State of Ohio,)
) SS:
County of Lorain.)

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IN THE COURT OF COMMON PLEAS

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Shwu-Chen Chai, Executrix of the Estate of An-Ti Chai, et al.,

Plaintiffs

vs.

The Oberlin Clinic, et al.,

Defendants.

Case No. 99 CV 124670

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DEPOSITION OF NATHAN LEVITAN, M.D.

WEDNESDAY, SEPTEMBER 5, 2001

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The deposition of Nathan Levitan, M.D., a witness herein, called by the Plaintiffs for examination under the Ohio Rules of Civil Procedure, taken before me, Ivy J. Gantverg, Registered Professional Reporter and Notary Public in and for the State of Ohio, by agreement of counsel and without further notice or other legal formalities, at the offices of Ulmer & Berne, 900 Bond Court Building, Cleveland, Ohio, commencing at 6:15 p.m., on the day and date above set forth.

APPEARANCES:
On Behalf of the Plaintiffs:
Michael F. Becker, Esq.
Becker & Mishkind
134 Middle Avenue
Elyria, Ohio 44035

On Behalf of the Defendants:

Brian N. Ramm, Esq.
Elizabeth A. Harvey, Esq.
Ulmer & Berne
900 Bond Court Building
Cleveland, Ohio 44114

(Thereupon, Plaintiffs' Exhibit 1 (Levitan) was marked for identification.)

NATHAN LEVITAN, M.D.

a witness herein, called by the plaintiffs for examination under the Rules, having been first duly sworn, as hereinafter certified, was deposed and said as follows:

CROSS EXAMINATION

BY MR. BECKER:

Q. Doctor, would you tell me your full name, please?
A. Dr. Nathan Levitan.
Q. Doctor, I am going to hand you what has been marked as Plaintiffs' Exhibit 1, and I wonder if you can identify that for the record, please?
A. Sure. That is my curriculum vitae as of March 3rd, 2000.
Q. Would you take a look at it and see if you can bring it up-to-date, if there are any changes to be made, particularly relative to medical journal articles or textbooks that you have authored or coauthored?
A. So this is about a year and a half old. I have several additional pulications that are not listed here. I am going to have a hard time recalling exactly what they cover. But in general, it is likely that they pertain largely to thoracic malignancies, lung and esophagus.
Q. May I look at your file.

(Thereupon, the file was handed to Mr. Becker.)

Q. (Continuing) While I am looking at this, let me just give you the standard caveats.
You have had your deposition taken before, I know, I have taken it before, but just to review the ground rules with you, this is a question and answer session under oath. It is important you understand the question that I ask. If the question doesn't make sense or is inartfully phrased, you stop me and tell me so, and I would be pleased to restate or attempt to rephrase the question, fair enough?
A. Yes.
Q. However, unless you indicate otherwise to me, I am going to assume that you have fully understood the question that has been posed and you are giving your best and most complete answer today, fair enough?
A. Yes.
Q. Would you tell me what you have reviewed in preparation for today's deposition? And I will hand your file back to you real quick.

(Thereupon, the file was handed to the witness.)

A. Could I have those documents (indicating)?
Q. Sure.
A. Thank you.
I have reviewed records from the Oberlin Clinic, from Allen Memorial Hospital, from the NASA Health Screening Clinic, from Dr. Chuang, Dr. Tavill, the death certificate, death notice, expert reports written by Drs. Morgenstern-Clarren and Rothstein, and depositions of Dr. Morgenstern-Clarren and Rothstein.
Q. I don't see any medical journal articles within your file on primary liver cancer or screening for liver cancer. Had you done research prior to generating your report on those topics?
A. You know, the only reference that I pulled was one that I knew of but wanted to make specific reference to in my expert report, and that was the New England Journal article cited here on 2-B of my report. But I didn't actually review textbooks or specific journal articles in preparation for writing my report.
Q. How about in preparation for today's deposition?
A. Again, nothing specific.
I will tell you, since it may come up later, that I -- pertaining not to this topic, but just in my general patient care activities, I did recently come across the most up-to-date National Cancer Institute recommendations

pertaining to screening for hepatocellular carcinoma, and I imagine the questions you ask me this evening might induce me to bring up that particular reference. I didn't actually go and search for it in preparation for tonight, but it is another reference that I am now familiar with and may refer to.

Q. Can you do the best you can and give me a citation for that medical journal article?

A. Well, it actually isn't a medical journal article, it is the National Cancer Institute formal recommendation regarding screening.

Q. What was the year of publication of that?

A. It is a policy statement that is updated periodically. It is actually available on the Internet, and is available to both patients and physicians through the National Cancer Institute website. And they summarize their current recommendations for cancer screening.

Q. Is there anything about that particular National Cancer Institute recommendation that provides any type of support for the opinions you have rendered in this case?

A. Yes. But to clarify the chronology, I wrote this letter certainly prior to coming across this document which I noted just a few days ago, actually. But this is a document which states that the National Cancer

Institute formal recommendation is not in support of the use of alpha-fetoprotein and ultrasound to screen for hepatocellular carcinoma in patients with underlying liver disease.

Q. What was the date of the recommendation -- or date of the publication? I guess I asked you that already.

A. Yes.

Q. All right. I am getting tired, so just bear with me.

Why don't we identify these three documents, and I will give Ivy a second to mark them as 2, 3 and 4.

(Thereupon, Plaintiffs' Exhibits 2 through 4 (Levitan) were marked for identification.)

Q. (Continuing) Doctor, I marked a document from your file as Plaintiffs' Exhibit 2. Would you identify that for the record, please?

A. Sure. This is a list of the materials -- records that I have reviewed pertaining to this case.

Q. Showing you what has been marked as Plaintiffs' Exhibit 3, would you identify that document?

A. This is a summary of dates that I imagined I might want to refer to in response to your questions tonight. This is a summary that I prepared over the weekend, after going through these records again.

Q. Plaintiffs' Exhibit 3 was recently prepared?

A. Yes, this weekend.

Q. In preparation for today's deposition?

A. Correct.

Q. Did you generate any notes as a result of your initial review of this case?

A. Those notes have been edited into this document here (indicating), which you have a copy of.

Q. Your report?

A. Correct.

Q. So you don't have the original notes?

A. No.

Q. Let me take a look at Plaintiffs' Exhibit 3 and see if I can read your handwriting.

Showing you what has been marked as Plaintiffs' Exhibit 4, would you identify that document for me, please?

A. This is a page from the American Joint Committee on Cancer Staging pertaining to the staging of hepatocellular carcinoma. I believe it is a 1996 edition.

Q. Doctor, the last time I took your deposition, you told me that you were doing primarily work with lung cancer patients. Is that the case today?

A. I don't believe that I told you that. My practice is general, but my research activities pertain to lung

cancer.

Q. Maybe I misunderstood.

So your area of particular interest or your area of research is lung cancer?

A. My area of clinical research is lung cancer, but my general -- but my patient practice is a general one.

Q. And when you say, general, you take care of all kinds of cancer patients?

A. I tend to take care of patients with what we call solid tumors, more than hematologic malignancies, that is to say I am Board certified in hematology as well as oncology, but only a minority of my practice consists of patients with blood disorders, leukemias, diseases of that sort.

Q. Well, if you can break down by type of cancer, would 50 percent of your patients be lung cancer and another 20 percent esophageal, or can you do that for me?

A. Well, my practice follows the pattern of incidence of solid tumors in the U.S., which is to say, I have a lot of patients with lung, breast, colorectal, I have a fair number of esophageal cancer patients, I have some myeloma patients, I have some hepatocellular carcinoma patients, I have some renal cancer patients, but any general medical oncologist will have a predominance of the major cancers.

Q. What percentage of your clinical practice has to do with hepatocellular cancer; would it be less than five percent?
A. Well, it depends on whether --
Q. As a primary, as a primary cancer.
A. It depends on whether you do that calculation on the basis of the number of visits a year by diagnosis or the number of new patients a year with this diagnosis. I would imagine that I see five to six new cases a year of hepatocellular carcinoma. It is a very unusual cancer.
Q. Primary?
A. Correct.
Q. So five or six cases a year?
A. Correct.
Q. Is there an oncologist at UH that has a particular interest in primary liver cancer?
A. No, it is a rare enough entity that no one person sees all of those.
Q. You have not written, authored or coauthored on the topic of primary liver cancer, correct?
A. No.
Q. You did write an article on nonresectable liver metastases from colorectal cancer; do you recall that article?
A. I do.

Q. Can you just kind of give me the general conclusions from that article?
A. Oh, this was a written a number of years ago. I recall writing it, I can't recall the specific contents.
Q. Okay.
Back in the '90s, Doctor, in the mid '90s, can you give me an idea of what your -- how your week broke down between clinical practice and research? Would you spend one day a week on research and four days a week seeing patients?
A. My research activities are actually a fairly small part of what I do. Most of my time is spent on patient care, with some administrative activities, as well.
Being in an academic institution, I do a lot of things, I do some teaching, but certainly more than 50 percent of my time is spent on patient care. And that was the case in the mid '90s, as well.
Q. And is it similar today?
A. Yes.
Q. When was the last time you were engaged in the general practice of internal medicine?
A. I haven't practiced general internal medicine in many years, except to say that as an oncologist, I become the primary care physician for my patients when they are ill. So in that situation, I refer them for screening, I

treat their urinary infections and their pneumonias. So I function as an oncologist for these patients, but I am actually functioning as an internist.
Q. I appreciate that. But when was the last time you practiced as a general internal medicine physician?
A. So if you are asking, when was the last time my schedule was open to new patients who had no diagnosis of cancer --
Q. Right.
A. -- that has been --
Q. Back to your residency days?
A. No, ten years.
Q. And ten years ago, you were seeing patients?
A. When I was at the Lahey Clinic outside of Boston, I had a number of general internal medicine patients in addition to my oncology patients.
But I want to stress that in terms of expertise in general internal medicine, I do a lot of that for my cancer patients, I do practice those skills.
Q. By way of hospital appointments on the vitae, it says, co-director and co-founder of the Breast Cancer Treatment Center at the Lahey Clinic, '90 to '91. Were you doing other things besides that?
A. I was doing full-time practice.
Q. You said in 1990 or '91. Was it for a period of

one year or two years while you were at the Lahey -- is it the --
A. Lahey.
Q. -- Lahey Clinic that you were doing general internal --
A. I was there for five years.
Q. And during the whole five years, did you do general internal medicine?
A. Correct.
Q. What percentage of your patients were general internal medicine?
A. Oh, I don't recall, Mr. Becker. It is long enough ago, I can't tell you that.
Q. So you stopped doing general internal medicine in at least 1991; would that be fair?
A. Well, in response to your question, when did I stop having new patients without a diagnosis of cancer assigned to my practice, that was in 1991.
Q. Okay.
A. But as I have said, I believe that I practice general internal medicine on my cancer patients everyday.
Q. I understand that.
Do you know whether or not defense counsel that hired you, Mr. Lenson, has attempted to obtain an internal medicine expert on the issue of standard of

care?
MR. RAMM: Objection.
Q. (Continuing) If you know, on this case.
A. I have no information in that regard.
Q. How do you keep current as to the standard of care for a general internal medicine specialist?
A. I would say through practicing internal medicine, particularly at an academic institution where I attend Medical Grand Rounds and interface with highly skilled physicians from multiple disciplines, through teaching house staff, which certainly has to keep me on my toes, and the house staff that I work with are general internal medicine house staff, part of the residency program at University Hospitals, and in addition to my oncology journals, I keep up with general medicine journals, as well.
Q. Which journals of those do you continue to subscribe to?
A. Well, New England Journal of Medicine, the Annals of Internal Medicine, Internal Medicine Alert, which is a summary journal of new developments, the Medical Letter, those are the ones that come to mind.
Q. Can you tell me when the last time was that you actively took care of a patient who had hepatitis B without a confirmed diagnosis of cancer?

A. While attending on the inpatient service, which I do every year for a number of weeks, I take care of a broad range of patients, and issues such as hepatitis arise among those patients. So I am certain that as recently as a few months ago when I was on service, we had patients with hepatitis without a diagnosis of hepatocellular carcinoma.
Q. Well, would you explain that to me in lay terms, what does it mean to be on service?
A. Sure. When a patient is admitted to University Hospitals, he or she is assigned to an intern and a resident, and also to an overseeing physician who makes rounds every day, seven days a week, with that team of house officers, of interns and residents.
The interns and residents primarily manage the patients, but the attending physician has ultimate responsibility for the well-being of those patients and for every decision that is made, and bills for the care that is provided to those patients, and sees those patients every day and performs physical examination and writes a note in the chart every day. And that attending physician is responsible for oversight and teaching of the house staff. So during -- and this generally is carried out in either two week or four week increments.
And during this time on service, an attending

physician will round on anywhere between 25 and 30 patients a day, with the house staff, most of them unknown to him or her prior to that time, and will manage all of their medical problems.
Q. How about on an outpatient basis, that is, when was the last time you took care, actively took care of a patient who had hepatitis B without a confirmed diagnosis of cancer, outside of a hospital setting?
A. Well, I actually have a patient in my practice currently who has sickle cell anemia and hepatitis C, as it turns out. And I have had others over the years in that situation.
Q. Why would a patient like that be in your current practice, without cancer?
A. Well, sickle cell anemia is a hematologic condition, and we all have a certain number of those patients in our practice.
Q. All right.
You are both a hematologist, as well as an oncologist?
A. Correct.
Q. So let me see if I can limit it a little bit further. When was the last time you took care of a patient who had hepatitis B without a confirmed diagnosis of cancer or a blood abnormality?

A. On an outpatient basis?
Q. Yes.
A. I can't specifically recall.
Q. Would it have been in your residency?
A. No, I am sure it has happened since that time, but I can't specifically recall.
Q. When was the last time that you actively took care of a patient who had cirrhosis of the liver without a confirmed diagnosis of cancer or a blood abnormality?
A. Well, again, I would say on an outpatient basis, I am sure that that has occurred, but it is not a common occurrence for me on an outpatient basis.
But I have to stress that, for instance, patients with head/neck cancer and esophageal cancer often have alcoholic cirrhosis, and so I will take care of those patients as part and parcel of their oncology care.
Q. I notice that you are the "course director" at Case for the subject entitled, "Introduction to Clinical Oncology."
A. That is correct.
Q. Now, do you have any general outlines or slides you utilize for that lecture or course presentation?
A. I have been doing that for so many years, my secretary handles that, at this point. But they are not slides, there are handout materials that are given to the

students.
Q. Is that something that you could produce and give a copy to Mr. Ramm?
A. Sure.
Q. You have been the director of the Ireland Cancer Center clinical seminars for some time, correct?
A. Correct.
Q. What does that mean?
A. It is an educational program for all of the Ireland Cancer Center clinicians, that is to say, medical and radiation oncologists, hematologists, the house staff, the Fellows, both at University Hospitals of Cleveland and at all of our community based sites. And every Wednesday morning, we have a speaker come in and make a presentation on some patient care related topic. I coordinate that lecture series.
Q. Okay, I notice that you have been on a planning committee for the annual education program entitled, "Update on Cancer for the Primary Care Physician." What is that all about?
A. This is again something that I do periodically, and my secretary does more of it than I do at this point. But it is a continuing medical education program for internists in the community to update them on cancer related issues that a primary care physician should

understand.
Q. Is it something that you actually produce a lecture, or an audio tape, or a videotape?
A. No.
Q. How is that disseminated?
A. For instance, this year, it is on October 6th at the Marriott, a Saturday morning, and it lasts from 7:30 until 1:00 o'clock, and we have a series of speakers that I have coordinated.
Q. All right.
Is that program recorded?
A. No.
Q. And to your knowledge, has anyone ever spoken at that program on screening for primary liver cancer in patients who are at high risk for the same?
A. We do have a speaker on screening. However, hepatocellular carcinoma is an unusual enough cancer that we don't even address it in that presentation. It is not something that is really on the radar screen of internists.
Q. Since 1994, you have provided lectures to community forums. Have any of those been on the topic of primary liver cancer or screening for liver cancer?
A. I am not sure what you are referring to from my curriculum vitae with that question.

Q. Maybe I misspoke, but right here (indicating).
A. Okay, over the years -- that simply refers to the fact that I have given a number of lectures around the metropolitan Cleveland area on different topics.
But in answer to your question, I can't recall lectures on hepatocellular carcinoma.
Q. Doctor, I am going to turn to Mr. Chai, and I want you to know that this is not a memory contest, you are more than free to look at the chart before responding to any of my questions, fair enough?
A. Yes.
Q. Before that, I forgot to ask you a couple of questions about medical malpractice. Have you ever been sued for malpractice?
A. Yes, on two occasions. One was when I was a -- either a resident or a Fellow in training, and I moonlighted in an emergency room in New Hampshire. And the patient had an orthopedic injury to the Achilles tendon, and many people were sued by this plaintiff for a delay in diagnosis, and my portion in that suit was settled for one dollar.
Q. Anything else?
A. Yes. When I was practicing at the Lahey Clinic, a suit was filed and subsequently dropped by the plaintiff.
Q. What were the allegations in that case?

A. It was so illogical, I can't even tell you. And it was short-lived, and dismissed by the plaintiff.
Q. All right, turning to Mr. Chai, would you agree that more likely than not, even as early as 1988, that Mr. Chai likely had cirrhosis of his liver, or in his liver?
A. On the topic of cirrhosis, what I remember from the records is a discussion by Dr. Rothstein, gastroenterologist expert for the plaintiff, where he indicates that the patient had a small liver on examination. And I believe he was referring to the time of Dr. Chuang's evaluation around 1991, and he concluded that at that point in time the patient likely had cirrhosis.
I am not a gastroenterologist, so I don't want to render opinions outside of my area of expertise. So on my own, I would not hazard a guess as to specifically when, and hence I refer to Dr. Rothstein's comments.
MR. BECKER: I didn't hear the end of that.
(Record read.)
BY MR. BECKER:
Q. You understand when I use the phrase, serial monitoring in a hepatitis B patient, I mean the modalities of ultrasound as well as regular checking alpha-fetoprotein; would you please understand that to be

true?
A. I do.
Q. Do you have an opinion, Doctor, more likely than not, that had serial monitoring been undertaken on Mr. Chai beginning in 1991, that his renal cell -- that his liver cancer -- too many cases -- that his liver cancer would have been diagnosed much earlier, do you have an opinion?
A. I have no way of knowing whether or not those modalities would have resulted in an earlier diagnosis, because their positive predictive value, their sensitivity and specificity, are so limited in detecting liver cancer.
Q. What is the basis of that opinion?
A. My general fund of knowledge concerning screening modalities, including these, indicates that these tests are of limited value in the early -- I will say they are of uncertain value in the early diagnosis of liver cancer, and more importantly, they have never been shown to have any impact on mortality.
Q. Have you, yourself, ever ordered serial monitoring of a hepatitis B patient with ultrasound and alpha-fetoprotein serum levels?
A. I don't specifically recall.
Q. You could have, you could not have; you don't

recall?
A. I do not remember.
Q. If you would have, what would have been the reason for you to do so?
MR. RAMM: Objection.
You can answer.
A. Well, it is so theoretical, I can't answer that. As I sit here today, I don't believe that those tests have any benefit in terms of reducing mortality from liver cancer.
Q. You didn't answer my question, Doctor.
My question, I asked you if you had ever ordered serial monitoring by way of ultrasound and AFP on a patient, and you said you may have, you may not have, and then I responded by saying, if you would have, under what circumstances would you have ordered the same?
A. Well, Mr. Becker, since I can't specifically recall having done it, it would be hard for me to recall the rationale in doing so.
Q. All right.
What stage was Mr. Chai's cancer ultimately diagnosed in?
A. Stage IV.
Q. Do you have an opinion as to the histology of his particular lesion, whether it was aggressive or

moderately aggressive or slow growing?
A. In terms of histology, there are various subtypes of liver cancer. But those categories are really not aggressive, nonaggressive, fast growing, slow growing, they are histologic descriptions of -- and this is an area, of course, only a histologist would have expertise in -- there is a hanging type, a pushing type, and so forth.
We don't know, if my memory serves me correctly, we don't know what the specific histologic subtype was of Mr. Chai's liver cancer because the diagnosis was made based on the elevated alpha-fetoprotein, and if I am not mistaken, I don't think he had a biopsy.
Q. Absent the histology, do you have an opinion as to the doubling time of this particular cancer?
A. In general, liver cancer is an extremely slow growing malignancy with a doubling time that has been described in the literature as being greater than a hundred days.
Q. Do you have an opinion whether ultrasound is more sensitive to picking up liver cancer than a CT scan?
A. I am not aware of specific data comparing the two, though in general, a CAT scan is a more sensitive test than an ultrasound.
Q. Can we agree in general that when liver cancer,

primary liver cancer, manifests itself causing the patient symptoms, that at that point it is usually well advanced?
A. If this answers your question, it is well known that most, i.e. the vast majority of liver cancers are advanced at the time of diagnosis such that they are not resectable, if that answers your question.
Q. Okay.
Hypothetically, if Mr. Chai's liver cancer had been diagnosed in the mid '90s, do you have an opinion whether he would have been a better candidate for a resection, or one for transplantation?
MR. RAMM: Objection as to the mid '90s time frame.
You can answer, if you can.
A. It would be more helpful if you could give me a sense of what time period you are referring to.
Q. Let's say 1996.
A. We know that in 1998, at the time of diagnosis, he had cancer involving the entire right lobe measuring 11 centimeters, there was portal vein thrombosis, there was additional lesion on the left lobe, he had lymph node involvement in the retroperitoneum and he had bilateral lung nodules and occlusion of the portal vein with tumor emboli.

So this was -- and let me add, his CAT scan at that time showed tumor involving the entire right lobe and 50 to 70 percent of the left. So this cancer, despite its slow growing nature, was huge in May and June of 1998.

Given how slowly this cancer grows, I don't believe that it would have been likely resectable in 1996.

Q. Same question, 1994.

A. Well, since I imagine you will ask me that question in 1992 and 1990, as well, let me try to cut to the chase and say that theoretically speaking, at some point in time, if it had been somehow possible magically to identify this cancer when it was small in size, he would have been a better candidate for resection.

If he in fact had cirrhosis as early as 1991, resection would have been quite problematic. But I guess it is theoretically possible that there might have been some point in time when he might have been either a resection or a transplant candidate, but the cirrhosis would certainly have been a complicating factor.

Q. Are you on any transplant teams, liver transplant teams at University Hospital?

A. I am not.

Q. Are you familiar with what the -- of the location

of the regional transplant, liver transplant center is in Northeast Ohio?

A. That is something that the transplant surgeons are involved in, rather than the medical oncologists.

Q. So you don't know which hospital would be considered the transplant regional center?

A. I don't know which hospital.

Q. Okay.

A. I know we do them at University Hospitals. So my involvement is with those transplants that are done there.

Q. Do you have any knowledge whether or not the chances of a cure with liver cancer are greater with resection or greater with a transplant?

A. Well, the literature --

MR. RAMM: I am sorry, did you say cure?

MR. BECKER: Yes.

MR. RAMM: Okay, thank you.

A. (Continuing) I am familiar with that literature.

As you probably are aware, the indications for resection and transplant are different. The patient populations are different. And following resection, the five year survival is only about 30 percent. It used to be about 20 percent, now it is as high as about 30 percent. And following transplant, the five year

survival is also about 30 percent.

Q. So your opinion is that the chances of cure are about the same between transplant and resection?

A. The numbers that I have seen most recently look a little bit better for transplant than for resection. However, the approach that is taken is that if a patient is healthy and has a small tumor, resection is preferred over transplant because the perioperative mortality is considerably less, the complication rate is considerably less.

So resection is the preferable approach over transplant, though as I said, the populations are different. But the five year survival for each is very poor.

Q. Are you currently following any patients who have had a liver transplant for primary liver cancer?

A. Yes.

Q. And how long have they been living?

A. I can think of two patients in my practice, one of whom has recurred and died recently, and one of whom is, oh, I think a couple of years out from transplant.

Q. So the first one died?

A. Right.

Q. After the transplant?

A. Correct, recurred, with liver cancer.

Q. And then you have one that is still living, and it is a few years --

A. Two years out, correct.

Q. You don't know where they had their transplant?

A. At University Hospitals.

Q. Do you know whether or not if a patient is resected, that is if they have liver cancer and their liver is amenable to resection, the type of surveillance that patient undergoes after surgery?

A. Yes. Patients who have undergone resection for liver cancer will undergo alpha-fetoprotein levels every few months, and either CT every -- it is variable, every six months, every four months, it depends on the duration of time following transplant, and to some extent, it depends on the preference of the surgeon.

Q. I think I asked the question about resection. You answered it in terms of transplant.

A. I am sorry.

I would say following resection or transplant, that kind of surveillance would be utilized.

Q. And have you ever ordered such a surveillance yourself?

A. In general, these patients are followed very closely by the transplant surgeons, and generally they will order these, in my experience.

Q. Is it your experience that this surveillance of alpha-fetoprotein and/or ultrasound and CT scan is effective in detecting recurrence?
A. Well, it is certainly done. A study has never been conducted to ask the question, does it impact on mortality, in contrast to the situation of a patient with hepatitis who has not yet developed liver cancer, where a study has been done asking that question, and as I said before, the results were negative.
Q. You are not aware of any literature that says the results are positive as far as the effectiveness of surveillance, are you?
A. To my knowledge, there has never been a randomized study that has shown a positive impact on mortality in the population of patients that we are discussing, i.e. underlying hepatitis screening for the development of liver cancer.
Q. Well, I don't know that you answered my question. Let me have that last question back, Ivy.
(Record read.)
A. I think I answered that question. Do you want to read the answer? I believe I answered it.
Q. I thought -- what type of study did you reference in your answer?
A. Okay, let's be clear.

Your question is, if I understand it properly, am I aware of any studies that have proven that screening of a population of patients who are hepatitis B or C positive, and they are screened with AFP and ultrasound, will that favorably impact their mortality from liver cancer.
And my answer is, there is no randomized study that has ever shown that, and there is a single study that I have referenced here showing a lack of benefit from that screening.
Q. All right, what I want to get at is, you used the phrase, randomized study --
A. Right.
Q. -- and I want to make sure I understand what you mean by that qualifier, randomized study. What do you mean by randomized study?
A. You have one group of patients that undergoes screening and another group of patients that do not, and then you can actually compare and determine accurately whether or not those screening measures impact mortality.
Q. All right.
What would you say to the physician that had an opinion there are ethical problems with doing a randomized study for screening for liver cancer?
MR. RAMM: Objection.

A. Well, I would say that in order for there to be ethical problems with doing a randomized study, you would need to have some evidence that these studies are in fact beneficial.
Q. And to your knowledge, you are not aware of any studies, any literature that says these screening techniques are beneficial?
A. Well, the best study that was ever done was the study referenced in the New England Journal, which was negative. And it is for this reason that the National Cancer Institute does not recommend routine screening.
Q. Do you have an opinion whether Mr. Chai was healthy enough for a liver transplant in 1994?
A. I have no way of knowing that.
Q. Okay.
A. But I think it is certainly possible that he was.
Q. What is it about hepatitis B that predisposes someone to liver cancer?
A. The actual mechanism isn't known. But the association is clear.
Q. Is there also an association between cirrhosis and liver cancer?
A. Yes.
Q. So if one had both cirrhosis as well as hepatitis B, then they would be at high risk to develop liver

cancer?
A. Correct.
Q. So if in fact Mr. Chai had longstanding hepatitis B as well as cirrhosis by 1991, he had two strong risk factors for the development of liver cancer?
A. Correct.
Q. How does one contract hepatitis B?
A. Hepatitis B is generally a blood borne virus, so it is generally contracted either through transfusions, or it can be contracted sexually, as well.
Q. Have you heard of something called genetically transferred hepatitis B?
A. Well, are you referring to transfer at the time of delivery?
Q. Yes.
A. That can happen, as well.
Q. What is it, to your knowledge, about the Far Eastern culture that makes those folks have such a high proportion of hepatitis B?
A. Well --
MR. RAMM: Objection.
Go ahead.
A. (Continuing) It is a fascinating question. There is no doubt about the fact that that population is at extremely high risk, but it is not known what in

particular is the cause of their increased incidence of liver cancer.
Q. Aren't gastroenterologists generally the type of physicians that take care of liver disease in patients who are at high risk for liver cancer?
A. I will say that gastroenterologists often take care of patients with hepatitis A, B and C, if that is what you are asking. More commonly B and C, since A is generally a short-lived illness.
Q. And to your knowledge, you don't know whether gastroenterologists regularly screen for hepatomas in people that are at high risk for the same?
MR. RAMM: Objection.
A. I don't know, not being a gastroenterologist.
Q. The article that you cited in Colombo -- I think his name is Colombo -- it references a study of hepatitis B patients, a study that was done in the Far East, where they had a very high yearly incidence of hepatocellular carcinoma vis-a-vis screening, anywhere in the range of 5 to 11 percent. Do you feel that statistic would justify regular screening for people at high risk for the same?
A. I would have to look at that reference to respond to it.
Q. Do you agree that the Colombo study confirmed that elevated alpha-fetoprotein levels were a predictor of the

development of hepatocellular cancers?
A. I don't believe that that was an end point in the design of that study.
Q. Is that referenced in the study, to your knowledge?
MR. RAMM: Do you recall?
A. I don't recall.
Q. Are you familiar with or aware of any medical literature on the topic of the efficacy of liver transplantation for hepatocellular carcinoma?
A. Yes, I am familiar with that literature.
Q. Are you familiar -- do you agree with the literature that liver transplantation is an effective treatment for small unresectable hepatocellular carcinoma in patients with cirrhosis?
MR. RAMM: Objection.
A. Well, I want to stress the point that if you look overall at the mortality rates for patients who undergo liver transplant for hepatocellular carcinoma, to begin with, a very small, carefully selected subset of patients are eligible for that procedure, and even in that carefully selected small subset of patients, only 30, 35 percent, in some studies, a little higher, of those patients are actually alive at five years.
Q. And that article -- the authority for that

position is what?
A. That is my general fund of knowledge in reading the literature on this topic.
Q. So let's go back to my -- are you familiar with any literature that concludes that liver transplantation is an effective treatment for small unresectable hepatocellular carcinomas in patients with cirrhosis?
A. Well, that is a very vague statement, because one might say that the ability to cure 30 percent of patients with liver cancer who are eligible for transplant, one might say that that in fact is an effective intervention for this group.
So the term, effective, needs to be more clearly defined. I would agree that in the right population, liver transplant is an appropriate procedure for somebody with liver cancer.
Q. Are you familiar with or aware of any medical literature that stands for the proposition that modern screening methods permit earlier detection of hepatocellular carcinomas?
A. It is likely that screening will lead to earlier detection in some cases, but the important question is, so what? Does it effect mortality?
Q. So the answer to my question is, you are familiar or you are unfamiliar?

A. I am familiar with literature suggesting that it can result in some cases in an earlier diagnosis of that cancer, but the missing link is, does it matter?
Q. They die anyways.
A. That is the question.
Mr. Becker, I want to be clear that I am not discrediting the value of either liver resection or liver transplantation in the treatment of this disease. However, it is very important to keep in perspective how likely these procedures are to achieve cure for every hundred patients that come in with liver cancer.
Q. Are you familiar with any literature that speaks to the topic of liver transplantation, long-term survival rates with patients with small hepatocellular carcinomas?
A. In the, again, carefully selected population of patients who undergo liver transplant for liver cancer, overall, about 30 to 35 percent of those patients, again, as I said, perhaps a little higher in some series, will be cured. But the majority, well over 50 percent, are dead at five years.
Q. Doctor, you keep mentioning this 30 or 35 percent. I am trying to pin you down for the source of that, you respond by saying, my general knowledge.
Is there anything that you can point me to, I mean, if you go back in your office and look at your

notes on liver cancer, that you can say, oh, I can give that to Becker, it says 30 or 35 percent? Because I am not familiar with that statistic.
A. I can certainly conduct a literature search for you, if you are interested in having me put the time into it, and come up with a wealth of literature to support that statement. But I can't quote you specific references as we sit here today.
Q. All right, but how is it that you remember 30 or 35 percent?
A. Because I am familiar with those kinds of statistics for a whole multitude of cancer related issues, and I can't cite journal articles and pages for specific numbers, though as I said, if you would like me to spend my time in that fashion, I am absolutely confident I could produce plenty of literature to support that.
Q. Are you familiar with any national survey to liver specialists to see whether or not they regularly screen --
A. I am not.
Q. -- for hepatocellular cancer in patients with cirrhosis or hepatitis B?
A. I am not familiar with that information.
Q. Are you familiar with a textbook entitled Harrison's?

A. I am.
Q. And do you have that in your library?
A. I do.
Q. Do you know what Harrison's says on the topic of screening for patients with hepatitis B and/or cirrhosis?
A. I don't recall specifically what they say on that topic.
Q. Do you think Harrison's is a recognized, reliable textbook?
A. Well, I don't consider any single textbook or journal article to be authoritative.
Q. Okay. Boy, I have heard that before.
Is there one internal medicine textbook that you would turn to, of the four, or five, or six or eight textbooks, and say this one is the most reliable?
A. I think it is very important to look at the references on which any statement is based, and to simply not accept any single textbook as authoritative.
Q. So can you answer my question? Do you remember my question?
A. I think that I answered your question.
Q. My question was -- I didn't ask you, is any one authoritative of the many, I said, is there any one more reliable than the others, in your mind?
A. Really, it is a hard question to answer. These

books are thousands of pages long, and address a whole variety of topics. I don't know how to say that one is more reliable than another.
Q. Can we agree that when a journal article is published, the work that supports the research, the data, the surveys, the support that goes into a journal article, that likely took place a year or two before the actual date of publication?
A. It depends on the textbook, but often a year or two, or sometimes more.
Q. I am talking -- I am not talking textbooks. My prior question was textbooks. But now I am talking about journal articles.
A. So your question again is?
Q. As to journal articles, if you see a study published, isn't it true that the study, the data for that study has generally been collected and refined and worked and processed and a paper developed for at least one year if not longer before it is actually published?
A. I think it really depends on the study. There are certainly rapid publications that occur in the medicine journals when important data are collected.
Q. Okay.
A. So I think it really varies.
Q. Okay, but going back to textbooks, I think you

already answered this, isn't it true that with textbooks, what you read in textbooks is generally an embodiment of what is recommended if not two, three years before the actual book is published?
MR. RAMM: Objection.
You can answer, if you know.
A. I am hesitant to generalize. It really depends upon the gestation period of that textbook. Clearly it takes time to write a textbook, but I wouldn't agree with a generalization of that sort.
Q. Well, would you stand by your one year if not longer earlier answer?
A. You could ask me -- the new version of Harrison's was published in 2001, and frankly in the computer age, I don't know how recently any particular chapter might have been edited before it went to press. So I frankly don't know. I mean, it is generally accepted that textbooks take longer to publish than journals.
Q. Thank you.
A. But I am not comfortable giving you a particular time period.
Q. Looking at your report dated August 28th, is this the only report you generated on this case?
A. Yes.
Q. And have you had an opportunity to look at this

report prior to today's deposition?
A. I briefly read it over this evening.
Q. Do you want to make any corrections, modifications, or do you want to stand on the report?
A. I would stand by the report.
Q. Can we agree that Dr. Chuang was Mr. Chai's primary care physician?
A. I think that there is a lot of ambiguity as to whether or not he was the primary care physician, or the physician at NASA, who actually saw him many more times than Doctor -- is it pronounced Chuang or Chuang?
Q. I don't know.
A. Than the physician in question here did.
Q. So you are uncertain on that issue?
A. Right, because there were so many visits to NASA.
Q. Well, it was just part of an annual physical, wasn't it, that NASA required?
A. Again, I think it is really unclear who would be considered his primary care physician.
Q. Well, if Dr. Chuang considered himself the primary care physician, would you disagree with that?
A. I don't remember seeing in the record where he stated that.
Q. Okay.
So if he did, then you would defer to Dr. Chuang?

A. I would still say, even if somewhere Dr. Chuang described himself as the primary care physician, in looking at the responsibility that one or another physician bore in his care, I think it is important to remain cognizant of how involved the physicians at NASA were in following Mr. Chai.
Q. Doctor, didn't you refer to Dr. Chuang as his primary care physician in your report?
A. Let me see where that is.
Can you help me out?
Q. Yes, Page 4, A.
A. I believe I said, as a primary care physician.
Q. Okay.
You don't feel that primary care physicians should be aware that individuals, in 1994 or 1996, individuals -- even 1991 -- individuals at high risk for liver cancer should be screened for liver cancer or referred to a liver specialist for such screening; you don't think primary care physicians, general internal medicine doctors, should know that?
MR. RAMM: Objection.
A. Mr. Becker, in believing that any screening procedure should be standard care for any type of physician, it must be demonstrated that that screening procedure will favorably impact mortality. And --

Q. By the --
A. Please let me finish.
And that information has not been established.
Therefore, I find it difficult to state that it is incumbent upon a primary care physician to perform the screening.
Q. You are saying, absent a randomized study demonstrating the advantages to a patient of screening high risk patients, there cannot be a standard of care for a general internist to do such screening?
A. No, I didn't say that. I said, looking at the available data on this topic, they don't support a favorable impact on mortality with screening, and will add to that the fact that the National Cancer Institute doesn't even recommend it.
Q. Well, you are taking two positions in this case, Doctor, you are wearing two hats. You have been around medical-legal cases for a number of years. You are wearing a standard of care hat, and you are wearing a proximate cause hat; do you understand that?
MR. RAMM: Is that a question, Mike?
MR. BECKER: Yes.
Q. (Continuing) Do you understand that in this case, you are the sole defense expert on standard of care, and you are the sole defense expert on causation; do you

understand that?
A. I certainly --
MR. RAMM: Do you understand that you are an expert in this case?
A. (Continuing) Yes.
MR. RAMM: Fair enough.
Q. Do you understand you are the only defense expert in this case?
A. I am not aware of that.
Q. Okay.
I mean, you are giving expert opinion on this case on standard of care as well as proximate cause, correct?
A. I am.
Q. Doctor, tell me the definition of standard of care in Ohio?
A. I cannot give you that legal term, legal definition, as a physician.
Q. You are giving the opinion in your report, you will give the opinion at trial, that Dr. Chuang met the standard of care of a reasonably situated internal medicine doctor, correct?
A. That is stated so in Section 4-C of my report, and I would stand by that, where I say, it is my opinion as an internist as well as a medical oncologist that Dr. Chuang practiced within the standard of care for a

primary care physician during each of his encounters with Mr. Chai.
Q. Okay, I want you to define standard of care as you have used it in that letter?
A. This will not be a legal definition, since I am not an attorney, but my understanding of standard of care is a medical practice which is generally expected of a physician based on similar practices of other physicians within a community.
Q. Okay.
A. And I would add that my sense of standard of care is also colored by the medical literature indicating whether any particular practice has been proven to be effective or not.
But to make this simple, I have been clear that I don't think there is sufficient data to mandate that a primary care physician, in following a patient with hepatitis, must obtain periodic alpha-fetoprotein and liver ultrasound testing because these procedures are not recommended by the National Cancer Institute and have not been shown to favorably impact mortality.
Q. What was the data? Did I ask you this earlier? What was the data of the National Cancer Institute publication?
A. I don't -- it is well referenced, but I don't have

that information with me. It is available on the Internet.
Q. Did you imply that it is a rather recent one, in the last year or two?
A. Oh, I don't know the date of this. It is a current recommendation, but I don't know the date of this particular document. I could certainly produce that for you, if you would like it.
Q. Well, would you do that, and give it to Mr. Lenson or Mr. Ramm?
A. Sure.
Q. Because I have promised Mr. Lenson to help him with his research, and my expert has tendered me reports, and I am going to do that shortly.
So would you do that, and send that to Murray?
A. I would be happy to.
Q. Now, you have worked with Murray before on other cases?
A. Yes.
Q. What type of cases?
A. I remember a breast cancer case, I remember a kidney cancer case, it might even have been two kidney cancer cases, I am not sure, and that is all I can recall at the moment.
Q. Are you still reviewing six or eight to ten

medical-legal cases a year?
A. That is about right.
Q. And predominantly for the medical provider?
A. About 20 percent are for the plaintiff.
Q. When we last met at a deposition, if you recall, I asked you about doing plaintiffs work, and you told me that you have that data at home, and you can look up the plaintiffs cases. Do you remember telling me that under oath?
MR. RAMM: Objection.
Do you recall?
A. I believe -- well, I believe what I told you, which is still the case, is that my active files are at home, and I can go through those and let you know which ones are plaintiff cases and which ones are defense cases. I don't keep an historical log of those, because I discard the records when the cases are completed.
But I believe I told you then, and would stand by that today, that I could go through my filing cabinet and tell you how they break down, and I would be happy to do it.
Q. Well, would it be too much trouble to -- how many cases are in your filing cabinet?
A. I don't know. I would have to look through.
Q. Twenty or 30?

A. Given the fact that these cases drag on for so long, I think it is probably more than 20. I don't think it is more than 30.
But if you would like me to spend the time doing that, I could certainly do it. It would take me some time to go through and clarify whether they are plaintiff or defense cases.
Q. Is it your opinion that you have active plaintiff cases?
A. Yes.
Q. And who are the plaintiffs' lawyers that hired you?
A. Give me a minute, and I will think of a couple of them.
There is a fellow named Terry Gafney in West Virginia for whom I have done some work and he is sending me a case currently.
Q. What type of cancer?
A. It is a breast cancer case.
Q. Okay.
A. And --
Q. Let's stay with him for a moment, okay?
A. Sure.
Q. Have you actually reviewed the case, found it meritorious, written a report?

A. No, I got an e-mail from him recently, the case is on the way.
Q. Okay, any active cases that you reviewed and found meritorious --
A. Yes.
Q. -- from a plaintiff's perspective?
A. Yes. I can't recall the attorney, but there is a colon cancer case, delay in diagnosis, where my opinion is in support of the plaintiff.
Q. And have you written a report in that case?
A. I can't recall whether I have written a report, but I have certainly verbally given my opinion to the attorney and have committed to my involvement in that case.
Q. And you don't recall the attorney?
A. I don't.
Q. Do you recall what state the case is from?
A. I think the case is from Southern Ohio, but I am not positive.
Q. Have you been deposed in that case?
A. No.
Q. Can you think of any -- going to plaintiffs cases, so you have found a colon cancer case, from a plaintiff's perspective, meritorious, correct?
A. Correct.

Q. Any other types of cancers, from a plaintiff's perspective, that you found meritorious?
A. I have gone to court and testified in a case where there was a delay in diagnosis in lung cancer, testified for the plaintiff.
Q. When was that?
A. Last year.
Q. Where did you testify?
A. I believe that I went to -- I think that was Dayton.
Q. What kind of lung cancer was it, small cell, large?
A. It was nonsmall cell.
Q. Okay.
A. And this is -- Mr. Becker, this is a memory game. I have this information, and I would be glad to provide it to you. But it is hard to pull up this information from memory.
Q. Have we covered the cases that you can recall from memory that you found -- I just want to exhaust your memory right now -- that you found meritorious?
A. I am sure there are others, because the 20 percent figure is actually pretty accurate.
Q. Dr. Rothstein, the plaintiffs' expert, one of the plaintiffs' experts, as you may recall, is a

gastroenterologist with a particular interest in liver transplantation; do you recall that?
A. I do.
Q. And he has followed liver transplant patients, transplantation being for liver cancer, anywhere from 30 to 40 patients over his 15 -- roughly 15 years involved in the liver transplant team, and approximately 85 percent of those patients are still alive.
Would you feel that Dr. Rothstein, based on that experience, is in a better position to comment on prognosis had Mr. Chai been subjected to and given the opportunity for an early diagnosis and transplantation, than you?
MR. RAMM: Objection.
First, first of all, Mike, I think I took a look at his deposition, I don't recall that testimony. So within that realm, I am going to object --
MR. BECKER: Okay.
MR. RAMM: -- to anything more than a hypothetical.
MR. BECKER: And I am winding up, Doctor. We are all tired.
A. I don't recall that testimony, either.
Q. Okay.

So I want you to assume it is true.
A. I would have two thoughts about that. First of all, a transplant surgeon or a hepatologist involved primarily in a transplant program works with a small subset of patients with liver cancer, because we all know, or at least I have expressed the opinion tonight, that approximately 80 percent of patients who are diagnosed with liver cancer are absolutely not candidates for any kind of surgical intervention. And it is that remaining 20 percent that Dr. Rothstein apparently is involved with. So already we are taking a small subset of patients who present with liver cancer. And of that 20 percent, some will be eligible for primary resection and some will be eligible for transplant.
And if Dr. Rothstein is primarily a transplant gastroenterologist, then he is working with a subset of that 20 percent, call it 10 percent, 12 percent. And of that 10 or 12 percent, my knowledge of the literature does not support that 80 percent of them are cured. But even if it did, we would be talking about curing less than 10 percent of patients who are diagnosed with liver cancer with these aggressive interventions.
Q. Repeat the very end of that.
So even if it did, we would be talking about --
A. Curing a very small minority of patients who are

diagnosed with liver cancer.
Q. You don't have any knowledge as to what percentage of the patients who have liver cancer diagnosed at an earlier stage than Mr. Chai, what percentage of those go on to resection and what percentage are recommended for transplant, do you, really?
MR. RAMM: Objection, referring to earlier stage, given the gradients of staging, I am just objecting, because that is not defined.
A. So my question is, are you talking about liver cancer in general, are you talking about Mr. Chai? If you are talking about Mr. Chai, at what point in time? Could you perhaps make the question clearer?
Q. Well, I wasn't talking about Mr. Chai. I was trying to get an understanding as to what is your perception.
You say Mr. Chai was diagnosed in a Stage III, or IV?
A. IV.
Q. So that implies that there is Stage I, II or III preceding Stage IV, correct?
A. Correct.
Q. And without getting into staging right now, assuming -- what percentage of patients that are diagnosed as Stage I, II and III are divided into

resection versus transplant? What is your understanding?
MR. RAMM: Objection.
Q. (Continuing) That is my question.
MR. RAMM: Objection.
A. Right.
The important statistics, in my opinion, are that for every hundred patients who are diagnosed with liver cancer, only 20 percent of them will have early stage disease, Stage I or II disease.
Q. And that is because, Doctor, they don't have surveillance of those patients --
MR. RAMM: Objection.
Q. -- and that is because, Doctor, those patients are diagnosed when they manifest themselves, that advanced cancer manifests itself, and it is too late to save that person's life?
MR. RAMM: Objection.
A. Let me respond to your statement by looking at another cancer, which I think is very illustrative, let's look at lung cancer.
It is very clear that with serial chest x-rays, you can -- or serial CT scans, but chest x-rays have been more carefully studied -- you can screen smokers and you can find their lung cancers when they are smaller.
Currently, 60 percent of patients with lung cancer

are diagnosed in Stage IIIB and IV, i.e. very advanced disease. But if you do sputum cytology and chest x-ray on smokers, you will pick up a large number of cancers when they are small and resectable.
However, multiple studies conducted over the years, over the past 30 years, by multiple groups, have confirmed that you can do these chest x-rays, and you can pick them up when they are golf balls or grapes instead of grapefruits, but it doesn't make one whit of difference in the mortality from lung cancer.
And you can say, why is it?
It isn't understood. Medicine isn't always logical. It doesn't make any difference.
Therefore, just to let me finish, for you to presume that just because a particular modality may be able to find a liver tumor when it is smaller, for you to presume that that translates into improved survival is without a basis.
Q. And Doctor, this is pretty much what you say in all your cases where you are acting as a defense expert, specifically that it wouldn't have made any difference, that the patient would have died?
MR. RAMM: Objection, Mike.
Q. (Continuing) Isn't that -- Doctor, I must have 20 depositions of yours where you say the same thing,

whether it is breast cancer, whether it is lung cancer, whether it is colon cancer, it is -- is it or is it not a common theme, a common statement by you, as a defense witness, that the patient would have died notwithstanding earlier diagnosis?
MR. RAMM: Objection, Mike.
A. You are asking for a gross overarching generalization that I don't feel comfortable making at all. If you would like to discuss a particular case in detail, I would be happy to do it. But I would have trouble making any kind of a generalization of that sort.
Q. You wouldn't dispute the fact that I can readily put my hands on 15 or 20 depositions, within the last few years, where you have concluded in an individual case that earlier diagnosis wouldn't improve the survival, wouldn't have made a difference; would you dispute that?
MR. RAMM: Objection.
A. I don't know what number of depositions you could produce to that effect, but you could also produce a significant number in which I have opined that a delay in diagnosis adversely affected that patient and contributed to his or her demise.
Q. And I guess, Doctor, I am going to have to ask you to produce those plaintiffs cases you have active, because we can't -- I can't find any plaintiffs cases by

you. And I am not saying they are not out there, I am just saying, would you please identify, take the time to notify your counsel, or the defense counsel who hired you, of the plaintiffs cases, your active plaintiffs cases, where you have reviewed and found it meritorious?

MR. RAMM: Well --

A. I have to ask about confidentiality issues.

MR. RAMM: I was about to say, I will tell you what, we will take that request under advisement. I will pass it along to Murray.

I certainly don't want you to get into any trouble with confidentiality issues, Doctor.

THE WITNESS: That is fine.

MR. RAMM: We will take that up later, Mike. That is fine.

BY MR. BECKER:

Q. Well, to your knowledge, in the plaintiffs cases that you have committed to, have you -- has your name been disclosed to the other side?

A. I would have no way of knowing that.

Q. Well, without disclosing the identity of the patient, would you disclose the identity of the plaintiff's lawyer?

A. I would have to find out from Mr. Ramm and Mr. Lenson whether I would be legally permitted to do

that. I am not an attorney, and I certainly would respect the confidentiality of those cases.

But if in fact there are no legal contraindications to it, and you want to pay me for my time, I would be happy to do it.

Q. Okay.

I mean, it wouldn't take long to go through 20 cases, would it?

MR. RAMM: One never knows.

A. I am not prepared to predict how long it will take me to look at these. I don't know.

Q. Well, let me say this, you can exclude Cleveland defense firms whose names appear on the outside of the file right away, couldn't you?

A. Mr. Becker, if you are asking me to do this, and it is legal, I would be happy to do so. For me to give you an estimate of the time involved as we sit here today, I think is not a reasonable request.

Q. You don't have any type of data spread sheet on your computer where you list, as some experts do, keep a list of their active cases?

A. No.

Q. Well, you estimate, then, your cost -- your time, by looking at your files, I am just asking you to look at how you keep your cases, and give me an estimate, and let

Mr. Lenson know, and he will get back to me, fair enough?

MR. RAMM: Mike, I will tell you what. I will run this past Murray, and you guys can take it up later. I don't think that has much to do with a discovery deposition of his opinions.

MR. BECKER: Well, okay.

MR. RAMM: I understand what you are asking. I don't know that we are going to get there tonight.

MR. BECKER: We are talking about it.

MR. RAMM: Like I said, I understand what you are asking. I just don't think we are going to get there tonight.

MR. BECKER: That is all I have.

MR. RAMM: Doctor, do you prefer to read?

THE WITNESS: Sure.

MR. RAMM: He will read.

(Thereupon, a discussion was had off the record.)

MR. BECKER: I just want to clarify something. I want to go back on the record.

BY MR. BECKER:

Q. When you cited that 20 percent of your cases for plaintiffs, is that 20 percent that you review or 20 percent that you find are meritorious?

A. I will only take on a case that I find is meritorious. So it is 20 percent of the cases that I am actively involved in.

MR. BECKER: Okay. I just wanted to clarify. Thank you.

THE WITNESS: Okay.

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(DEPOSITION CONCLUDED)

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Nathan Levitan, M.D.

CERTIFICATE

State of Ohio,)
) SS:
County of Cuyahoga.)

I, Ivy J. Gantverg, Registered Professional Reporter and Notary Public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the above-named NATHAN LEVITAN, M.D., was by me first duly sworn to testify to the truth, the whole truth, and nothing but the truth in the cause aforesaid; that the deposition as above set forth was reduced to writing by me, by means of stenotype, and was later transcribed into typewriting under my direction by computer-aided transcription; that I am not a relative or attorney of either party or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office at Cleveland, Ohio, this 24th day of September, 2001.

_____
Ivy J. Gantverg, Notary Public
in and for the State of Ohio.
Registered Professional Reporter.
My commission expires November 5, 2003.