing with you.

Q. And in October of '94, there were indications from the radiologist that she had hilar adenopathy proximal to where this lesion was; correct?

A. Correct.

Q. And clinically she continued to complain of wheezing; right?

A. As far as I know that's correct.

Q. And the wheezing was treated with an asthma medication that did not resolve the asthma?

A. I don't recall whether it made her symptomatically better or not. I can't answer that. I don't recall.

Q. So all the while that this lesion didn't change in size or appearance, there were other things that were going on, wouldn't you agree, that did indicate that we were dealing with a cancerous lesion?

A. Oh, absolutely. We know that she had a cancer because it was biopsied. Something was biopsied from her left main stem bronchus and there was certainly x-ray evidence of lesions in her pubic bone that progressed over time. I agree.

MS. MOODY: Could you read back that

question and answer?

(Whereupon, the court reporter read the following:

"Question: So all the while that this lesion didn't change in size or appearance, there were other things that were going on, wouldn't you agree, that did indicate that we were dealing with a cancerous lesion.

"Answer: Oh, absolutely. We know that she had a cancer because it was biopsied. Something was biopsied from her left main stem bronchus and there was certainly x-ray evidence of lesions in her pubic bone that progressed over time. I agree.")

BY MR. MADDEN:

Q. Doctor, in your practice, as a surgical oncologist, if you had this twenty-eight year old nonsmoker present to you with this lesion in the lung field, with hilar adenopathy, with wheezing that wasn't resolved through asthma medication, with those factors in mind, would you be inclined to biopsy to determine whether or not the lesion was cancerous?

A. It's a difficult question because I know all that took place after that. Where I would be at that

time in an otherwise healthy woman I couldn't exactly say. Certainly if she had been bronchoscoped, it's possible they may have found the left main stem bronchus cancer. What I didn't notice on the report is how close it was in proximity to the carina. They may have made the diagnosis then, and maybe they would have done her bone scan then and everything else. I believe that she had metastases either recognizable or nonrecognizable in her pubic bone at the same time because there was a very large metastases when they were recognized. And so I absolutely believe those metastases were in place. And if I had to guess, I would guess that they would have been picked up on the bone scan. But not everything is picked up on a bone scan, just like we operate for curing a lot of other things and subsequently years later the bone scan is positive, the tumor was present.

So it's a tough answer -- question to answer right now because I wasn't there in that time sequence. It's easy to argue, oh, yes, if they would have done this, but it would have been a stage IV cancer probably in the primary left main stem bronchus.

Q. Back in October of '94?
A. Back in October of '94.
Q. We can agree that if the cancer, whether it's where you say it was or Dr. Ettinger or Dr. Kanarek said was picked up back in October of '94 would Rebecca's chances of survival have been greater than they were when it was diagnosed in April of '97?
A. No. Because in my opinion, as I think I explained, is I think she had a tumor in her pubic bone that early on, and we know it was a refractory tumor and we -- I think all of us would basically agree that if she had metastases, the likelihood of cure is slim. There are some five-year survivors but and she may have appeared to have survived longer because the diagnosis would have been established earlier. But her life would not have been extended. Knowing about something sooner doesn't mean you really survive longer because we make survival from the point of diagnosis. So if they diagnosis something earlier, you appear to survive two years longer.
Q. Well, if she was diagnosed stage IV in October of '94, the opinions have been she would have had a zero to two percent chance of survival?

A. Correct.
Q. She would not have been a candidate for surgical resection?
A. Correct.
Q. And that was her best shot at surviving the cancer?
A. Agreed.
Q. If she had a zero to two percent chance of survival in October of 1994, and she actually lived through September of '98, some four years later almost, doesn't that dictate away from a stage IV diagnosis?
A. No. If you look at the data from the VA Lung Cancer Study Group where they had extensive tumor, which means it was outside that hemothorax, that half of the chest, and it's big numbers, there is a certain percent that survive five years. Probably in spite of whatever we gave them for treatment they survived five years.
Q. So if you are asked at trial, Dr. Lerner, what her chances of survival were from October of '94 through April of '97, I think it's clear that your opinion is she was stage IV by October of '94 with the zero to two percent chance of survival that

remained unchanged through the date of diagnosis?
A. That's correct. And survival, we are talking about a five-year survival meaning you're just alive at the five-year anniversary of your diagnosis.
Q. Her clinical presentations, her symptoms, her pulmonary function test results, her peak flow results, those aren't items that you're going to get into at trial for your opinions?
A. No.
Q. You're staying with the biology of the cancer?
A. Yes.
Q. At the beginning of the deposition, Dr. Lerner, you were kind enough to summarize your opinions for me and to list them, but summarily your opinion is that the delay was not significant to the outcome?
A. Not in this case. It's easy to be smart in retrospect. It's tough to be really a genius prospectively.
Q. You and I can agree there was a delay in the diagnosis of this cancer?
MS. YOUNG: Object to form.
THE WITNESS: The diagnosis was not

established until she had clinical metastases. I agree to that.

BY MR. MADDEN:

Q. Okay. Have we covered all of the bases for your opinion that that lesion, the one and a half centimeter lesion was a granuloma? Is there anything else you wanted to add to that opinion?

A. As far as I can see, unless something really lights up at another point in time, I can't think of anything else to say to that. I mean, I could probably talk with you for hours about what I think the biology is and go through some statistical things about that, but I think I have summarized it.

Q. And if I over-summarize it, you tell me, but your belief that it's a granuloma is because it didn't change in size or appearance?

A. Over significant time period.

Q. And what is that time period?

A. Well, we know it essentially didn't change in time from 10/3/94 through 4/11/97. Now there may be another chest x-ray that you or the other attorneys may know about, and I would guess that at some point she had another chest x-ray following her radiation therapy.

Q. Not in that time period except for Dr. Echavarre's chest x-ray in January of '96, so I think you're aware of that?
A. It's hard to escape getting chest x-rays if you're treated at a hospital.
Q. All right. So then we have covered the basis of your opinion that this was a granuloma?
A. That it was benign, probably a granuloma.
Q. We have covered your opinions on chance of survival?
A. We have covered that.
Q. I think I know exactly what your testimony is going to focus on. You're clear you're on the biology of the cancer; that's your role in this case?
A. Correct.
Q. Are you going to talk about doubling time in this case?
A. If I'm asked, I will.
Q. What is your opinion about the doubling time? How does that enter into support of your opinions?
A. Well, all cancers over time double as they continue.
Q. What does that mean that they double? They

regenerate?

A. The doubling time is the length of time it takes to double the volume of cells, i.e., to go from one million to two million or one billion to two billion. The number of doublings is different than the doubling time. One is the length of time it does it and the number of doublings is related to the size of a tumor. And those are fairly well established in many, many texts about size and the number of doublings that has gone through.

So if I'm asked to explain any of that, I would be glad to do that. If you ask me questions about that at trial, I will be glad to discuss them with you.

Q. How would you explain to the jury -- first of all, how are you going to calculate what the doubling time was? It requires a measurement; right?

A. It requires a measurement.

Q. And you don't have that measurement yet?

A. I don't have a measurement of the primary tumor yet; that's correct.

Q. And the primary tumor you're talking about, that's the left main stem bronchus?

A. Correct.

Q. But we need a radiology film that has that tumor in the left main stem bronchus?
A. Right, to calculate the doubling time or the number of doublings that that main stem bronchus tumor went through.
Q. So you would start at whatever the date is of that particular film?
A. Or another film. Wherever I can have two measurements of the same lesion over time, we can estimate an average doubling time. Now it's not going to be exact to the day or hour, but I don't know of any better method of estimating the duration of a tumor other than by knowing the number of doublings or the doubling time. Otherwise, most people would say -- or me -- would say, well, in my opinion, I think it was there or not there. And what do you base it on, well, the x-ray looked pretty good at that time. But they really weren't, you know, a hundred percent diagnostic. They are clinical on things like that.
Q. And you have made it clear for me that you don't believe this lesion that you're calling a granuloma was a cancerous lesion, so that isn't something you could measure to calculate the doubling

time?
A. Well, it essentially didn't change over time. If it had changed over time, then we could kind of estimate or calculate a potential doubling time or probable a doubling time during that time frame.
Q. And if we can calculate the doubling time of that particular lesion --
A. We can estimate some of the time frames of some of these things, duration.
Q. Okay. Are there any other opinions or impressions that you have in this case that we haven't talked about?
A. I'm sure there are, but I can't think of them.
Q. You were good enough to give me a list earlier. Let me just check them off. This was probably an adenocarcinoma?
A. I believe that. I think everybody will agree to that.
Q. It was biopsied. There was subsequent metastases to the bones or liver?
A. Correct.
Q. The tumor was refractory?

A. Was refractory to chemotherapy. It did not regress. The chemotherapy didn't make that tumor regress or disappear, so it was refractory. And she had radiation therapy to her chest bronchial lesion, the main stem bronchus. And in my opinion, that was just to make her breathe more comfortably because they knew at the time she was getting that that she had metastases, *so* it was palliative therapy.

Q. Do you have any exhibits that you plan to put up in front of the jury? Are you coming to Cleveland to testify if it goes to trial?

A. I can. I'm not an exhibitionist, but if you have something in mind.

Q. The trial is scheduled for the end of October.

A. I don't know what exhibits they plan to do and I guess sometime after this I will huddle with the attorney to discuss, you know, what I would like to show or tell or do or --

Q. As you sit here today --

A. We have never had that show and tell and do between us today. Today was our first meeting and we never had any super in-depth discussions.

Q. You have not worked with Ms. Moody's firm

before?

A. I don't believe so.

MS. MOODY: You worked with Ken.

THE WITNESS: But I think he was in that firm.

MS. MOODY: That's true.

MR. MADDEN: But you have worked her firm in the past?

THE WITNESS: Yes, I got invited a couple of times to, I guess it was University of Ohio, Toledo, and gave some lectures to the medical staff. And somebody was foolish enough to pay attention or whatever, and they said, do you mind if I have my attorney call you, and that's probably how I got involved with Ken.

MR. MADDEN: So you have had one prior case where you worked with Ms. Moody outside of this one?

THE WITNESS: I don't think I have worked with you.

MR. MADDEN: Who is Ken?

MS. MOODY: Ken White.

MR. MADDEN: Jacobson?

MS. MOODY: Ken White. He is my partner right now.

MR. MADDEN: Oh, oh. Okay.

BY MR. MADDEN:

Q. Have you ever worked with the Jacobson, Kushman firm?

A. That's probably where I knew him from.

Q. Have you ever testified as an expert in Ohio before?

A. Yes, probably three or four times over a long period of time.

Q. Who is the lawyer, do you remember?

A. The only guy I remember is Ken White. I know there was another male attorney. It was a lung cancer. And I think it was Cleveland but I couldn't tell you.

Q. Long time ago?

A. Long time ago. I mean, last week is always a long time ago, but it's got to be lot of years, a lot of years.

Q. And again, this is so I'm clear where your testimony is going, is there anything else any other thoughts or opinions that you have in this case that we haven't talked about? I think we have covered

everything.
A. I'm probably sure I have lots of thoughts or opinions, but unless you really --
Q. That you're going to testify to.
A. When you start talking about a subject you say, oh, yes, and, you know, you keep expanding and expounding.
Q. You don't have any particular exhibits that you're contemplating using? That's all going to be a subsequent conversation?
A. Well, yeah, we have to talk about that, I guess. I don't know what this -- Miss Moody has in mind.

MR. MADDEN: Give me a minute and a half just to go over some notes.

MS. MOODY: Justin, you had asked Dr. Lerner about doubling times with relationship to whether or not we can ascertain a size for the left main stem bronchus. I just want you to be clear that I'm going to question him about doubling time. Whether or not we are able to get that measurement, there are other factors that we can use to discuss doubling times in the case, just so you're clear on

that.

MR. MADDEN: And you know, you have always been straightforward, so I appreciate you pointed that out. I probably will get to this in a letter, anyway, but if he gets the measurements and if he makes a calculation, I am going to want to take some more testimony from him on it. So I understand where we are, what we are, what the conclusions are. We could probably do it by phone. If there are things to look at, then we will be back.

MS. MOODY: Now he already had the measurement that he can calculate. He testified to that, but maybe --

MR. MADDEN: Well, I thought we were waiting.

MS. MOODY: No. Remember, he said that there was a measurement of the pubic -- I told you this before we started actually, was the measurement that could be taken at the pubic tumor in May of 1997 and then again in September of 1998, and he has those measurements. Maybe he has those written.

MR. MADDEN: I know I didn't talk about

it. If the doctor will indulge me five more minutes --

MS. MOODY: That's one of the exhibits he had from Dr. Potchen, the handwritten notes.

MR. MADDEN: The notes?

MS. MOODY: Yes, the notes.

MR. MADDEN: Why don't we explore this?

(At which time there was a brief recess.)

BY MR. MADDEN:

Q. Your counsel indicated that when we were talking about doubling time, I was under the impression that you were still awaiting a measurement so that you could make that calculation, but apparently you have the measurement that you need'?

A. I have a measurement; correct.

Q. Right. And that's a measurement from where?

A. From the pubic area. You looked at that.

Q. And that's on your handwritten notes regarding Dr. Potchen?

A. Yes.

Q. What exhibit sticker is that?

A. Three.
Q. What is the measurement that you're using or that you're referencing?
A. There is a measurement on 5/1/97 of the pubic ramus and I can give you a Xerox of this --
Q. Okay.
A. -- that measures it.
Q. What's the measurement?
A. 4.9 times 2.6 times one centimeter. And another date 9/15/98, it's 9.5 times 3.9 times 2.5. And for practical purposes, it doubled in size during that time frame.
Q. That's the lesion of the pubic ramus?
A. Yes.
Q. Now what does that tell you that lesion of the pubic ramus doubled in time between that date in '97 and '98?
A. It takes basically three doublings to double the size. And so during that time frame of about fifteen, sixteen months it went through three doublings. And while not exactly accurate, it comes out to be about five months per doubling time, at least for that lesion. And it tells me that if the metastases are doubling in time over the time

reference, that if the left upper lobe lesion were a cancer, it should have certainly increased in size and more than doubled during that time reference.

Q. The left upper lobe lesion should be doubling at the same rate as a lesion?

A. At a similar rate.

Q. Or a similar rate?

A. It might not be exact. Studies you have seen as reported by different reporters and been known for a while that it gives you some estimates of how tumors grow and double, and things like S-phase kind of imply some of these things. And that lesion in the left upper lobe essentially is unchanged.

Q. Now you haven't seen the films but you're going to the radiology measurements?

A. That's correct.

Q. I brought the CT films with me from October of '94 that Dr. Watson had available to him.

A. Okay.

Q. Do you have a viewbox here?

A. I have a viewbox.

Q. Would you be able to look at them and do a similar doubling time, or you wouldn't think that was necessary because you don't think it's a cancerous

lesion?
A. Well, if I'm going to accept measurements, I can measure. But as I stand here and will always stand in front of peers, I would rather have the measurements from a radiologist, an objective measurement from them than my measurements in general. Because I don't want somebody saying, Lerner, you're not a radiologist, you can't measure.
Q. But you do look at films as part of your practice and in making decisions?
A. All the time, all the time; right.
Q. Well, these CT films that I have with me are going to be those that were in existence in October of '94. Do you want to look at them for any reason?
A. Not particularly. I would be glad to look at them but I accept the measurements of the radiologist who measured at the time and I would assume that he was very objective, or if there was something different, somebody would have said those measurements were really incorrect. And to date I have not seen a challenge to those measurements, so I accept those measurements.
Q. Okay. Putting the measurements aside, in terms of the appearance of this lesion with the

adenopathy, the nodule that is involved, if you were to look at the CT film, would that give you a reason to further analyze in your mind whether or not it was, in fact, a cancerous lesion?

A. I envision in my mind's eye that the adenopathy that subsequently was visible was probably as a result of the primary tumor in the left main stem bronchus that became visible. I can't absolutely guarantee that, but that's what I think is the sequence of events.

MR. MADDEN: All right. Let's go off the record.

MS. YOUNG: I'm going to note an objection.

THE WITNESS: I would not be the one to say that. I would want a radiologist. I looked at them all.

(Discussion off the record.)

BY MR. MADDEN:

Q. We are back on the record. Did you have an opportunity to look at the CT films, the six different films with the different images on each film --

A. Correct.

Q. __ which Dr. Watson had back on October eleven, 1994; correct?
A. Correct.
Q. On one particular film there was also a measurement grid that was on there and you felt that the radiology measurements were accurate. You had no quarrel with it, again?
A. I have no quarrel with it.
Q. Look at the CT films. Is there anything that you observed with respect to this lesion that we have been talking about that causes you to change your impressions or opinions?
A. No.

MS. MOODY: Note an objection but go ahead.

BY MR. MADDEN:
Q. Was there anything at all of significance for your impressions in this case having looked at the films?
A. Nothing has changed any of my opinions.

MR. MADDEN: Thank you, Doctor. Again, I'm very grateful for all your time today. Thank you.

THE WITNESS: Thank you.

- - -

(Witness excused.)

- - -

(Whereupon, the examination concluded at 1:30 p.m.)

C E R T I F I C A T I O N

I, PATRICIA CRUDO, a Court Reporter in and for the Commonwealth of Pennsylvania, hereby certify that the foregoing is a true and accurate transcript of the deposition of said witness who was first duly sworn by me on the date and place hereinbefore set forth. I FURTHER CERTIFY that I am neither attorney nor counsel for, nor related to or employed by, any of the parties to the action in which this deposition was taken, and further that I am not a relative or employee of any attorney or counsel employed in this action, nor am I financially interested in this case.

PATRICIA CRUDO

DEPOSITION SUPPORT INDEX

Direction to Witness Not to Answer

Pase	Line	Paqe	Line	Paqe	Line
(None)					

Request for Production of Documents

Paqe	Line	Paqe	Line	Paqe	Line
(None)					

Stipulations

Paqe	Line	Paqe	Line	Paqe	Line
4	1-6				

Question Marked

Paqe	Line	Paqe	Line	Paqe	Line
(None)					

CURRICULUM VITAE

May 6, 1998

Harvey J. Lerner, M.D

Home Address:	728 Conshohocken State Road Narberth, PA 19072
Office Address:	907 Pine Street Philadelphia, PA 19107
Social Security Number:	053 28 8040
Date of Birth:	April 9, 1932
Place of Birth:	Paterson, NJ
Marital Status:	Married

Education:

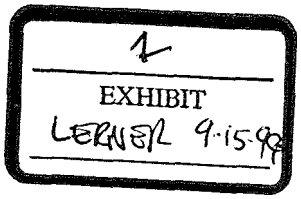
1950-54 B.S. University of Georgia
1954-58 M.D. Temple University School of Medicine

Post Graduate Training and Fellowship Appointments:

1958-59 Internship, Northeastern Hospital, Philadelphia, PA
1959-63 Surgical Residency, Pennsylvania Hospital, Philadelphia, **PA**
1961-63 Fellow, American Cancer Society

Faculty Appointments:

1963-66 Instructor of Surgery
1966-68 Associate of Surgery
University of Pennsylvania School of Medicine
1968-72 Assistant Professor of Surgery
University of Pennsylvania School of Medicine
1982-92 Clinical Professor, Department of Surgery
Temple University School of Medicine
1982- Adjunct Professor of Surgery in the Associated Faculty of the School of Medicine
University of Pennsylvania School of Medicine



Hospital and Administrative Appointments

1963-65	Assistant Surgeon Pennsylvania Hospital
1967-78	Head, Section of Cancer Chemotherapy Pennsylvania Hospital
1969-77	Assistant Surgeon to Pennsylvania Hospital (General Surgery and Cancer Chemotherapy)
1974-81	Director, Interdisciplinary Group on Oncology Pennsylvania Hospital
1979-81	Chairman, Executive Committee Northeastern Hospital
1979-81	Co-Chairman, Department of Surgery Northeastern Hospital
1980-82	Consultant Reviewer for Clinical Oncology Review Committee National Cancer Institute
1981-82	Chairman and Director, Department of Surgery Northeastern Hospital
1982-83	President, Medical Staff Northeastern Hospital
1974-82	Chief, General Surgery Northeastern Hospital
1977-	Surgeon to Pennsylvania Hospital
1978-	Head, Section of Surgical Oncology and Cancer Chemotherapy Pennsylvania Hospital
1979-86	Consultant Reviewer for **CIDAC** for Carcinogenesis Information National Cancer Institute
1981-83	Member, Committee on Community Oncology and Technology Transfer National Cancer Institute
1981-85	State Chairman of the Field Liaison Program for the Commission on Cancer for Eastern Pennsylvania (Appointed by the American College of Surgeons)
1982-	Chairman, Department of Surgery Germantown Hospital and Medical Center
1985-	Member of Board of Directors Pennsylvania Oncologic Society

Specialty Certification:

1964	American Board of Surgery

Licensure

Pennsylvania, New Jersey, Florida

Memberships in Professional and Scientific Societies:

National Societies:

American Medical Association
Fellow, American College of Surgeons
American Federation for Clinical Research
Pan-Pacific Surgical Association
American Association for the Advancement of Science
American Association for Cancer Research
American Society of Clinical Oncology
Pan American Medical Association
International Association for the Study of Lung Cancer
Society of Surgical Oncology
American Association for Cancer Education
American Society of Preventive Oncology
American Council on Science and Health
Cell Kinetics Society
The Society for the Study of Breast Disease

Local Societies:

Philadelphia Physiological Society
Philadelphia County Medical Society
New York Academy of Sciences
Philadelphia Academy of Surgery
Pennsylvania State Medical Society
Pennsylvania Oncologic Society

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① Rebecca (Bish) Devine
DOB 6/16/66

age 28+ 10/3/94 chest xray - 2 cm density ② upper lung field
suggest CT - SINA S. HAZNEDI

10/11/94 - CT chest c contrast - 1.6 x 1.9 cm L U Lobe mass -
c enlarged hilar nodes.
highly suggestive of primary ca of lung -
(poss TB or granulomatous infection
Bronchoscopy Bx suggested
YOUNG-H, KIM

1/19/96 - chest - no interval change from 10/3/94
ROBERT L BARRETT

3/27/97 - chest - R U lobe pneumonia - small left pleural effusion
YOUNG-H CHOY

4/11/97 - CT-chest c contrast - enlarged - L Hilar mass -
1.8 x 2.3 cm - c
Impression - enlarged ② hilar mass (or adenopathy)
significant aortic pulmonic & subcarinal
lymphadenopathy extending from the ② hilar mass.
CHOY

5/1/97 CT - head - OK

5/1/97 bone scan - met to - ① pubic bone ② R femur

5/2/97 CT - liver - poss hepatic mets

chemo -
rads to chest

© Grade 2 – ④ main stem bronchus primary – which caused wheezing – (unilateral) met to ① upper lobe aspiration

– Bronchoscopy – 97 (Dr Watson)

Dr Mike Patchen –

5/1/97 pubic rami – 4.9 x 2.6 x 1 cm

9/15/98 – " " 9.5 x 3.9 x 2.5 cm.

essentially doubled in size – or 3D / in 16 mo –

5/1/97 or 4.9 x 2.6 x 1 = 8.5 cm³ ÷ 3 = 2.8 cm –

9/15/98 9.5 + 3.9 + 2.5 = 15.9 ÷ 3 = 5.3 cm – or 3D –

3
EXHIBIT
LERNER 9/15

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May 24, 1999

Harvey J. Lerner, M.D.
907 Pine Street
Philadelphia, PA 19107

RE: Rebecca Devine, et al. v. Blanchard Valley Medical Associates, Inc., et al.
Our File No. 600001

Dear Dr. Lerner:

Accompanying this letter is the expert book, relative to the above-captioned case which I discussed with Maria recently.

Basically, the facts are as follows: This case involves alleged delay in diagnosis of adenocarcinoma of the lung in a 28 y/o female, unmarried at the time. The defendants are: Dr. Rick D. Watson, pulmonologist, Dr. Irineo P. Echavarre, cardiac and vascular surgeon, Dr. Frank R. Cosiano, family practitioner, and BVRHC. I represent Dr. Watson.

Dr. Watson first saw Ms. Bish (subsequently Mrs. Devine) on October 5, 1994 as a referral from Dr. F.R. Cosiano. Dr. Cosiano had ordered a chest X-ray, done 10/3/94, which showed a questionable 2 cm. nodule in the left upper lobe, anterior segment. Dr. Watson ordered a CT of the chest, done 10/11/94, which showed the same nodule. Affordable Chiropractic had performed X-rays in 2/94 which also showed a nodule. Dr. Watson personally viewed the Affordable Chiropractic films and felt that the nodule was the same size on all films. **A** discussion regarding the pros and cons of bronchoscopy was had, with Ms. Bish declining the procedure in lieu of monitoring the situation with serial X-rays, with the understanding that bronchoscopy would again be explored if the nodule changed size or new symptoms developed. Ms. Bish did not follow up with Dr. Watson as anticipated after 12/12/94. She saw Dr. F.R. Cosiano on 1/17/96 and reported that she had seen Dr. Watson, and still had a wheeze. Dr. Cosiano referred her to Dr. Echavarre "for bronchoscopy". Dr. Echavarre's note indicates that in 1994, X-rays showed a "small nodular mass upper lobe - granuloma? Considering her age - TB or Histo". His plan was to repeat the chest X-ray, compare it with 10/94 films and "go from there". The X-ray was repeated on 1/19/96 and showed no change in comparison to the earlier 10/94 film. Ms. Bish did not return to Dr. Echavarre's office. She then saw Robert Conkle, D.C. from 7/11/96 - 11/11/97 for neck, back and hip pain. Dr. Edwin Davis was

Dr. Harvey Lerner
May 24, 1999

seen next with complaints of wheezing and shortness of breath between 1/97 and 3/27/97 when she was admitted to BVRHC with pneumonia. Chest films on 3/27/97 revealed a right upper lobe pneumonia and small left pleural effusion.

Ms. Bish was discharged from BVRHC on 3/29/97 and seen in Dr. Davis' office on 3/31/97 with complaints of tiredness, hoarseness, abdominal tightness and dry cough. She was then referred to Dr. Watson, who performed a bronchoscopy with biopsy of the left mainstem bronchus on 4/24/97, which showed adenocarcinoma, T2 N2 M, Stage IV. Ms. Bish-Devine had extensive treatment after her diagnosis consisting of both radiation and chemotherapy and had metastasis to her liver and bones. Some treatment occurred at BVRHC, but it was primarily at Medical College of Ohio Hospital in Toledo. She has since expired.

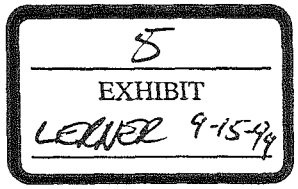
If you need any further information, or if I can be of any further assistance to you in your review, please do not hesitate to contact me at my office. When you have had an opportunity to review the materials, please contact me so that we may discuss your opinions. I would prefer that you put nothing in writing at this point in time. Please forward a current curriculum vitae at your earliest convenience. Thank you for agreeing to review this case for me.

Very truly yours,

Nancy D. Moody

NDM/mjb
Enclosure

Document:C:\data\moody\devine\lerner



EXPERT BOOK

REBECCA DEVINE V. RICK WATSON, M.D.

600001

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mjb 5/99