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1	IN THE CIRCUIT COURT OF HARRISON COUNTY
2	WEST VIRGINIA
3	
4	
5	The Estate of Dennis Cowan,)
6	et al.,
7	Plaintiffs, Civil Action No.) 98C-554-2
8	vs.)) Judge Thomas A. Bedell
9	Ahmed Husari, M.D., et al.,)
10	Defendants.)
11	
12	THE DEPOSITION OF NATHAN LEVITAN, M.D.
13	MONDAY, SEPTEMBER 25, 2000
14	
15	The deposition of NATHAN LEVITAN, M.D., a witness,
16	called for examination by the Plaintiffs, under the West
17	Virginia Rules of Civil Procedure, taken before me,
18	Michelle R. Hordinski, Registered Merit Reporter and
19	Notary Public in and for the State of Ohio, pursuant to
20	agreement, at the Hilton Hotel, 3663 Park East Drive,
21	Beachwood, Ohio, commencing at 5:30 p.m., the day and
22	date above set forth.
23	
24	
25	

Stevenson Reporting Service, Inc. (216) 221-0140

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1	APPEARANCES:	1	A.	Yes.	
2		2	Q.		
3	On behalf of the Plaintiffs: MICHAEL M. DJORDJEVIC, ESQ.	3	ν.	questions only if you understood them and can give	
•	The Nantucket Building at Maiden Lane	4		me the correct response.	
5	17 South Main Street	5		We work under a premise at these proceedings	
6	Akron, Ohio 44308	6		that, if I pose a question, and you answer it, that	
7	AND -	7		you understood the question you gave me, and you	
8	GEORGE E. LOUCAS, ESQ.	8		gave me the correct answer.	
9	CATHRYNN. LOUCAS, ESQ.	9		So if for whatever reason you're confused by a	
	1370 Ontario Street	10		question, or you don't know what the question's	
10	Suite 1700 Cleveland, Ohio 44113	11		significance is, please stop me so that we can get	
11	Cicverand, Onio 44115	12		that hashed out before we go further.	
12		12		Fair enough?	
13	On behalf of the Defendants:	14	A.	-	
-	STEPHEN R. BROOKS, ESQ.	14			
14	Flaherty, Sensabaugh & Bonasso	16	Q.	state your full name and spell your last name for	
15	7000 Hampton Center Suite I	17		the record?	
	Morgantown, West Virginia 26505	17		MR. BROOKS: Mike, if I	
16 17				may, as I indicated before we got on the	
$17 \\ 18$		19		record, I would, with your permission, like	
19		20		• •	
20 21		21		to articulate the opinions that Dr. Levitan will be asked to render at trial.	
21		22 23			
22					
23 24		24		MR. BROOKS: Our	
25	· · ·	25		disclosures aren't always as precise as they	
	3				5
1	NATHAN LEVITAN, M.D.	1		need to be. The hopes is two-fold. One is	
2	a witness, called for examination by the Plaintiffs,	2		to make sure we have a record of what	
3	under the Rules, having been first duly sworn, as	3		everybody is going to ask. And two is to	
4	hereinafter certified, deposed and said as follows:	4		help you focus your questioning a little bit	
5	CROSS-EXAMINATION	5		more.	
6	BY MR. DJORDJEVIC	6		First, Dr. Levitan will opine that,	
7	Q. Doctor, as I told you. my name is Mike	7		because of Mr. Cowan's other pulmonary and	4
0	Djordjevic. I'm one of the attorneys in this case	8		cardiac concerns, Dr. Husari recognized that	•
8 9	that represents the estate of Dennis Cowan,	9		there are many benign etiologies that can be	
	deceased.	10		recognized and can be visualized on	
10		10		-	
11	What I'm going to be doing here this evening,	11		x-rays. Second, Dr. Levitan will opine that it	
12	hopefully over not too protracted a period of time,			is within the standard of care for Dr.	
13	is to ask you some questions under oath as if on	13 14		Husari to have followed this patient with	
14	cross-examination.			-	
15	You've been identified on behalf of the	15 16		serial x-rays rather than CT scan from September of 1994 or actually from early	
16	Defendant as an expert, and that entitles me to	1			
17	examine you relative to the issues of this case.	17		1995 when Mr. Cowan first became a patient	
18	I'm going to ask that you follow two simple rules	18		of Dr. Husari's.	
19	during the course of the deposition.	19		And third, in the overall management of	
20	First, I need you to make all of your answers	20		this patient, considering everything, Dr.	œ
21	to my questions verbal and out loud. Michelle, as	21		Levitan has absolutely no problem supporting	g
22	good a court reporter as she is, can't take down an	22		that Dr. Husari did not deviate from the	
23	uh-huh or an uh-uh or a yeah or a nah, a shake or	23		appropriate standard of care in treating and	
24	nod of the head, so you're going to have to speak	24		following Mr. Cowan.	
25	up, okay?	25		MR. DJORDJEVIC: Anything	

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2 (Pages 2 to 5)

1 2 3	ہ else? MR. BROOKS: That's it. MR. DJORDJEVIC: No proximate	1 2 3	A. Q.	And graduated with an M.D. degree in 1980?
4 5	cause opinions? MR. BROOKS: No proximate	4 5	A. Q.	Correct. Would you tell me, Doctor, about your postgraduate
6 7	cause opinions. MR. DJORDJEVIC: All right,	6 7	`	education starting with your PGY 1 and go forward in time from there?
8	very good.	8	A.	I spent three years as an internal medicine intern
9	BY MR. DJORDJEVIC:	9		and resident at the Boston Veterans Administration
10 11	Q. All right, Dr. Levitan, let's begin very briefly with your training, education, and background.	10 11	0.	Medical Center. All right, so PGY 1, 2, and 3 would be internal
12	I understand that you went to Brandeis	12	۲.	medicine internship, junior residency, and senior
13	University from 1972 to 1975, is that correct?	13		residency?
14 15	A. Correct.Q. And apparently you graduated from Brandeis with a	14 15	A. Q.	
15	B.A. in 1976?	16	Q.	What did you do next?
17	A. Correct.	17	A.	•
18	Q. And which area of study did you study at Brandeis?	18		the same institution.
19	A. Neareastern studies.	19		And then when my mentor, who ran the
20	Q. That would be a liberal arts degree, basically?	20		fellowship, was recruited to M.D. Anderson in
21 22	A. Correct.Q. And from Brandeis, then, you went to the Jewish	21 22		Houston, I switched to a different program at U.
22	Q. And from Brandeis, then, you went to the Jewish Theological Seminary of America in New York, New	22		Mass. Medical Center for my second and third year of hematology oncology fellowship.
24	York, from '75 to '76, is that correct?	24		And during the course of that time I also
25	A Correct.	25		became board eligible in blood banking.
		1		
1	7 I take it that was not a degreed course of study at	1	0	<i>g</i> Who was your mentor that went down to the
1 2	Q. I take it that was not a degreed course of study at that point?	1 2	Q.	Who was your mentor that went down to the Anderson?
2 3	Q. I take it that was not a degreed course of study at that point?A. Actually, it is an academic institution, and some	2 3	A.	Who was your mentor that went down to the Anderson? A fellow named Ki Hong.
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3 (Pages 6 to 9)

	10			12
1 Q. Do	you know if Dr. Mountain was at the Anderson	1	Q.	All right.
	n Dr. Hong transferred or moved to the	2		You are not, if I am reading your CV correctly,
3 And	erson?	3		a surgical oncologist, are you?
4 A. Ide	onot.	4	А.	Correct.
	ain, I'm not sure I understood.	5	Q.	You're not a cardiothoracic or thoracic surgeon?
	/hat happened to you in your education when Dr.	6	A.	
	g left to go to the Anderson?	7	Q.	U 1 I
1	ell, hë offered me the opportunity to move to	8		resected a lung?
	ston with him, but for family reasons I	9	A.	
	ined. And with his departure, I thought that	10	Q.	5
	quality of the fellowship program could be in	11 12		And you and I can agree that you've never
	ardy, and therefore sought a different program	12		performed any type of intrathoracic surgery for a non-small cell lung carcinoma?
1	nish my training. d where did you ultimately wind up?	13	A.	
	University of Massachusetts Medical Center.	15	А. О.	
	hich year would have found you first at University	16	¥۰	Staging Handbook. That goes through the various
1	Iassachusetts Medical Center?	17		stage groupings, and you have written or someone
18 A. I'm		18		has written in the margin certain numbers in
	nich would be your first year, calendar year, at	19		parenthesis?
	sachusetts?	20	A.	Correct.
21 A. 198	34-'85.	21	Q.	Are those your numbers?
22 Q. Ok		22	А.	Those are numbers that I have written down as being
	nd that's when you were, according to your CV,	23		representative of the approximate five-year
	clinical and research fellowship in blood	24		survival for patients with stage 1 through 4
25 bank	king and immunohematology, is that correct?	25		non-small cell lung cancer.
	77			13
1 is		1	0.	
	11 that what you did? rrect,	1 2	Q	. That's what I presumed them to be.
2 A. Con 3 Q. The	that what you did? rrect, en in 1985-'86, you were in a clinical		Q	
2 A. Con 3 Q. The 4 fello	that what you did? rrect, en in 1985-'86, you were in a clinical owship in hematology oncology at the	2 3 4	Q	. That's what I presumed them to be. So you and I can agree I don't it appears to me, Doctor, as if your survival statistics start with stage 1B?
2 A. Con 3 Q. The 4 fello 5 Univ	that what you did? rrect, en in 1985-'86, you were in a clinical wwship in hematology oncology at the versity of Massachusetts Medical Center, is that	2 3 4 5	A	 That's what I presumed them to be. So you and I can agree I don't it appears to me, Doctor, as if your survival statistics start with stage 1B? No, that's not correct.
2 A. Con 3 Q. The 4 fello 5 Univ 6 corre	that what you did? rrect, en in 1985-'86, you were in a clinical owship in hematology oncology at the versity of Massachusetts Medical Center, is that ect?	2 3 4 5 6		 That's what I presumed them to be. So you and I can agree I don't it appears to me, Doctor, as if your survival statistics start with stage 1B? No, that's not correct. All right.
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2 A. Con 3 Q. The 4 fello 5 Univ 6 correc 7 A. Con 8 Q. And	that what you did? rrect, en in 1985-'86, you were in a clinical owship in hematology oncology at the versity of Massachusetts Medical Center, is that ect? rrect. d then did you have any additional postgraduate	2 3 4 5 6 7 8	A	 That's what I presumed them to be. So you and I can agree I don't it appears to me, Doctor, as if your survival statistics start with stage 1B? No, that's not correct. All right. Although they're not written in rows straight across, the first set of numbers, 60 to 70, would
2 A. Cot 3 Q. The 4 fello 5 Univ 6 correc 7 A. Cot 8 Q. And 9 med	that what you did? rrect, en in 1985-'86, you were in a clinical owship in hematology oncology at the versity of Massachusetts Medical Center, is that ect? rrect. d then did you have any additional postgraduate ical training following 1985 to 1986?	2 3 4 5 6 7 8 9	A. Q.	 That's what I presumed them to be. So you and I can agree I don't it appears to me, Doctor, as if your survival statistics start with stage 1B? No, that's not correct. All right. Although they're not written in rows straight across, the first set of numbers, 60 to 70, would be stage 1?
2 A. Cot 3 Q. The 4 fello 5 Univ 6 correc 7 A. Cot 8 Q. And 9 med 10 A. NO	that what you did? rrect, en in 1985-'86, you were in a clinical owship in hematology oncology at the versity of Massachusetts Medical Center, is that ect? rrect. d then did you have any additional postgraduate ical training following 1985 to 1986?	2 3 4 5 6 7 8 9 10	A . Q.	 That's what I presumed them to be. So you and I can agree I don't it appears to me, Doctor, as if your survival statistics start with stage 1B? No, that's not correct. All right. Although they're not written in rows straight across, the first set of numbers, 60 to 70, would be stage 1? 1A.
2 A. Co. 3 Q. The 4 fello 5 Univ 6 correc 7 A. Co. 8 Q. And 9 med 10 A. No 11 Q. Wr	that what you did? rrect, en in 1985-'86, you were in a clinical owship in hematology oncology at the versity of Massachusetts Medical Center, is that ect? rrect. d then did you have any additional postgraduate ical training following 1985 to 1986? nat did you do then professionally, Doctor?	2 3 4 5 6 7 8 9 10 11	A. Q.	 That's what I presumed them to be. So you and I can agree I don't it appears to me, Doctor, as if your survival statistics start with stage 1B? No, that's not correct. All right. Although they're not written in rows straight across, the first set of numbers, 60 to 70, would be stage 1? 1A. Allright.
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2 A. Cot 3 Q. The 4 fello 5 Univ 6 correc 7 A. Cot 8 Q. And 9 med 10 A. No 11 Q. Wr 12 A. I as 13 oncot 14 Mas	that what you did? rrect, en in 1985-'86, you were in a clinical owship in hematology oncology at the versity of Massachusetts Medical Center, is that ect? rrect. d then did you have any additional postgraduate ical training following 1985 to 1986? nat did you do then professionally, Doctor? ssumed a staff position as a hematologist	2 3 4 5 6 7 8 9 10 11 12	A . Q.	 That's what I presumed them to be. So you and I can agree I don't it appears to me, Doctor, as if your survival statistics start with stage 1B? No, that's not correct. All right. Although they're not written in rows straight across, the first set of numbers, 60 to 70, would be stage 1? 1A. Allright. So it's your belief that the survival for five years of a non-small cell lung carcinoma is 60 to 70 percent?
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2 A. Coi 3 Q. The 4 fello 5 Univ 6 correction 7 A. Coi 8 Q. And 9 med 10 A. No 11 Q. Wr 12 A. I as 13 onco 14 Mas 15 Q. Hor 16 A. Fiv 17 Q. Wr 18 1991 19 A. Cor 20 Q. Wr 21 A. I w	that what you did? rrect, en in 1985-'86, you were in a clinical owship in hematology oncology at the versity of Massachusetts Medical Center, is that ect? rrect. d then did you have any additional postgraduate ical training following 1985 to 1986? nat did you do then professionally, Doctor? ssumed a staff position as a hematologist blogist at the Lahey Clinic Medical Center in sachusetts. w long were you at the Lahey Clinic? re years. hich would bring you up to what, 1989, 1990 or so, 1? rrect. nat did you do then? as recruited by the director of the Ireland	$\begin{array}{c} 2\\ 3\\ 4\\ 5\\ 6\\ 7\\ 8\\ 9\\ 10\\ 11\\ 12\\ 13\\ 14\\ 15\\ 16\\ 17\\ 18\\ 19\\ 20\\ 21\\ \end{array}$	A . Q: A . Q: A .	 That's what I presumed them to be. So you and I can agree I don't it appears to me, Doctor, as if your survival statistics start with stage 1B? No, that's not correct. All right. Although they're not written in rows straight across, the first set of numbers, 60 to 70, would be stage 1? 1A. Allright. So it's your belief that the survival for five years of a non-small cell lung carcinoma is 60 to 70 percent? Yes. And all of those numbers are give or take five or ten percent in either direction. There is some variation in the literature. But those are a representative ball park figure. It's your belief that stage 1B is 40 to 50 percent?
2 A. Coi 3 Q. The 4 fello 5 Univ 6 correction 7 A. Coi 8 Q. And 9 med 10 A. No 11 Q. Wh 12 A. I as 13 onco 14 Mas 15 Q. Hoi 16 A. Fiv 17 Q. Wh 18 1991 19 A. Con 20 Q. Wh 21 A. I w 22 Canadiana Con	that what you did? rrect, en in 1985-'86, you were in a clinical owship in hematology oncology at the versity of Massachusetts Medical Center, is that ect? rrect. d then did you have any additional postgraduate ical training following 1985 to 1986? nat did you do then professionally, Doctor? ssumed a staff position as a hematologist blogist at the Lahey Clinic Medical Center in sachusetts. w long were you at the Lahey Clinic? re years. hich would bring you up to what, 1989, 1990 or so, 1? rrect. hat did you do then? as recruited by the director of the Ireland cer Center to come here and develop a lung	$\begin{array}{c} 2\\ 3\\ 4\\ 5\\ 6\\ 7\\ 8\\ 9\\ 10\\ 11\\ 12\\ 13\\ 14\\ 15\\ 16\\ 17\\ 18\\ 19\\ 20\\ 21\\ 22\\ \end{array}$	А. Q. А. Q. А. Q. А.	 That's what I presumed them to be. So you and I can agree I don't it appears to me, Doctor, as if your survival statistics start with stage 1B? No, that's not correct. All right. Although they're not written in rows straight across, the first set of numbers, 60 to 70, would be stage 1? 1A. Allright. So it's your belief that the survival for five years of a non-small cell lung carcinoma is 60 to 70 percent? Yes. And all of those numbers are give or take five or ten percent in either direction. There is some variation in the literature. But those are a representative ball park figure. It's your belief that stage 1B is 40 to 50 percent? Correct.
2 A. Coi 3 Q. The 4 fello 5 Univ 6 correction 7 A. Coi 8 Q. And 9 med 10 A. No 11 Q. Wr 12 A. I as 13 onco 14 Mas 15 Q. Hoi 16 A. Fiv 17 Q. Wr 18 1991 19 A. Coi 20 Q. Wr 21 A. I w 22 Canc 23 canc	that what you did? rrect, en in 1985-'86, you were in a clinical owship in hematology oncology at the versity of Massachusetts Medical Center, is that ect? rrect. d then did you have any additional postgraduate ical training following 1985 to 1986? nat did you do then professionally, Doctor? ssumed a staff position as a hematologist blogist at the Lahey Clinic Medical Center in sachusetts. w long were you at the Lahey Clinic? re years. hich would bring you up to what, 1989, 1990 or so, 1? rrect. hat did you do then? as recruited by the director of the Ireland cer Center to come here and develop a lung per research program.	$\begin{array}{c} 2\\ 3\\ 4\\ 5\\ 6\\ 7\\ 8\\ 9\\ 10\\ 11\\ 12\\ 13\\ 14\\ 15\\ 16\\ 17\\ 18\\ 19\\ 20\\ 21\\ 22\\ 23\\ \end{array}$	A . Q. A . Q. A . Q.	 That's what I presumed them to be. So you and I can agree I don't it appears to me, Doctor, as if your survival statistics start with stage 1B? No, that's not correct. All right. Although they're not written in rows straight across, the first set of numbers, 60 to 70, would be stage 1? 1A. Allright. So it's your belief that the survival for five years of a non-small cell lung carcinoma is 60 to 70 percent? Yes. And all of those numbers are give or take five or ten percent in either direction. There is some variation in the literature. But those are a representative ball park figure. It's your belief that stage 1B is 40 to 50 percent? Correct. Your belief that stage 2A is 30 to 40 percent?
2 A. Con 3 Q. The 4 fello 5 Univ 6 correction 7 A. Con 8 Q. Ann 9 med 10 A. No 11 Q. Wr 12 A. I as 13 onco 14 Mas 15 Q. Hor 16 A. Fiv 17 Q. Wr 18 1991 19 A. Con 20 Q. Wr 21 A. I w 22 Cano 23 cano 24 Q. Ann	that what you did? rrect, en in 1985-'86, you were in a clinical owship in hematology oncology at the versity of Massachusetts Medical Center, is that ect? rrect. d then did you have any additional postgraduate ical training following 1985 to 1986? that did you do then professionally, Doctor? assumed a staff position as a hematologist blogist at the Lahey Clinic Medical Center in sachusetts. w long were you at the Lahey Clinic? re years. hich would bring you up to what, 1989, 1990 or so, 1? rrect. hat did you do then? as recruited by the director of the Ireland cer Center to come here and develop a lung ter research program. d you've been here ever since?	$\begin{array}{c} 2\\ 3\\ 4\\ 5\\ 6\\ 7\\ 8\\ 9\\ 10\\ 11\\ 12\\ 13\\ 14\\ 15\\ 16\\ 17\\ 18\\ 19\\ 20\\ 21\\ 22\\ 23\\ 24\\ \end{array}$	A. Q. A. Q. A. Q. A.	 That's what I presumed them to be. So you and I can agree I don't it appears to me, Doctor, as if your survival statistics start with stage 1B? No, that's not correct. All right. Although they're not written in rows straight across, the first set of numbers, 60 to 70, would be stage 1? 1A. Allright. So it's your belief that the survival for five years of a non-small cell lung carcinoma is 60 to 70 percent? Yes. And all of those numbers are give or take five or ten percent in either direction. There is some variation in the literature. But those are a representative ball park figure. It's your belief that stage 1B is 40 to 50 percent? Correct. Your belief that stage 2A is 30 to 40 percent? Correct.
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4 (Pages 10 to 13)

2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25	 Q. I wonder, Doctor, if you could tell me where you got those numbers? A. Those numbers represent my fund of knowledge concerning lung cancer. Q. Well, I want to talk specifically about non-small cell lung cancer. You and I can agree that there's a world of difference between survival figures for non-small cell lung cancer and small cell lung cancer, can't we? A. And those figures pertain to non-small cell lung cancer. Q. That's what I'm asking you. Could you tell me where you got these? I'm familiar with most of the major studies, and I can't recall these numbers being cited by any of them. I wonder if you could give me a citation? A. I do not carry those citations in my memory, but I read hundreds of articles every month, and those are representative figures. Q. We can agree, then, you and I, that, if in this case well, let's see if we can develop some points of agreement. 	 on those lines. MR. DJORDJEVIC: Right. MR. BROOKS: Once you inquire along those lines, it's certainly an opinion that you have discovered. MR. DJORDJEVIC: No question about it. If I ask a question, I hear the answer, I've discovered it. MR. BROOKS: That's right. A. You know, in preparing for this deposition, knowing that I was not going to be asked about proximate cause, I did not focus on trying to back date in detail what stage this tumor was likely to be at particular points in time. It was my understanding that the focus of the questioning would be on standard of care. Q. Let's see if we can establish some other general points. The statistics that you and I have just discussed relative to survivability for stage 1A is dependent on the TNM staging of the cancer, am I correct? A. Every stage has a particular array of TNM categories that either do or do not fit into that
2 3 3 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25	 non-small cell lung cancer? A. Correct. Q. We can agree, therefore, as a non-small cell lung cancer, had he been diagnosed and resected as a stage 1A, the likelihood is more likely than not that he would still be alive after five years'? A. Correct. Q. And we can agree that none of your profession consider a five-year survival rate to be the same as cure in cancer statistics? A. A five-year disease-fret survival rate would be tantamount to cure under most circumstances. Q. We c3n agree that, if Mr. Cowan would have been diagnosed at a stage where at a point in time where he was stage 1A, more likely than not he would have been cured by surgical resection, can we not? A. Correct. Q. Sir, do you have an opinion as to when Mr. Cowan, in this case, went from stage 1A to a stage 1B? MR. BROOKS: Excuse me, Im going to object only because that's not among the opinions that he will be asked at trial. But I certainly don't want to imply 	 Q. What I'm trying to what I'm trying to establish with you, and I thirk we can agree, that those TNM categories are exclusive of grade of cancer, that grade of cancer is subsumed within the TNM categories? Can we agree? A. I'm not quite sure what you mean by the grade is subsumed within the categories. But it is correct that these staging categories do not differ based on whether a tumor is well, moderately, or poorly differentiated. Q. Right. Let me ask the question in this way. If a patient with a non-small cell lung cancer as we've agreed Mr. Cowan had in this case, correct? A. Correct. Q. All right. If a patient with a non-small cell lung cancer is treated surgically at such time when the cancer is stage 1A, the probable outcome is that patient will be cured of his cancer, regardless of the grade of cancer at time of surgery. Can we agree?

1	18			20
1	A. Well, it's important for me to clarify, since I	1		germane to the contribution I'll be making in this
2	know in legal parlance, when you talk about	2		case (Indicating).
3	probably, or more likely than not, you're referring	3	Q.	
4	to the 50 percent threshold.	4	£.	general way.
5	Q. That's correct.	5		What is your understanding as to the clinical
6	A. It's certainly worth stressing that, even for	6		parameters or radiological parameters that have to
7	. patients with 1-A lung cancer, there is a	7		be demonstrated for a cancer to go from stage 1A to
8	substantial risk that those patients will develop	8		stage 1B?
9	metastatic disease and die.	9		What has to happen?
10			A.	**
11		11		simplicity's sake. And when a cancer moves from a
12		12		1A to a 1B, it moves from a T1 to a T2. And there
13	e , i	13		is a whole variety of characteristics that render a
14		14		tumor T2, which I'd be glad to read through, if
15		15		that would be helpful.
16		16	Q.	1
17		17	۲.	centimeters in its largest dimension?
18		18	A.	Or it can involve the main stem bronchus. It can
19		19		be involving the visceral pleura. It can be
20	-	20		associated with atelectasis or obstructive
21	1 · · ·	2 1		pneumonia extending to the hilar region, but not
22	6	22		the entire lung.
23	• •	23	0.	•
24	1 0	24	£.	particular case, we see no evidence that Mr.
25		25		Cowan's non-small cell lung cancer was ever a stage
		1		
	19			21
Ι	don't know if those data exist.	1		1B, isn't that right?
2	Q. You and I can therefore clearly agree that the data	2		I'm not sure I understand your question.
3	that you've seen supports the premise, and it's	3	Q.	All right.
4	your opinion in this case, that, regardless of what	4		Do you see anywhere in the records that you've
2	the grade of the cancer is and you have seen no			
6		5		reviewed that any of the tumor criteria in the TNM
	data that distinguished between grade regardless	6		reviewed that any of the tumor criteria in the TNM nomenclature were met in order for this cancer to
7	data that distinguished between grade regardless of what the grade of the cancer is, if the cancer	6 7		reviewed that any of the tumor criteria in the TNM nomenclature were met in order for this cancer to be a 1B cancer as opposed to a 1A cancer?
7 8	data that distinguished between grade regardless of what the grade of the cancer is, if the cancer is diagnosed at a point uhere it's a stage 1A, more	6 7 8		reviewed that any of the tumor criteria in the TNM nomenclature were met in order for this cancer to be a 1B cancer as opposed to a 1A cancer? Let's go through them one at a time. Was his
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6 (Pages 18 to 21)

and the second second

22	24
1 surgically, the probability is that it would have	1 A. Well, there's a value judgment in your statement
2 been cured, can't we, more likely than not, greater	2 that I wouldn't agree with.
3 than 50 percent?	3 I would agree factually that no CAT scan of the
4 A. I'm afraid I can't agree with that statement.	4 chest was performed prior to April 9th of 1998.
5 Q. All right.	5 wouldn't agree with the implicit criticism
6 Why don't you tell me why not?	6 regarding the standard of care compliance of the
7 A. Because of the issue of lymph node involvement.	7 physicians that is inherent in your statement.
8 Q. Okay.	8 Q. I'm not sure that I offered any criticism. I'm
9 A. We know that, in April of 1998, this cancer was	9 asking you simply, we don't know when there was
10 locally advanced, that is to say there was	10 hilar involvement, because the test that would be
11 extensive mediastinal adenopathy rendering this	11 specific enough to demonstrate hilar involvement,
12 cancer surgically unresectable.	12 CT scanning of the chest, was never ordered, isn't
13 When a tumor is associated with extensive	13 that true from a factual point of view?14 A. It is true that a CAT scan was not ordered prior to
14 mediastinal adenopathy, it is surgically	14 A. It is true that a CAT scan was not ordered prior to 15 April 9th, 1998.
15 unresectable not because it's impossible to get16 those nodes out, but because of the certainty that	
16 those nodes out, but because of the certainty that17 there's microscopic metastatic disease and that the	16 Q. So we know, Doctor, you and I, that sometime by 17 April of 1998 there was involvement of the:
17 there's incroscopic inetastatic disease and that the 18 surgical procedure won't help that patient.	18 mediastinal nodes, is that right?
19 Q. No question once there was mediastinal metastasis	19 A. Your statement is that, sometime prior to April
20 this patient was no longer curable through surgery.	20 9th, 1998, the nodes became involved with the
20 My question, sir, is, would the patient be curable	21 mediastinum? I would agree with that, yes.
22 when there was positive hilar adenopathy as opposed	22 Q. Right.
to mediastinal adenopathy?	We don't know exactly when that happened,
24 A. Well, a patient with hilar adenopathy is by	24 correct?
25 'definition a patient with stage 2 non-small cell	25 A. Correct.
23	25
1 lung cancer.	1 Q. And you have no opinion when that happened,,
2 And a small percentage of these patients is	2 correct?
3 curable. Using your 50 percent threshold, it is	3 A. Well, again, I want to be careful how I answer
4 more likely than not, once a patient has hilar	3 that.
5 lymph node involvement, that he or she would not be	5 It is my belief that lung cancer grows very
6 surgically cured.	6 slowly over a period of many years, and that the 7 process of spread to other nodes likely occurred
 7 Q. Do you see hilar involvement on any of the x-rays 8 at any time or any of the imaging studies in this 	7 process of spread to other nodes likely occurred8 well prior to 1998.
8 at any time or any of the imaging studies in this9 case?	 9 This cancer was old at the time of diagnosis.
10 A. Well, the first CAT scan that we have, as I said,	10 And spread to sites outside of the lung itself
is in April of 1998. And plain chest x-rays are	11 likely occurred years before the April, 1998 time
12 not a sensitive instrument for detecting hilar	12 of diagnosis.
13 adenopathy.	13 Q. Sure.
14 Q. So my question is. do you see hilar adenopathy at	14 So this was an old cancer, regardless of the
15 any time, or don't you?	15 grade of cancer, isn't that the truth?
16 A. Well, you don't, although one cannot conclude	16 A. Correct.
17 anything about its absence because the necessary	17 Q. Okay.
18 study to detect it wasn't performed.	18 And we know that this cancer, in your opinion,
19 Q. And the necessary study to detect it would be CT	19 was present to some extent for years, is the term
20 scanning?	20 that you used?
21 A. Correct.	21 A. Correct.
	22 Q. Five years?
22 Q. The truth of the matter is, we don't know in this	
23 case when this cancer went from a stage 1A to a	23 A. That is possible.
 case when this cancer went from a stage 1A to a stage 1B, because never was the proper test, a CT 	24 Q. Is that likely?
23 case when this cancer went from a stage 1A to a	1

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7(Pages 22 to 25)

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1 was present for five years?	1 fashion from hilar to mediastinal nodes.
2 A. I believe so.	2 Spread to the blood stream occurs through a
3 Q. Okay.	3 different mechanism and can occur very early on.
4 A. I don't believe necessarily that it was	4 Q. Do you have any opinions as to when, in this
5 radiographically detectable.	5 particular case, the hilar nodes first became
6 Q. I understand.	6 involved?
7 A. But I believe it was likely present at least in	7 A. It's hard for me to hazard a guess.
8 microscopic form.	8 And again, I haven't taken the time to clearly
	9 thirk through the dates. I wasn't anticipating
9 Q. We can agree, you and I, that this cancer was 10 certainly present. And again, whether or not it	10 this line of questioning. So I, at this moment,
11 was radiographically detectable is something you	11 don't feel comfortable trying to answer that
12 and I will spend some more time with. But it was	12 question without some careful forethought.
13 certainly radiographically detectable in 1993,	
14 wasn't it, Doctor?	
15 A. Again, and please excuse my ignorance about the	
16 rules of these proceedings. This line of	16 right?
17 questioning clearly pertains to proximate cause,	17 A. That is true.
18 and I just want to make sure that it's permissible	18 THE WITNESS: Again, a
19 for me to continue to answer these questions.	19 question for Mr. Brooks. If this line of
20 I'm comfortable doing it.	20 questioning opens up at trial, and I
21 MR. BROOKS: It's	21 re-focus my attention on this case and the
22 certainly permissible. The understanding	22 chronology, I could probably come up with a
23 is, at the outset of this deposition,	23 rough opinion in that regard.
24 there was a clearly defined area in which	24 But I'm not prepared today to offer
25 .I intended to ask your opinions at trial.	25 that.
 He's permitted to ask you about anything he wants to with the understanding that it 	 BY MR. DJORDJEVIC: Q. By the way, this AJCC method of staging, is this
3 will be evidence at trial because he's	3 the method of staging that was initially described
 3 will be evidence at trial because he's 4 opened it up if I choose to use it or if he 	 the method of staging that was initially described by Dr. Mountain at the Anderson, Dr. Clifton
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 3 will be evidence at trial because he's 4 opened it up if I choose to use it or if he 5 chooses to use it. 6 So yes, you can answer. 	 3 the method of staging that was initially described 4 by Dr. Mountain at the Anderson, Dr. Clifton 5 Mountain? 6 A. Dr. Mountain has been principally involved in
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8 (Pages 26 to 29)

30	32
1 Q. Are you credited by any hospital to practice	1 patient?
2 pulmonology?	2 A. In most cases, that patient would undergo surgical
3 A. No.	3 resection.
4 Q. Have you ever been credentialed by any hospital to	4 Q. Same question, hypothetical patient of yours with
5 practice pulmonology?	5 the diagnosis of a stage 2 non-small cell lung
6 A. No.	6 cancer, how is that patient treated?
7 Q. Have you ever sought to be credentialed by any	7 A. We have an experimental protocol in which some of
8 hospital to practice pulmonology?	8 these patients are offered preoperative
9 A. No, sir.	9 chemotherapy. But ultimately those patients
10 Q. But it's your testimony in this case that you're	10 undergo surgical resection in most cases.
11 familiar with the standards of care that apply to	11 Q. All right.
12 pulmonologists?	12 Your use of the word preoperative chemotherapy
13 A. I am quite familiar with the standards of care	13 was kind of a tip off to where you were going.
14 pertaining to the diagnosis, screening, and	14 There's no mystery. Stage 1 and stage 215 patients get operated on, right?
15 treatment of lung cancer.16 Q. That's a little different than my question.	15 patients get operated on, right?16 A. In most cases, that's correct.
 16 Q. That's a little different than my question. 17 My question to you, sir, is, despite the fact 	17 O And that's how you treat your patients where you
17 My question to you, sir, is, despite the fact 18 that you're not board certified, presumably not	17 Q. And that's now you treat your patients where you 18 make this diagnosis, is that correct?
19 board eligible, and never have been credentialed at	19 A. Correct.
20 any institution to practice pulmonology, are you	20 O. Now, you and I can certainly agree, sir, I think,
21 familiar with the standards of care that apply to	21 that the diagnosis of non-small cell lung cancer is
the practice of clinical pulmonology?	22 not made from x-rays, is it?
23 A. Regarding the procedures that should be carried out	23 A. If you're asking whether histologic confirmation is
24 in evaluating abnormal chest x-rays that could	24 necessary to make the diagnosis of cancer, the
25 signify the presence of lung cancer, I am	answer is, of course.
31	33
1 extensively experienced in that area, work closely	1 Q. Ofcourse.
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9 (Pages 30 to 33)

34	36
1 will have a disagreement on what that threshold is.	1 two institutions.
2 But in concept, the way it works is there's a	2 But at all of the institutions where I have
3 threshold of suspicion at which point it's the	3 worked closely with pulmonologists, they may look
4 obligation of the treating physician to do a	4 at x-rays, as do I, but they ultimately rely on the
5 definitive pathological study to see firstly	5 expertise of those who are specifically trained in
6 whether the questionable finding on the radiographs	6 radiology, i.e. radiologists.
7 .is cancerous, and secondly, what the	7 Q. Well, aren't pulmonologists specifically trained to
8 histopathology of the cancer is, should it prove to	8 deal with diseases and problems of the chest and
9 be cancerous.	9 lungs?
10 Is that how it works?	10 A. They are, but they're not radiologists.
11 A. That's fair.	11 O. And you, as a medical oncologist, you deal with
12 Q. Okay.	12 cancers throughout the body, don't you?
13 And the question that we're discussing in this	13 A. Although I have a particular subspecialty expertise
14 case is, when is that threshold met, correct?	14 in cancers of the lung.
15 Is that your understanding of this particular	15 Q. Small cell or non-small cell cancers of the lung?
16 case?	16 A. I don't follow your question.
17 A. Correct.	17 Q. Allright.
18 Although the term threshold, I think, is	18 Is your expertise in the area of small cell
19 potentially misleading, in that, you know, in the	19 lung cancer or non-small cell lung cancer?
 20 general population, especially those with chronic 21 obstructive pulmonary disease, radiographic 	20 A. Lung cancers in general, thoracic malignancies in general.
21 obstructive pulmonary disease, radiographic 22 abnormalities are ubiquitous. And rather than	21 general.22 Q. I've noticed some publications in your CV, Doctor,
22 abiomanties are doiquitous. And rather than 23 calling it a threshold point, I'd say that the	 and I need I'll be honest with you. I kind of
24 physician has to use clinical judgment in	24 breezed through it quickly.
25 'determining when an abnormality is sufficiently	25 I've noticed that you've had some publications
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10 (Pages 34 to 37)

38	40
1 9-Aminocamptothecin Colloidal Dispersion 120-Hour	1 But it's not a it's not a precise term.
2 continuous Intravenous Infusion in Advanced	2 Q. All right, hilar nodal involvement, is hilar nodal
3 Non-Small Cell Lung Cancer."	3 involvement, in your nomenclature, advanced
4 Q. That was going to be my guess.	4 disease?
5 When you're talking about advanced non-small	5 A. I don't generally think of it as such.
6 cell lung cancer, presumably those are patients	$\boldsymbol{\delta}$ Q. Let me, then, re-focus my questions so we don't
7 that have either €ailed surgery or have had a	7 spend a lot of time on this.
8 time of diagnosis when their stage was too	8 I'd like you, sir, to point out to me any
9 advanced to have surgery as their primary mode of	9 articles that you've authored that deal with non-
10 treatment?	10 advanced non-small cell lung cancer.
11 A. That's correct.	11 A. I don't believe that I have published specifically
12 Q. You see these patients generally in one of two	12 on stage 1 and 2 non-small cell lung cancer, though
13 ways, either they fail surgery or they're diagnosed	13 probably more than half of these publications deal
14 at a time where they are already worse than a stage	14 with non-small cell lung cancer.
15 2?	15 Q. Okay, very good. That kind of shortens that up,
16 Is that a fair way to put it?	16 Doctor, thank you.
17A.No, that's not true.18Q.Okay.	17 I'm curious , and maybe you could explain to me 18 how it comes to pass that a medical oncologist
18 Q. Okay.19 A. I'm involved in the initial diagnosis of patients	18 now it comes to pass that a medical oncologist 19 originally, or in the first instance, makes the
20 with lung cancer, as well, including patients with	20 diagnosis of lung cancer.
2% stage 1 and 2 disease.	21 How does that happen?
22 Q. All right, so article 23.	22 A. Patients are referred to me with abnormal chest
23 Let's go through the rest of your articles.	23 x-rays that could conceivably represent cancer.
24 A, On page 11, number 21 pertains to largely patients	And I'm asked to clarify whether, in fact, there is
25 with non-small cell lung cancer.	25 cancer present, help to make the diagnosis of
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39	41
1 Q. Okay, allright.	1 cancer.
 Q. Okay, allright. And again we're talking about advanced 	 cancer. Q. So patients are referred to you by their primary
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11 (Pages 38 to 41)

42	44
1 an x-ray, look for stability or resolution of a	1 radiologists, is that right?
2 questionable abnormality.	2 A. Correct.
3 If the radiology expert, my radiology	3 Q. Do you call up the radiologists that originally
4 colleague, opines that the abnormality on chest	4 interpreted the film for the patient, or do you
5 x-ray is sufficiently concerning to merit a CT	5 avail yourself of other consulting radiologists
6 scan, then I would get a CAT scan.	6 that work at the Ireland Cancer Center?
7 Q. Do you ever, in your exercise of your medical	7 A. The latter.
8 obligation to the patient, decide whether or not	8 Q. Allright.
9 the patient should get a CT scan?	9 So that there's no confusion on the record,
10 A. I generally work closely with the radiologists in	10 when a patient comes in with the film that you
11 making that determination.	1I believe or films that you believe are suspicious of
12 Q. And I'm going to make sure that I understand what's	12 something, what you do is you will consult with a
13 going on here.	13 third radiologist or another radiologist here at
14 The patient comes in on referral from a primary	14 the Ireland Cancer Center, is that right?
15 care physician. Can we agree that that's the bulk	15 A. That's right, unless the patient has come from my
16 of the way it happens?	16 own institution. And if the films were read by
17 A. Well, I work at a national cancer institute	17 radiologists at my own institution, or at one of
18 designated comprehensive cancer center where a	18 the University Hospitals Health System institutions
19 great many of our patients are self-referred	19 and there are nine hospitals that are part of
20 through discovering us on the internet or seeing	20 our system then I would rely on the expertise of
21 advertisements.	21 those radiologists.
22 So I wouldn't say the bulk. I'd say the two	22 Q. And how do you do that?
23 sources of patient referrals are either physician24 directed or self-referral.	23 Do you take the films and you go see the
	24 radiologist, or you make an appointment with the
25 Q. All right.	25 radiologist, or you call the radiologist on the
 And when the patient comes in to see you initially, you're serving as a consultant either to the patient who is self-referred or to the physician that sends the patient to you for evaluation. am I correct? Am I right'? 	 45 1 phone? 2 How do you do that? 3 A. Well, very often, if I'm comfortable with the expertise of the radiologist who has rendered the original reading, I'll have his or her report in
6 A. Correct.	6 front of me, and I'll have the films, and I'll
7 Q. All right.	7 simply read the report and look at the films.
8 Now, when the patient comes in, the patient	8 Q. And then you're done at that point'?
9 generally probably almost 100 percent of the rime	9 A. Yes, unless there's some reason that additional
10 already has chest films, is that right?	10 clarification is needed. But usually I would rely
11 That's what prompts the consultation with	11 on the expertise of the radiologist.
12 you?	12 O. What I'm failing to understand, Doctor, is if
13 A. Unless the patient comes in because he or she is	13 that's the case, what function are you serving?
14 coughing up blood or has some other symptom that	14 Why doesn't the primary physician simply ask
15 might be suggestive of cancer. But you're correct.	15 the radiologist, or why doesn't the patient simply
16 Abnormal chest films are certainly the most common	16 ask the radiologist?
17 finding.	17 Why are you in the link? Why are you in the
18 Q. The most common finding is a patient comes in with	18 chain?
19 a film or more films, and you are then charged with	19 A. Well, there are many components to the diagnosis of
20 the responsibility of deciding whether the lesion	20 lung cancer other than the radiographs. There are
21 or the structure shown on film is womsome or not	21 other symptoms involved. There are invasive tests
22 womsome, right?	that may be needed.
23 A. That's correct.	But you're only focussing on the interpretation
24 Q. Now, when you're in the process of doing that,	of a questionably abnormal radiograph. And my job
25 you've told me that you will consult with	as a medical oncologist is to assemble all of the

12 (Pages 42 to 45)

46	48
appropriate data, of which the radiograph is only	1 So I think it's easy for you as an attorney to
2 one component.	2 look back and say, well, you know, this or that
3 Q. Would the pulmonologist treating the same patient	3 should have been done. But when you're faced with
4 have the same job, to assemble all the relevant	4 a subtle abnormality on x-ray, it's analogous to a
5 data?	5 breast surgeon being faced with a breast lump.
6 A, Yes.	6 A small number of breast lumps, in fact, are
7 I think in regard to this piece of the	7 breast cancer. And what one has to do is follow a
8 diagnosis of lung cancer, there is overlap between	8 breast lump over time. And you don't take them all
9 what I do and what the pulmonologist does. I don't	9 out and disfigure women.
10 do bronchoscopies. The pulmonologist does.	10 Similarly, you don't biopsy or even CAT scan
11 But in terms of making this kind of assessment,	11 all abnormalities on chest x-ray. You have to
12 there is considerable overlap.	12 consider, over time, whether the abnormalities
13 Q. And that really hones in on the difference between	13 appear to either stabilize or recede.
14 the role of the radiologist and the role of either	14 Q. All right, are you finished? I don't want to cut
15 you or the pulmonologist as the primary care	15 you off.
16 physician.	16 A. Yes.
17 The radiologist is looking at films at discreet	17 Q. And I appreciate your answer. I'm not sure it was
18 points in time, correct, and it's your obligation,	18 responsive to my question. I don't think I'm quite
19 or the treating pulmonologist's obligation, to, as	19 to the point in my questioning that you are in your
20 you put it, and we can have the court reporter read	20 answers. And let me tell you what my question is
21 it back, put together all the information and	21 designed to do.
22 decide what to do next?	22 My question isn't designed to obtain from you
23 A. That's correct, although, again, I mean, I'm not	23 your opinions as to what the standard of care
24 , sure where you're going with that.	requires that the pulmonologists do. My questionis designed to elicit from you whether it's the
25 If I understand your question, if a patient has	25 is designed to elicit from you whether it's the
47	49
1 multiple films that have been read by multiple	1 pulmonologist's responsibility to do it as opposed
2 radiologists, you're asking whether there is a need	2 to the radiologist's responsibility to do it.
3 to assemble all those films and have them read by a	3 I think you've already told me, and maybe we
4 single radiologist?	4 can harken back to Harry Truman where he says, "The
5 \bigcirc Well, I think you told me that there's a need for	5 buck stops here."
5 Q. Well, I think you told me that there's a need for 6 somebody, and you said in the case where you're the	 5 buck stops here." 6 The buck stops with somebody in these cases.
	1
6 somebody, and you said in the case where you're the	6 The buck stops with somebody in these cases.
 somebody, and you said in the case where you're the physician who is doing the consultation. it's your 	6 The buck stops with somebody in these cases. 7 doesn't it, Doctor?
 6 somebody, and you said in the case where you're the 7 physician who is doing the consultation. it's your 8 obligation to put together all the information to 9 see what needs to be nest. 10 Do you remember your testimony to me along 	 6 The buck stops with somebody in these cases. - doesn't it, Doctor? 8 A. Well, you know, I might have an easier time 9 answering thst question if we become less 10 theoretical and actually look at the chronology in
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 6 somebody, and you said in the case where you're the 7 physician who is doing the consultation. it's your 8 obligation to put together all the information to 9 see what needs to be nest. 10 Do you remember your testimony to me along 11 those lines? 12 A. I do. 13 Q. All right, and 14 A. I think, though, that you need to remember the real 15 world. and you need to you need to consider not 16 just what things look like in hindsight, but how 17 things really happen. And you need to remember 18 that, among patients with a cigarette smoking 19 history, or a history of chronic obstructive 20 pulmonary disease, the frequency of abnormalities 21 on chest x-ray is great. 22 One particular study using CAT scans showed 23 that, among smokers, 25 percent of those patients 	 6 The buck stops with somebody in these cases. 7 doesn't it, Doctor? 8 A. Well, you know, I might have an easier time 9 answering thst question if we become less 10 theoretical and actually look at the chronology in 11 this particular case. 12 Q. Well, let's do that. 13 What would be helpful to you in the chronology 14 in this case? 15 A. Well, if we look at the x-rays that were obtained 16 in the case of this patient, and we see that, in 17 August of 1991 18 Q. Doctor, you're looking at something now as you are 19 testifying, right? 20 Can you identify what you're looking at? Are 21 those your notes? 22 A. Yes. 23 Im looking at my summary of some of the key

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50	52
 me. I just want to see if I can find it while you're testifying. So if you'll MR. LOUCAS: The doctor has it now. BY MR. DJORDJEVIC: Q. Do you only have one copy of the summary? A. Only one copy. Q. Do you know, can we get a copy of that? (Thereupon, a short recess was taken.) Q. Doctor, while we're waiting, let's just go to some general matters in terms of your background in testifying. How was it that you were contacted in this case? A. I have no idea how this law firm found my name. Q. Qkay. Do you advertise your services at all? A. Absolutely not. Q. Are you a member of any service organization that provides A. No. Q expert testimony? A. No. Q. Have you testified in cases other than this case? A. Yes. 	 A. I don't specifically recall. But as I made clear a few minutes ago, the function of a pulmonologist and a medical oncologist in this regard has a great deal of overlap. Q. I understand that, but we can agree, you and I, to the best of your recollection, this would be the first case where you've ever given standard of care testimony as to what the standard of care is for a pulmonologist, right? A. I don't believe that I said that. I said that I can't recall either way. Q. Well, that's my question. To the best of your recollection, this would be the first do you recall it, or don't you? A. I think it's entirely possible that I have. I simply don't recall the specifics of those prior cases. But I wouldn't agree with you that we can conclude, therefore, that I have not testified to that effect. Q. You think maybe you've testified as to the standard of care for a pulmonologist, but you can't recall?
 1 Q. And give me an idea of how frequently you do that. 3 A. I probably review six or eight cases a year. sometimes less. 5 Q. And how long have you done that? 6 A. About four years. 7 Q. I understand we're talking ball park, but six to eight for four years would be somewhere between, what, 24 and 32 cases that you've reviewed? 10 A. I think that's fair. 11 Q. Of those 34 to 32 cases, what percentage of those cases would be on behalf of Plaintiffs or patients? 14 A. About 20 percent are on behalf of the Plaintiff, and about 80 percent are on behalf of 'he physician. 17 Q. Have you ever testified as to standard of care for a pulmonologist prior to this case? 19 A. I don't specifically recall, though I certainly have testified pertaining to the standard of care in the work up and diagnosis of lung cancer. 20 Allright. 21 Let's talk about the work up and diagnosis of lung cancer as performed by a pulmonologist. 22 Have you ever done that before? 	 A. I don't recall the specifics to that degree of derail. Q. All right. Relative to giving testimony at trial or by video tape to be played at trial, have you ever testified at trial or videotaped to be played at trial on behalf of a Plaintiff? i. Yes. once. Q. And car, you tell me what issues those were involved in that case, Doctor? A. As I recall, that pertained to a delay in diagnosis of lung cancer. Q. And what was your testimony in that case? A. Well. I don't recall the details, but my testimony was in support of the fact that a delay in diagnosis contributed to the patient's demise. Q. And I would guess, given my limited knowledge about lung cancer? A. I believe that was. Q. So the only time that you can recall testifying for a trial by tape or by trial testimony for a Plaintiff or a patient, you took the position that delay in diagnosis of non-small cell lung cancer materially altered the outcome for that patient,

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14 (Pages 50 to 53)

84	86
1 right?	1 reports."
2 A. Correct.	2 Q. You're right. I'm a little bit dyslexic.
3 The details of that case were quite different	3 Did you look at any original x-rays in this
4 from the details of this case.	4 case?
5 Q. Where was that case filed, do you know?	5 A. Not that I remember.
6 A. Well, the trial was in Dayton, Ohio.	6 Q. Did you look at any copies of x-rays?
7 Q. Do you recall any of the attorneys involved in that	7 A. Again, I'm fairly conscientious about making notes
8 case?	8 of what I review, so I must conclude, because I
9 A. I don't recall their names.	9 didn't write it down, that I have not reviewed
10 Q. And you don't recall who was defending the case,	10 x-rays in this case.
11 either, I take it?	11 O_{1} . So the truth of the matter is, Doctor, that you
12 A. No.	12 don't know, as a matter of fact, from your own
13 Q. In the 24 to 32 cases in which you've testified,	13 review, what any of the x-rays actually show?
14 can you give me an approximation as to the cases in	14 A. You're asking whether I have personally interpreted
15 which you've testified on behalf or in regards,	15 any of these x-rays?
16 I guess, to the standard of care issue as opposed	16 Q. Right.
17 to the proximate cause issue?	17 A. I don't consider myself a radiologist, so I believe
18 MR. BROOKS: Objection to	18 that I have a sense of what they show based on the
19 form. I think he said he reviewed 24 to 32.	19 expertise of the reading radiologists.
20 I'm not sure he said he's testified.	20 Q. Well, you know that these expert radiologists
21 MR. DJORDJEVIC: Fine. I'll	21 settled out of this case, don't you? Don't you,
22 withdraw that and ask you the same way as	22 Doctor?
23 counsel has indicated.	23 A. Well, Imnot sure how that is relevant.
24 BY MR. DJORDJEVIC:	24 O. Does that indicate to you as to whether or not
25 O. In the 24 to 32 cases that you've reviewed, what	25 their interpretations were correct or incorrect?
· · · · · · · · · · · · · · · · · · ·	
55	57
 percentage of those cases involved elicitation of your opinions on the cause issue as opposed to the 	 A. It doesn't indicate to me either way. Q. It doesn't matter either way to you?
3 care issue?	 2 Q. It doesn't matter either way to you? 3 A. I'm not following your point.
4 A. I'm afraid I couldn't hazard a guess in that	
5 regard.	4 Q. Well, I'm asking you, does it matter to you 5 whether or not the radiologists in this case
6 Q All right.	6 settled out'? You re willing to assume their
And in the Dayton case where you testified at	7 interpretations at face value'?
8 trial for the Plaintiff patient, do you recall the	³ 8 A. I'm afraid I don't understand this line of
9 patient's name, or the Plaintiff's name?	9 questioning.
10 A. I'mafraid I don't.	10 Q. Well, you don't need to.
11 Q. How recently was that, Doctor?	11 I guess my question, sir, to you is, and let me
12 A. That was about a year ago.	12 ask it in a very simple manner, do you know and
13 Q. And did you go down to Montgomery County to testify	13 this question can be answered by a simple yes or no
14 live?	14 whether the radiologists in this particular case
15 A. Yes.	15 settled out of court?
I6 Q. Do you recall what the verdict was in that case. or	16 A. I was informed of that moments before the
17 what the outcome was?	17 deposition began, and you have stated that
I8 A. I believe that the outcome was in favor of the	18 yourself.
19 Plaintiff.	19 Q. And I take it, being aware that they settled out,
20 Q. Do you know what the amount of the award was?	20 you have no idea why they settled out of court, do
21 A. I don't.	21 you, Doctor?
22 Q. Doctor, before we get to your chronology, you say	22 A. Correct.
23 in your records, reviewed multiple x-rays. That's	23 Q. Does it stand to reason to you that they settled
24 the first thing that you list, correct?	24 out of court because their interpretations of the
25 A. I believe I listed, "Reviewed multiple x-ray	25 filns were incorrect?

15 (Pages 54 to 57)

1A. I have no basis on which to make such a judgment.1that I had available when I reviewed this of in fact, one of those x-ray readings was incorrect, in retrospect, Dr. Husari had no2Q. And since you've never looked at the films, you don't know as a matter of fact whether or not1that I had available when I reviewed this of in fact, one of those x-ray readings was incorrect, in retrospect, Dr. Husari had no	case, if,
2Q. And since you've never looked at the films, you2in fact, one of those x-ray readings was3don't know as a matter of fact whether or not3incorrect, in retrospect, Dr. Husari had not	, ,
3 don't know as a matter of fact whether or not 3 incorrect, in retrospect, Dr. Husari had no	
· · ·	way of
4 their interpretations were correct or incorrect, do 4 knowing that. So therefore, that type of	5
5 you? 5 information is not likely to alter my opini	on
6 A. Well, even if I looked at the films, not being a 6 regarding whether or not Dr. Husari comp	
7 radiologist, it wouldn't be appropriate for me to 7 the standard of care.	
8 declare their readings to be incorrect. 8 Q. Explain to me how Dr. Husari wouldn't l	know if one
9 O. So you will defer to the expertise of the 9 of the interpretations was correct simply b	
10 radiologists in this case as to what the correct 10 looking at the film.	5
11 interpretation of each specific film would be, is 11 Couldn't he simply look at the film and	know
12 that right? 12 whether the interpretation was correct or	
13 A. Well, I don't know for a fact how many expert 13 incorrect?	
14 radiologists are going to be brought into the case 14 A. Well, I think we've covered this ground	a few
15 and whether or not they're disagreeing with one 15 minutes ago, and that is I've been very clear	
16 another. 16 stating that Dr. Husari, like myself, is not	
17 As a practicing doctor, I can tell you that I 17 radiologist. And therefore, he must rely of	
18 do not consider myself to be a radiologist. And 18 expertise of the radiologists regarding the	
19 therefore I rely on the expertise of my radiology 19 interpretation of these films.	
20colleagues in managing patients.20So there's no way that I would expect I	Dr.
21Q. All right.21Husari to overrule a radiologist in rhe	
22 My question, sir, is you aren't going to be 22 interpretation of a film.	
23 rendering any opinions in this case as to what any 23 Q. Despite the fact that Dr. Husari is a pulm	
24 of these films show at any point in time? 24 and these are specifically films of the che	
25 A. Other than the information that has been provided 25 your position that he has no obligation to	look at
59	61
1by reading radiologists.1those things?2Q.All right, well, that's what I'm asking you.2A.The training program for pulmonologis	ts is not the
3 Is it going to be your position. sir, in this 3 same as the training program for radiolo	
3 case, that the interpretation of the reading 4 And to my knowledge, Dr. Husari is n	
5 radiologist for any particular film was correct? 5 in radiology.	
6 MR. BROOKS: I'll represent 6 Q. I'mot sure that answers my question.	
7 no. I don't intend to have him even look at 7 My question to you is. is it your posit	ion.
8 the films. 8 sir. in this case, that a pulmonologist, or	
9 BY MR. DJ ORDJEVIC: 9 doctor, has no obligation to look at the c	
10 Q. You're not going to vouch for the correctness of 10 x-rays of his patient?	
11 any of these interpretations? 11 A I don't believe that I said that	
12 A. No. 12 Q It's a question	
13 I think I've been very clear over the last 13 A I look at the chest x-rays of most of my	patients.
14 hour: stated multiple times, that I'm not a 14 and I believe not all of them, but in m	-
15 radiologisr and therefore don't feel 15 cases, when there's a particularly striking	0
16 appropriately trained to render an official reading 16 abnormally identified by the radiologist	t, I will
17of an x-ray.17pull out those films and look at them.	1
18 Q. And can you and I agree that, if any of these 18 But I would expect that a pulmonolog	
19 interpretations are incorrect, that may or may not 19 look at x-rays with a similar frequency t	•
20alter your opinions in this case, correct?20which means that a pulmonologist will r	
21 A. Well, in view of the fact that I am testifying 21 radiologist for his or her interpretation of	of those
22 largely regarding standard of care, and in view of 22 films.	c .
23 the fact that Dr. Husari made his clinical 23 Q. Well, let me ask you in a very straight	iorward,
 judgments based on the x-ray readings available to him at that time, those being the same readings Does the pulmonologist have an oblig 	ntion to
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16 (Pages 58 to 61)

62	64
1 look at chest x-rays done on the pulmonologist's	1 to make a determination, in this particular case
2 patient, or does the pulmonologist have no	2 involving Mr. Cowan, as to whether additional
3 obligation to look at the chest x-rays done on his	3 follow-up studies should be done, or is that
4 or her patient?	4 another thing, it's okay if they did, it's okay if
5 A. So you're asking whether the pulmonologist has to	5 they didn't?
6 look at every x-ray that he or she orders, or	6 A. Well, it might be easier to answer your question if
7 .whether I, as a-thoracic oncologist I'm also a	7 we do what we started to do before the break, and
8 general oncologist but in my practice as a	8 that is to go through the chronology. I think that
9 thoracic oncologist, whether I'm obligated to look	9 can answer your question more clearly.
10 at every single x-ray that I order?	10 Q. Why don't you do whatever you think would be
11 Q. Well, let me make my question very specific.	11 helpful?
12 I have no interest at all in learning whether a	12 A. Okay. Let's start back in August of 1991 where we
13 thoracic oncologist or a medical oncologist has an	13 started before. And a chest x-ray is obtained on
14 obligation to look at x-rays. My sole interest is	14 August 28th, which shows opacification anteriorly
15 whether a pulmonologist has an obligation to look	15 seen on the lateral view. It's thought to
16 at the x-rays, and that's my question.	16 represent most likely a pericardiac pleural
17 Is it your testimony in this case that a	17 reflection.
18 pulmonologist has no obligation to look at chest	18 There's a slight increased opacity on this film
19 x-rays that he or she orders for his patients?	19 at the left lung base, not a striking abnormality,20 but something that is called attention to
 A. It is my testimony that, in the course of his or her work day, a pulmonologist probably orders 	20 but something that is caned attention to 21 nonetheless. And therefore, just a couple of weeks
21 ner work day, a pumonologist probably orders 22 x-rays on most of the patients who walk in the	 22 Information interferore, just a couple of weeks 22 later, an x-ray is repeated, and this abnormality
22 door, as do I.	23 seems to have resolved. The only abnormality that
24 So there is considerable similarities between	24 remains is thought to represent a fat pad.
25 what they do and what I do. And there is no	25 The conclusion is, "No evidence of acute
63	65
1 obligation that the pulmonologist would review, for	1 cardiopulmonary disease." So again, that's great
1 obligation that the pulmonologist would review, for 2 instance, a normal film or a resolving pneumonia,	 cardiopulmonary disease." So again, that's great in terms of standard of care.
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17(Pages 62 to 65)

1 O Well is there any onacification that is visible on	68 1 A. It reads, "A single frontal portable view of the
1 Q. Well, is there any opacification that is visible on 2 the 1-25-92 film, Doctor?	2 chest dated 1-25-92 shows heart, lungs, and
3 A. The conclusion of the radiologist is no active	3 mediastinum to be within normal limits. Cardiac,
4 cardiopulmonary disease.	4 no active cardiopulmonary process is seen."
5 Q. Does that say anything about an opacification?	5 So there's no reference to any type of
6 A. I don't have the fill text of that report in front	6 infiltrate.
7 . of mePerhaps, if that's important, we could look	7 Q. We don't know whether there's an opacity there in $\frac{1}{2}$
8 at it.	8 '92, do we, one way or the other?
9 Q. Well, why don't we? 10 Do you have it in the materials that you	 9 A. Well, if I'm not mistaken, these films were all 10 taken at the same institution and read by the same
10 Do you have it in the materials that you11 brought with you?	11 group of radiologists.
12 MS. LOUCAS: Which x-ray?	12 So it is my assumption that these films were
13 MR. BROOKS: 1-25-92.	13 compared with prior films when they were read.
14 MR. DJORDJEVIC: 1-25-92.	14 Q. That's your assumption in this case?
15 THE WITNESS: If you can	15 A. Yes.
16 find it more quickly, I'll look at your	16 Q. Okay.
17 copy.	17 How about the 10-25-93 interpretation?
18 BY MR. DJORDJEVIC:	18 A. The conclusion there is no acute changes.
19 Q. While we're looking, Doctor, are these your notes,	19 Q. And again, does that say anything about the opacity
20 these typewritten notes?	20 that's referred to in the '91 films?21 A. No. They see nothing wrong here at all.
21 A. Yes, sir.22 Q. And how did you prepare these, sir?	A. No. They see nothing wrong here at all.Q. So what does that mean, that there is no opacity?
23 A. I went through the records, again, over the last	23 Is that your interpretation?
24 few days, and pulled out what I felt to be the	24 A. It means there is no opacity as far as the
25 'important x-rays.	25 radiologist could determine in this film. It looks
67	69
67 1 O. Allright.	69 1 like a normal film.
1 Q. Allright.	1 like a normal film.
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70	72
 1 chest. 2 Q. Well, let's talk about if I understand the way radiologists should work as opposed to the way they do work. 5 Does that make more sense? 6 A. I'm not sure what you're referring to. 7 Q. That's the way radiologists should work. They should report an opacity if they see it, right? 9 A. I'm not sure what you're driving at. I look at this report, and I see the radiologist has looked at this film and concluded there are no abnormalities. 13 Q. But we don't know whether he's correct in that conclusion or not, do we, because you never looked at the film? 16 A. Well, even if I did look at the film, I'm not a radiologist, sir. 18 Q. So you wouldn't know whether any of these interpretations are correct or incorrect? 20 A. As I said, I would rely on the radiologist's expertise since he or she alone is boarded in radiology. 23 Q. Please listen to my question. We'll get out of bars sooner 	 I certainly don't look at all my patient's films. I wouldn't have time to do my work. Q. How do you know whether or not there's anything sufficiently abnormal without looking at the films? A. Based on the radiologist's report. Q. So when you look at films in your practice, the only time you look at films is if the radiologist has suggested that there's something sufficiently abnormal in the film, is that how it works? A. In general, I wouldn't be so rigid as to say the only time, but that is generally what will lead me to do that. Q. When the radiologist reports an opacification, is that important enough for you to look at? A. If the radiologist tells me that's just a fat pad, I certainly don't see the need to take 20 minutes out of my day and go down and look at the film. Q. And if he says that it's what else here - a pericardial reflecbon, not important enough for you to take 20 minutes out of your day to look at it? A. Absolutely.
 24 here sooner. 25 Would you know, Doctor, whether any of these 	Q. What does he have to report to you for it to beimportant enough for you to take 20 minutes to look
 radiographic interpretations were correct or incorrect? Could you interpret any of these films for us'? you rely on the radiologist's interpretation'? A. I think, when one is treating a patient. working up a lung mass and so forth, it's important to have a visual image of what one is dealing with. 	 at the film? A. Well, you know, again, we're getting into kind of absurd theoretical discussions here. Perhaps since what you're most interested in is whether I believe that Dr Husan complied with the standard of care, I d be happy to tell you at each step of the way here whether I believe it was incumbent upon Dr Husari to look at any particular chest film Q Well, let's see if we can cut to the chase It's your belief in this case that it was never Dr Husan's obligation to look at any of these films? A Based on the fact that every abnormality that is potentially let me restate that. Every finding that potentially represents an abnormality is so conscientiously followed up with senal films all along the course of this patient's treatment, and in each instance, these films normalize such that there is no enduring abnormality identified by the radiologist. Given that fact, there is no instance in this chronology where Dr. Husan deviated from the standard of care in not looking at those films. Did there come a time when the cancer diagnosis was

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	•	74			76
1		made in this case, Doctor?	1		chronic interstitial changes but no acute
2	A.		2		infiltrates or effusions. No interval changes seen
3	1 1.	was made here?	3		when compared to the prior study. The previously
4	Q.	Sure.	4		suspected left upper lung infiltrate is now less
5	-	Yes.	5		well seen and may be obscured by overlying rib
6		In April of 1998, a discreet mass for the first	6		shadows. If further evaluation is deemed
7		time is identified on the x-ray dated April 6. And	7		clinically necessary for the assessment of any left
8		a CT scan is obtained three days later and confirms	8		upper lung lesion, apical lordotic film may be of
. 9		the presence of this mass as we've discussed	9		benefit, fluoroscopy, CT, et cetera."
10		earlier with mediastinal adenopathy.	10		And then in follow up of this, a few weeks
11	Q.	And is there something about a discreet mass that's	11		later, Dr. Husari orders yet another chest x-ray
12		important?	12		which describes an ill-defined area of increased
13	A.	Well, if this is what you're asking, the x-ray	13		density in the left upper lung essentially
14		report by the radiologist on April 6th, 1998,	14		unchanged from the prior films dating all the way
15		clearly identified, unequivocally described this as	15		back to September of 1994.
16		an abnormality in need of follow up. And at this	16		And the radiologist then concludes this is, in
17		point in time, appropriate follow-up studies were	17		all likelihood, fibrosis. No acute changes,
18	0	done which lead to the diagnosis.	18		chronic changes, as described. So here again,
19 20	Q.	So in this particular case involving Mr. Cowan, Dr. Husari, the managing pulmonologist, had no	19 20		there's a questionable abnormality and very careful follow up with two serial films.
20		obligation to do anything with the films until the	20	Q.	
21		radiologist told him that it was time to do	21	Q.	lordotic films, a chest fluoroscopy, or CT?
22		something, is that right?	22		Isn't that what the radiologists suggest Dr.
23	A.		23		Husari do?
25		abnormality that was clearly suggestive of	25	A.	
					···· , · ··· , · · · · · · · · · · · ·
					· · · · · · · · · · · · · · · · · · ·
		75			77
1		malignancy, I think that what Dr. Husari was	1		clinically necessary. And I would assume that, if
2		obligated to do was obtain follow-up films, which	2		the patient were symptomatic, that would constitute
3		he did with great care.	3		clinical necessity.
4	Q.		4		But for an asymptomatic patient, where this
3		what was seen on the film until the radiologist	5		film was compared and shows no interval change
6	_	told him that that's what he should do.	6		compared to the prior study, I think that's
7	Q.		,		sufficient.
8		were quite subtle. And in every instance. they	8	Q.	
9		resolved over time.	9		21st, 1995 film, the radiologist suggested a CT
10		So given that fact, there was no indication to	10 11	*	scan, right? Well, his first recommendation is comparison to
11	Q.	do anything else. Didn't the radiologist suggest to Dr. Husari	11	А.	Well, his first recommendation is comparison to prior films. And only if this is not possible is a
12	ų.	following the November 21st, 1995 film that a CT	12		CT scan recommended.
13		scan be done?	13	Q.	
14	.4.		15	<u>۲</u> .	Did Dr. Husari follow the radiologist's
16	.т.	nodule in the left second anterior interspace,	16		recommendation, get the prior films and compare
17		recommend comparison film. If this is not	17		them?
18		comparison with prior films. If this is not	18	A.	
19		possible, CT scan of the chest is recommended.	19		Husari do this, but that this be done.
20		So the very next day, Dr. Husari obtains a PA	20		And the answer to your question is yes.
21		and lateral. And, as recommended, it is compared	21		Because, on 11-22-95, that x-ray is compared with
22		with the prior film. So this is precisely	22		the 3-30-95 films. So yes, the recommendation of
23		following the recommendation of the radiologist.	23		the radiologist is carried out precisely.
24		And the report reads, "PA and lateral	24	Q.	
25		projections compared with 3-30-95 demonstrate	25		by someone else?

20 (Pages 74 to 77)

78	80
1 A. It was done by someone better than Dr. Husari,	1 with these symptoms, you have to have sufficient
2 because Dr. Husari is not a radiologist.	2 abnormality over time to justify invasive or
3 Q. And then when the comparison of the films is done,	3 extensive work ups.
4 that somebody better than Dr. Husari recommends	4 And again, in the real world, it's unfair to
5 that apical lordotic films, CT scan, or chest	5 look back with this approach and this perspective
6 fluoroscopy be done, right?	6 and criticize Dr. Husari.
7 A. Well, no, that's not true.	7 The number of x-rays that he got was indicative
8 Q. No? Okay.	8 of how cautious he was in following this patient.
9 A. That expert says no interval changes seen when	9 And in every instance, the questionable abnormality
10 compared to the prior study. The previously	10 that was identified improved or resolved before he
11 suspected left upper lung infiltrate is now less	11 let go of it.
12 well seen.	12 Q. Well, that's not my question.
13 So cancer doesn't go away. And he says, "If	13 My question is, Doctor, is there anything in
14 further evaluation is deemed clinically	14 the interpretations of the November 21st or
15 necessary," that's what he says. And to my	15 November 22nd, 1995 films that rules out non-small
16 knowledge, this patient was asymptomatic and	16 cell lung cancer as the explanation for that
17 therefore didn't have clinical indications to	17 lesion?
18 obtain further studies.	18 We don't need to have a retrospectoscope to
19 So again, I believe that he follows the letter	19 answer that question. Do you see anything that
20 of the recommendation.	20 rules it out?
21 Q. What are the clinical symptoms of a stage 1	21 A. Well, the fact that it is not well seen and the
22 non-small cell lung cancer?	22 fact that the subsequent x-ray done 12 months later
23 A. Well, a patient with stage 1 disease, depending	23 is also read as normal is very powerful in telling
24 upon the location, a 2.8 or two and a half	24 us that it is unlikely that there was an
25 centimeter tumor could cause airway obstruction,	abnormality that was diagnosable at that point on
	20
79	81
1 could cause chronic cough, could cause a	l chest x-ray.
2 post-obstructive pneumonia, could cause	2 Q. You're the one that's using the retrospectoscope,
3 hemoptysis. Those are all possible in association	3 aren't you, Doctor? You're the one that's looking
4 with a stage 1.	3 at the next film. I'm not asking you about '96.
5 Q. Was this a 2.8 or 2.5 lesion in November of '95,	5 I'm asking you about '95.
6 Doctor?	6 A. So you want to know whether there is anything here
7 A. Oh, even a smaller ission could potentially cause	that absolutely rules out lung cancer?
8 cough or hemoptysis.	8 Q. That's what I want to know.
9 Q. isn't the truth that most stage 1 non-small cell	9 A. You could ask me that question about even; x-ray
10 lung carcinomas are asymptomatic'?	10 that was ever done on this patient, and the answer
11 A. That's usually the case. Not always, but that's	11 would be the same. No.
12 usually the case.	12 _{O.} Nothing on any of these films ever rules out lung
13 $Q_{\rm L}$ And there is nothing on the interpretation of the	13 cancer as the explanation for the irregularity
14 radiologists in November of 1995 or thereafter that	14 described, is that right'?
15 rules out non-small cell lung carcinoma as the	15 A. You know, the fact that the irregularity continues
16 cause of what they're seeing on those films, isn't	16 to improve or resolve in these series of films
17 that right?	17 grouped together as we've discussed them, the 11-95
18 A. You know, again, you're using what we call a	18 to 11 excuse me, 11-21-95 and then 12-96 this
19 retrospectoscope in medicine, which is to say it's	19 is, again, in the real world, in the functioning of
20 very easy to look back and say, what about this,	20 a clinician evaluating a patient, there is
21 and what about that, and why didn't you do this.	21 insufficient evidence of malignancy to have
22 In fact, in the course of taking care of	22 required further testing.
23 patients day to day, and in the course of looking	23 Q. In your opinion?
 patients day to day, and in the course of looking at little ditzels on the x-rays of patients who are 	23 Q. In your opinion?24 A. Correct.
23 patients day to day, and in the course of looking	23 Q. In your opinion?

21 (Pages 78to 81)

	82 84
 have shown had it been done in November of A. I think it's impossible to know. Q. Do you have an opinion as to what chest fl would have shown had it been done in 1995 A. Likewise, there's no way to know that. Q. Or what an apical lordotic film would have 1995?	of 1995?1Q. And your survival statistics in your handwriting on your note are, more likely than not, these people aliagnosis is made at stage 1A.5A.That's right.6Q.And you and I agree we can't agree whether the AP or whether a CT scan or fluoroscopy or 8 anything else would have been diagnostic in '95, but we can agree that, if it was diagnostic in '95, this would have been a stage 1A cancer, wouldn't in1112A.You know, I follow your reasoning, and you're raising what is a classic paradox in the natural history of lung cancer, which is to say that both are true.16And if you're going to present this, for in stance, to a jury, or to any group of people who need to learn about this, to be fair, both pieces io f data need to be presented.1120On the one hand, it is true that an earlier stage at diagnosis is associated, in general, with at at2122Men you do chest x-rays earlier and earlier in
 to improve survival. I don't know if you're familiar with this literature. 	24 time for patients with lung cancer, those earlier 25 x-rays don't seem to improve their survival. And
 Q. I'm very familiar with it. A. Basically what these studies show is that do x-rays every six months or every year i smoker to try to pick up a cancer when it's smaller. And even when you do this, the of that patient is not improved. And the reason for that is most likely because microscopic metastatic disease ha early. Q. Well, the counterpart to that, Doctor, and already agreed that, if the diagnosis is made stage 1A cancer, the likelihood is that the is going to survive, right? A. Well, because won're not acking me to tage 	n a3In your experience. you've told me, when you get a stage 1 or stage 2 cancer, as part of the team approach, that patient is treated surgically, is that right?outcome of5team approach, that patient is treated surgically, is that right?outcome of7A.A.That's correct.s occurred8Q.In your experience, have you kept track of mortality in your own patients who have undergone resection for stage 1A cancer?le as a11A.I don't hate specific data from our institution regarding stage 1A patients. My opinions are reflective of a larger body of experience.
 A. Well, because you're not asking me to tess regarding proximate cause, I don't know the need to get into that. But I think that your conclusion isn't necessarily correct. And the screening studies show that ver possibly, when you find a cancer earlier, a you're doing is introducing what we call a time. But, in fact, you're not impacting that patient's outcome. Q. Doctor, I'm taking the survival figures from own handwriting on your own note. A. That's correct. 	hat we15You've told me that you have personal16experience in this regard, right?17A.17A.18understand statistics, it's much more powerful to19conclude what the survival is for a particular19lead20stage with a larger denominator.21Therefore, my opinion regarding five-year22survival statistics for lung cancer is not derived

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22 (Pages 82 to 85)

1 Memorial Sloan-Kettering trials, from the Mational Lung Cancer Study 1 patients? 2 Chain trials, from the Mational Lung Cancer Study 2 A Yes. 3 Group trials, which are the largest groups, I think you'll agree. 2 Can we agree that the reason that you order those tests is to see whether they will reveal additional information that may better the pulient's lesion, as you're asking whether Thave data regarding the specific survivals by stage at our institution? 9 A. You're asking whether Thave data regarding the specific survivals by stage at our institution? A A You're asking you prove patients? A A A lif's generally done upon recommendation of the radiologist recommends it, you do it, don't you? A That's correct. A A lif's generally done upon recommendation of the radiologist recommends it, you do it, don't you? 13 A gain, I don't collect those form yown patients? A A A lif's generally done upon recommends it, you do it, don't you? 14 Careally. Q Add when the radiologist recommends it, is it your 15 A. Revin, Mark as ome point between 1995 and't don't have to do it, is that the standard of care to obtain a to whether the adiologist steement that CT or a theradiologist recommended to patient that the standard of care would do it. 24 A. Well, if I remember corneculy regarding my testainer tha statement than,		86			88
 Clinic trials, from the National Lung Cancer Study Group trials, which are the largest groups, I think you'll agree. But let's put that aside, because apparently you're questioning that. I'm asking yous, itr, what is your personal-experience? A. Yes. Q. Can we agree that the reason that you order those tests is to see whether they will reveal additional information that may be helpful to you in a determining whether the patient's lesion, as you're asking whether I have data regarding the specific survivals by stage at our institution? Q. Just for stage 1A. A. Jain, I don't collect those form yow on patients. A. Agin, I don't collect those form yow on patients. A. Agin, I don't collect those form yown patients? A. Agin, I don't collect those form yown patients? A. Agin, I don't collect those form yown patients? A. Agin, I don't collect those form yown patients? A. Haw out not the statistically valid opinion to tell you, oh, I remember John Smith, and he lived for for years. I mean, that would not be valuable information. Q. Let's see if we canjust get a couple other areas of agreement. We know that, at some point between 1995 and a forger greater than the stard and point to tell you, on, I reght? A. Well, if I remember correctly regarding my testimony earlier this seening. I finit that 1 does it would'n i dentify that as a loop hole. A. Well, if I remember correctly regarding my testimony earlier this seening. I finit that 1 stage i. A clicace, in general, have a greater than 50 percent likelihood of sargical crue, of this statement than, CT or scans, but yes. A. Tatis correct. A. Well, if I remember correctly regarding my testimal whet are that patients with stage would have the figure may clinical the sease of the statement than. CT or scans, but yes. A. Have you ordered pical londotic films in my practice?	1 Memorial Sloar	-Kettering trials, from the Mayo	1		patients?
4 you'l agree. 4 tests is to see whether they will reveal additional 5 But let's put that aside, because apparently information that may be helpful to you in 6 You're asking whether I have data regarding the specific survivals by stage at our institution. 10 0. Just for stage 1A. 6 11 A row hout for your own patients. 7 12 Q. How about for your own patients. 7 13 A again. I don't collect those for my own patients. 10 14 Q. And you have no recollection as to what they would 14 15 G. All right. 13 16 A. It would not be a statistically valid opinion to 14 17 tell you, oh, I remember John Smith, and he lived 16 18 of agreement. 10 20 Let's see if we can just get a couple other areas 11 21 we know that, at some point between 1995 and 12 22 we know that at therefore, declined to say 12 24 well, if I remember correctly regarding my 12 25 A. Well, if I remember cor				А.	-
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6 you're questioning that. I'm asking you, sir, what 6 determining whether the patient's lesion, as 7 is your personal experience? monneoplastic? nonneoplastic? 9 A. You're asking whether I have data regarding the specific survivals by stage at our institution? nonneoplastic? 9 10 A. I don't have those from own institution? 9 A. That's correct. 12 Q. How about for your own patients. 10 An di's generally done upon recommends it, you do it, don't you? 14 Q. And you have no recollection as to what they would be be istatistically valid opinion to tells for four years. I mean, that would not be valuable information. 10 A. If would not be a statistically valid opinion to tells for four years. I mean, that would not be valuable information. 10 A. It would not be a statistically out could be is the standard of care to obtain a CT scan? 19 Q. Let's see if we can just get a couple other areas 10 A. Think it depends upon the clarity with which it's recommended by the radiologist says, ther's a mass on tech scare, you must follow this up with a CT. I 21 A. Well, if I remember correctly regarding my testimany anything other than tapatients with a staff at discase, in general, have a generate than a statustically no curve of any of the the fadiologist words. And if the trace a clinical signs or symptoms that, in most case, i.e. chest fluoroscopy? 24 Decreat fl	4 you'll agree.		4	~	tests is to see whether they will reveal additional
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 8 A. You're asking whether I have data regarding the specific survivals by stage at our institution? 10 Q. Just for stage 1A. 1 don't have those from or own institution. 11 A. 1 don't have those from or own institution. 12 Q. Hot wobout for your own patients? 13 A. Again, I don't collect those for my own patients? 14 Q. And you have no recollection as to what they would be be just by treating your patients? 16 A. It would not be a statistically valid opinion to tell you, oh, I remember John Smith, and he lived 18 for four years. I mean, that would not be valuable information. 20 Q. Let's see if we can just get a couple other areas of agreement. 21 of agreement. 22 of the know that, at some point between 1995 and 1995. Mr. Coward's cancer went from being surgically not curable, more 25 likely than not, am I right? 37 A. Well, if I remember correctly regarding my testimony earlier this evening. I think that I declined to speculate what his stage would have the be in in 1995. 30 percent likelihood of surgical cure. 31 A. Yes. 32 O. You have ordered chest fluoroscopy in your partice? 34 A. Yes. 35 A. Yes. 36 A. Yes. 37 These days, we use that far less than CAT is proteice? 36 A. Yes. 37 These days, we use that far less than CAT is proteice? 34 A. Yes. 35 A. Yes. 35 A. Yes. 36 A. Yes. 37 These days, we use that far less than CAT is proteice? 36 A. Yes. 37 A. Yes. 38 A. Yes. 39 A. Yes. 30 A. Yes. 31 A. Yes. 31 A. Yes. 32 A. Yes. 33 A. Yes. 34 A. Yes. 34 A. Yes. 34 A. Yes. 35 A. Yes. 36 A. Yes. 37 A. Yes. 38 A. Yes. 39 A. Yes. 30 A. Yes. 30 A. Yes. 31 A. Yes. 31 A. Yes. 31 A. Yes. 34 A. Yes.<th>6 you're questioni</th><th>ng that. I'm asking you, sir, what</th><th></th><th></th><th></th>	6 you're questioni	ng that. I'm asking you, sir, what			
 specific survivals by stage at our institution? Q. Just for stage 1A. 11 A. I don't have those from our own institution. 12 Q. How about for your own patients? 13 A. Again, I don't collect those for my own patients. 14 Q. And you have no recollection as to what they would 15 be just by treating your patients? 16 A. It would no the a statistically valid opinion to 17 tell you, oh, I remember John Smith, and he lived 18 for four years. I mean, that would no the valuable 19 information. 20 Q. Let's see if we can just get a couple other areas 21 of agreement. 21 We know that, at some point between 1995 and 22 We know that, at some point between 1995 and 23 testimony earlier this evening. I think that I 24 declined to specified what his stage would have 4 been in 1995. A. Well, if I remember correctly regarding my 2 testimony earlier this stage would have 4 been in 1995. A. Well, if I remember correctly regarding my 2 anything other than the far that patients with 3 50 percent likelibood of surgical cure. 4. Depending upon the situation, that may be done. 3. Q. You have recommended to Dz-Husan in this 3 case, i.e. chest florosscopy in your 4 practice? 4. Yes. 5. A. Yes. <l< th=""><th></th><th></th><th></th><th></th><th></th></l<>					
10 Q. Just for stage 1A. 10 And wire stage 1A. 11 A. Idon't have those from our own institution. 12 Q. And when the radiologist. 12 Q. And when the radiologist recommends it, you do it, don't you? 14 Q. And when the radiologist recommends it, is it your obligation by virtue of the standard of care to obligation by virtue of the standard of care to obligation by virtue of the standard of care to obligation by virtue of the standard of care to obligation by virtue of the standard of care would dictate that that the standard of care would dictate that that the standard of care would dictate that that can should be done. 20 Let's est if we can just get a couple other areas of agreement. 87 20 Q. Let's est if we can just get a couple other areas of agreement. 20 21 We know that, at some point between 1995 and 1998, Mr. Cowan's cancer went from being surgically not curable, more 21 23 If I remember correctly regarding my 1 a loop hole, and you don't have to do it, is that that stage would have 4 been in 1995. A. Well, if I remember correctly regarding my 4 A. Well, if the the far tha patients with it stage would have 4 5 operent likelihood of surgical curc. 37 7 </th <th></th> <th></th> <th></th> <th></th> <th></th>					
 11 A. John have hose from our own institution. 12 Q. How about for your own patients? 13 A. Again, I don't collect hose form yown patients? 14 Q. And you have no recollect hose form yown patients? 15 Q. All right. 16 A. It would not be a statistically valid opinion to tell you, oh, I remember John Smith, and he lived information. 10 Go Tray rears. I mean, that would not be valuable information. 20 Q. Let's see if we can just get a couple other areas 1 of agreement. 21 We know that, at some point between 1995 and 1998, Mr. Cowan's cancer went from being surgically curable, more 25 fikely than not, am I right? 22 A. Well, if I remember correctly regarding my 2 testimony earlier this evening, I think that 1 declined to speculate what his stage would have 4 been in 1995. 23 A. I blink that 1, therefore, declined to say 6 anything other than the fact that patients with 35 agreement thing there a greater than 85 op recent likelhood of surgical cure. 24 A. Depending upon the situation, that may be done. 25 Q. Doctor, in your practice, do you ever do any of the ting gas 1. c. chest fluoroscopy? 24 A. Depending upon the situation, that may be done. 25 Q. How have ondered chest fluoroscopy in your practice? 26 A. Yes. 20 A. Yes. 21 A. New, Yue. 				A.	
 12 Q. How about for your own patients? 13 A. Again, I don't collect those for my own patients. 14 Q. And yoo have on recollection as to what they would 15 bejust by treating your patients? 16 A. It would not be a statistically valid opinion to 17 tell you, oh, I remember John Smith, and he lived 19 for four years. I mean, that would not be valuable 19 information. 20 Q. Let's see if we can just get a couple other areas 21 of agreement. 22 We know that, at some point between 1995 and 23 1998, Mr. Cowan's cancer went from being surgically 24 curable to being surgically not curable, more 25 likefy than not, am I right? 27 A. Well, if I remember correctly regarding my 28 29 A. Well, if I remember correctly regarding my 20 21 A. Well, if I remember correctly regarding my 23 think that I, therefore, declined to say 24 disease, in general, have a greater than 25 op ercent likelihood of surgical cure. 30. Doctor, in your practice. do you ver do any of the 31 think that I, therefore, declined to Say 34. Yes. 357 358 369 360 360 360 361 361 362 362 363 364 364 364 365 366 366 367 367 368 368 368 369 369 369 360 360 360 360 360 361 362 361 362 363 364 364 364 365 366 366 367 368 368 368 369 369 360 360 360 360 360 360 360 360 361 361 362 363 364 <li< th=""><th></th><th></th><th></th><th></th><th>-</th></li<>					-
 A. Again, I don't collect holes for my own patients. A. Again, I don't collect holes for my own patients. A. Again, I don't collect holes for my own patients. A. It would not be a statistically valid opinion to tell you, oh, I remember John Smith, and he lived information. Q. Let's see if we can just get a couple other areas of agreement. We know that, at some point between 1995 and 1998, Mr. Cowarks cancer wont from being surgically curable to being surgically not curable, more External thick it depends upon the clarity with which it's curable to being surgically not curable, more External thick it depends upon the clarity with which it's curable to being surgically not curable, more External thick it, if I remember correctly regarding my testimony earlier this evening. I think that I therefore, declined to say anything other than the fact that patients with So precent likelihood of surgical cure. Q. Doctor, in your practice, do you ever do any of thing state with my gractice? Q. Doctor, in your practice, do you ever do any of thing state with stat genereal, have a greater than 6 for precent likelihood of surgical cure. Q. These days, we use that far less than CAT resens, but yes. A. Yes. May way ourdered apical lordotic films in thing you factice? A. Yes. A.				_	
 14 Q. And you have no recollection as to what they would is bejust by treating your patients? 14 A. Generally. 15 Q. All right. 15 Q. All right. 16 Q. All right. 17 obligation by virtue of the standard of care to oblig atom by virtue of the standard of care to oblig atom by virtue of the standard of care to oblig atom by virtue of the standard of care to oblig atom by virtue of the standard of care to oblig atom by virtue of the standard of care to oblig atom by virtue of the standard of care to oblig atom by virtue of the standard of care to oblig atom by virtue of the standard of care to oblig atom by virtue of the standard of care to oblig atom by virtue of the standard of care to oblig atom by virtue of the standard of care to oblig atom by virtue of the standard of care to oblig atom by the clarity with which it's recommended by the radiologist. 20 Q. Let's see if we can just get a couple other areas of agreement. 21 G. Went what, at some point between 1995 and 1998, Mr. Cowan's cancer went from being surgically curable to being surgically not curable, more 25 G. A. Well, if I remember correctly regarding my 1 testimony earlier this evening, I think that I deelined to speculate what his stage would have testimony earlier this evening, I think that I deelined to speculate what his stage would have testimony earlier this end of a surgical cure. 20 Doctor, in your practice do you ever do any of the this that were commended to IZ. Husan in this case, i.e. chest fluoroscopy in your practice? 24 Depending upon the situation, that may be done. 35 A. Yes. 36 These days, we use that far less than CAT scans, but yes. 37 A. Yes. 38 A. Yes. 39 A. Yes. 30 A. Yes. 31 A. Yes. 31 A. Yes. 32 A. Yes. 33 A. Yes. 34 A. Sen obligation to consider the larger picture. 34 A. Think they seou ordered CT scans? 35 A. Yes	-			Q.	
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16 A. It would not be a statistically valid opinion to 16 When the radiologist recommends it, is it your obligation by virtue of the standard of care to 17 till for four years. I mean, that would not be valuable information. 17 obligation by virtue of the standard of care to 20 Q. Let's see if we can just get a couple other areas 16 Think it depends upon the clarity with which it's recommended by the radiologist asy, there's a mass on 21 We know that, at some point between 1995 and 19 A. I think it depends upon the clarity with which it's recommended by the radiologist asy, there's a mass on 22 We know that, at some point between 1995 and 20 12 If the radiologist asy, there's a mass on 23 think that the standard of care would dictate that 14 that the standard of care would dictate that 24 testimony earlier this evening. I think that I 3 A I would read the radiologist's words. And if 25 Meen in 1995. 4 Set 4 I would read the radiologist's words. And if 36 A Well, if I remember correctly regarding my 1 a loop hole, and you don't have to do it, is that 36 A or and I think that I, therefore, declined to say 3 A I would read the radiologist's words. And if			t		•
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 20 Q. Let's see if we can just get a couple other areas of agreement. 21 We know that, at some point between 1995 and 23 J998, Mr. Cowan's cancer went from being surgically curable to being surgically not curable, more fikely than not, am I right? 24 curable to being surgically not curable, more fikely than not, am I right? 25 fikely than not, am I right? 26 A. Yes. 20 recommended by the radiologist. 21 If the radiologist says, there's a mass on chest x-ray, you must follow this up with a CT, I 25 Q. But if he says if it's clinically necessary, that's 26 aloop hole, and you don't have to do it, is that how it works? 27 A. Well, if I remember correctly regarding my testimony earlier this evening. I think that I therefore, declined to say anything other than the facr that patients with stage would have the sets in general, have a greater than 50 percent likelihood of surgical cure. 29 Q. Doctor, in your practice, do you ever do any of the things that were recommended to z. Husan in this in case, i.e. chest fluoroscopy? 21 A. Depending upon the situation, that may be done. 30 A. Yes. 31 A. Yes. 32 A. Yes. 33 A. Yes. 34 Depending upor the situation this in your practice? 34 A. Yes. 35 A. Yes. 36 A. Yes. 37 A. Yes. 30 A. Yes. 31 A. Yes. 31 A. Yes. 32 A. Yes. 33 A. J. Well, I think by clinical it means in view of the larger picture. 34 A. Yes. 35 A. Yes. 36 A. Yes. 37 A. Yes. 39 A. Yes. 30 A. Yes. 30 A. Two you ordered Apical lordotic films in your practice? 31 A. Yes. 32 A. Yes. 33 A. J. Well, I think by clinical it means in view of the larger picture. 34 A. Yes. 35 A. Yes. 36 A. Yes. 37 A. Yes. 38 A. Yes. 39 A. Yes. 30 A. The		mean, that would not be vuluable		A.	
21of agreement.21If the radiologist says, there's a mass on22We know that, at some point between 1995 and1998, Mr. Cowan's cancer went from being surgically122chest X-ray, you must follow this up with a CT, I231998, Mr. Cowan's cancer went from being surgically1think that the standard of care would dictate that24curable to being surgically not curable, more24think that the standard of care would dictate that25fikely than not, am I right?27871A. Well, if I remember correctly regarding my1a loop hole, and you don't have to do it, is that3declined to speculate what his stage would have44been in 1995.3A. I wouldn't identify that as a loop hole.4uber in 1995.4I would read the radiologist's words. And if5fing eneral, have a greater than50 percent likelihood of surgical cure.9Q. Doctor, in your practice, do you ever do any of the11cases, i.e. chest fluoroscopy?124. Depending upon the situation, that may be done.13Q. You have ordered chest fluoroscopy in your14Radiologists don't know very much about the15A. Yes.16These days, we use that far less than CAT17scans, but yes.18Q. Have you ordered apical lordotic films in19your practice?20A. Yes.21Q. In your practice, have you ordered CT scans?22A. Yes.23A. Yes. <t< th=""><th></th><th>can just get a couple other areas</th><th></th><th></th><th></th></t<>		can just get a couple other areas			
 We know that, at some point between 1995 and 1998, Mr. Cowar's cancer went from being surgically curable to being surgically not curable, more likely than not, am I right? A. Well, if I remember correctly regarding my testimony earlier this evening. I think that I declined to speculate what his stage would have been in 1995. A. Well, if hink that I, therefore, declined to say anything other than the fare that patients with stage 1A disease, in general, have a greater than 50 percent likelihood of surgical cure. Q. Doctor, in your practice. do you ever do any of the things that were recommended to Dz. Husan in this case, i.e. chest fluoroscopy? A. Depending upon the situation, that may be done. Q. You have ordered chest fluoroscopy? A. Yes. Q. Have you ordered apical lordotic films in your practice? Q. Have you ordered apical lordotic films in your practice? Q. A. Yes. Q. Is their obligation to consider the larger picture. isn't it? Q. Not rank of the situation, that may be done. Q. Have you ordered apical lordotic films in your practice? Q. Have you ordered apical lordotic films in your practice? Q. A. Yes. Q. Not rank on the situation of the situation, that may be dore. Q. Have you ordered apical lordotic films in your practice? Q. Have you ordered apical lordotic films in your practice, have you ordered CT scans? Q. Su think so, yee. Q. It's their obligation to consider the larger picture, isn't it? Q. Matter and the situation is your practice, have you ordered CT scans? Q. It's their obligation to consider the larger picture, isn't it? Q. A. Yes. Q. It's their obligation to consider the larger picture, isn't it? Q. Have you ordered CT scans? Q. Su that so yee. 		J	21		
 24 curable to being surgically not curable, more likely than not, am I right? 24 that scan should be done. 25 Q. But if he says if it's clinically necessary, that's 26 Q. But if he says if it's clinically necessary, that's 27 A. Well, if I remember correctly regarding my testimony earlier this evening, I think that I declined to speculate what his stage would have been in 1995. 28 A. Yes. 29 A. Yes. 20 Deterd, in your practice, have you ordered CT scans? 21 A. Yes. 24 that scan should be done. 25 Q. But if he says if it's clinically necessary, that's 26 J. A. Yes. 27 J. A. Depending upon the situation, that may be done. 29 A. Yes. 20 A. Yes. 21 Q. In your practice, have you ordered CT scans? 22 A. Yes. 24 that scan should be done. 25 Q. But if he says if it's clinically necessary, that's 26 J. Well, I think that I, therefore, declined to say anything other than the fact that patients with stage 1.A discase, in general, have a greater than 50 percent likelihood of surgical cure. 24 that scan should be done. 25 Q. But if he says if it's clinical it means in view of the things that were recommended to Dr. Husan in this 11 case, i.e. chest fluoroscopy in your practice? 21 A. Yes. 22 A. Yes. 23 A. Yes. 24 A. Think so, yes. 	-	t, at some point between 1995 and	22		chest x-ray, you must follow this up with a CT, I
 25 fikely than not, am I right? 25 Q. But if he says if it's clinically necessary, that's 27 A. Well, if I remember correctly regarding my 28 testimony earlier this evening, I think that I 29 declined to speculate what his stage would have 4 been in 1995. 7 And I think that I, therefore, declined to say 3 anything other than the fact that patients with 4 beer are clinical signs or symptoms that, in my 6 judgment. render that appropriate, I would to it. 7 But that's a different statement than, CT or 8 Q. Doctor, in your practice. do you ever do any of the 10 things that were recommended to Dr. Husan in this 21 case, i.e. chest fluoroscopy? 23 A. Yes. 24 A. Yes. 25 Q. But if he says if it's clinically necessary, that's 25 a. Yes. 26 A. Yes. 27 A. Yes. 27 A. Yes. 28 A. Yes. 29 Q. In your practice, have you ordered CT scans? 20 A. Yes. 21 Q. In your practice, have you ordered CT scans? 22 A. Yes. 23 A. Tes. 24 A. Yes. 25 Q. But if he says if it's clinically necessary, that's 29 A. Yes. 20 A. Yes. 20 A. Yes. 21 Q. In your practice, have you ordered CT scans? 22 A. Yes. 23 A. Yes. 24 A. Yes. 25 Q. But if he says if it's clinical the larger 26 A. Yes. 27 A. Yes. 28 A. Yes. 29 A. Yes. 20 A. Yes. 20 A. Yes. 21 Q. In your practice, have you ordered CT scans? 22 A. Yes. 23 A. Yes. 24 A. Yes. 25 A. Yes. 25 A. Yes. 26 A. Yes. 27 A. Yes. 27 A. Yes. 28 A. Yes. 29 A. Yes. 20 A. Yes. 20 A. Yes. 21 A. Yes. 22 A. Yes. 23 A. Think so, yes. 	23 1998, Mr. Cowa	an's cancer went from being surgically	23		think that the standard of care would dictate that
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22 A. Yes. 22 A. I think so, yes.				Q	
		e, have you ordered CT scans?			
23 Q. And Doctor, in your practice, have you ever ordered 23 Q. So you and I can agree that the standard of care					
	-			Q	
24 one of those tests that then leads to the 24 for the pulmonologist in this case is to consider					
25 ultimate diagnosis of cancer in one of your 25 the larger picture over and above what the	25 ultimate diagnos	sis of cancer in one of your	25		the larger picture over and above what the
	1		1		

23 (Pages 86 to 89)

90	92
1 individual films may or may not show, isn't that	1 judgment here. He says, if it's clinically
2 right?	2 indicated, get a CAT scan, right?
3 A. I think that's true.	3 A. What he says is very mild. He says, if this is
4 You know, your use of the word "larger picture"	4 very mild. "If further evaluation is deemed
5 is probably one that you're going to define in a	5 clinically necessary for the assessment of any left
6 particular way, and so I would answer that with	6 lung lesion, apical lordotic films may be of
7 -caution	7 benefit."
8 Q. I thought I was using your term.	8 This is a very mild statement, very different,
9 Didn't you use "larger picture" originally?	9 in my mind, from, "There's an abnormality here, get
10 A. Yes, but I think it's possible you may be using it	10 a CAT scan."
11 in a slightly different way than I am. I have a	11 Q. Doctor, let's agree, you're not a technician, and
	12 Dr. Husari isn't a technician, is he?
13 Q. Why don't you tell me how you're using it?	13 You don't simply wait around and have the
14 A. I don't have any definition for that.	14 radiologist tell you what to do, do you?
15 Q. I'm a pretty easy guy to figure out.	15 A. As I said before, I rely heavily on the
16 A. So am I.	16 interpretation of the radiologist and the
17 Q. Why don't you tell me how you're using "larger	17 recommendation of the radiologist regarding other
18 picture?"	18 studies.
19 A. I don't have any particular definition for that.	19 Q. And ultimately you decide, as Dr. Husari presumably
20 Q. Neither do I.	20 did in this case, as to whether or not additional
21 A. Okay.	21 study was indicated, isn't that right?
22 MR. DJORDJEVIC: Can we agree	22 A. Well, I have to rely on the radiologist. I don't
23 on that?	23 believe that, with subtleties such as interpreting
24 MR. BROOKS: Yeah, we can	24 changes in a vague infiltrate or nodule over time,
,	
25 · agree on it.	25 that I have, or that Dr. Husari as a pulmonologist
 BY MR. DJORDJEVIC: Q. You and I can agree that, in the way you practice medicine, you sometimes order CT scans, and those CT scans are helpful in either ruling out or ruling 	 93 1 has the expertise to make that judgment. 2 Q. So was the radiologist, you think, wrong, in 3 saying, "If further evaluation is deemed clinically 4 necessary?" Should the radiologist know, gees,
5 in non-small cell cancer, right?	5 this doctor doesn't have the clinical judgment to
	j uns doctor doesn't have the enhied judgment to
6 A That's true.	
	6 make that determination?
7 Q. And your goal, presumably. in doing that is io	 6 make that determination? 7 A. Your question is
7 Q. And your goal, presumably. in doing that is io 8 either rule it in or rule it out before :t goes	 6 make that determination? 7 A. Your question is 8 Q. Yeuh, I mean. h e a pulmonologist have the le/el
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94	96
1 around 11-22-95 and think about it, can we agree	1 It's a similar line of reasoning.
2 he had an obligation to sit down and think about	2 Q. I don't expect that you are.
3 it?	3 What's the down side? What is the con to
4 A. I think that's fair.	4 ordering a CT scan for this particular patient in
5 Q. Should I order additional studies or shouldn't I,	5 November of 1995?
6 is that fair?	6 Is it dangerous to the patient?
7 A. Yes	7 A. You know, again, I would hazard a guess that, in a
8 Q. Can we agree that the standard of care required	8 pulmonary practice, caring for patients with
9 that, on or about November the 22nd, 1995, Dr.	9 chronic obstructive pulmonary disease, that almost
10 Husari think about what to do in his patient?	10 every patient has abnormalities on chest x-ray.
11 A. That he read the radiologist's interpretation and	11 And one simply cannot obtain CAT scans on all those
12 then decide on his own how he should proceed based	12 patients. The problem in doing that is identifying
13 on that information?	13 an endless number of nodules that one then doesn't
14 Q. Let's go through what would be the pros of ordering	14 know what to do with.
15 additional studies.	15 For instance, as I said earlier, 25 percent of
16 A. You know, I wasn't - I can't put myself in Dr.	16 patients who are smokers have nodules on their CAT
17 Husari's shoes at that point in time. I don't have	17 scan.
18 very much information about this patient at that	18 MR. LOUCAS: What was the
19 point in time. I can't answer that question.	19 question? Could you read the question back,
20 Q. Well, let me ask you this, let me ask you if we can	20 please?
 agree that one of the potential pros of ordering more tests at that time would be, maybe this is a 	 21 (Thereupon, the record was read.) 22 A. Right, and I believe I'm trying to answer that
 more tests at that time would be, maybe this is a stage 1, non-small cell lung cancer, and maybe, if 	 A. Right, and I believe I'm trying to answer that We have CAT scan technology. We have PET
23 stage 1, hon-small centruing cancer, and maybe, h 24 I order a CT scan, I'll be able to diagnose it	24 scans. We have MRI scans. We have colonoscopies.
24 Forder a CT scan, Th be able to diagnose it 25 before this is a dead man.	25 We have all kinds of diagnostic tests available.
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25 (Pages 94 to 97)

AVENUES AND ADDRESS

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$ \begin{array}{c} 1\\2\\3\\4\\5\\6\\7\\8\\9\\10\\11\\12\\13\\14\\15\\16\\17\\18\\19\\20\\21\\22\\23\\24\end{array} $	 CROSS-EXAMINATION BY MR. LOUCAS: Q. Doctor, we've been introduced. My name is George Loucas. I'm going to continue briefly. I heard you reference well, would you agree with me that, if a patient presents with two I'm <i>sorry</i>, if-a patient presents with signs, symptoms, or findings on a laboratory test which may be consistent with two different disease states, which one of which may be life-threatening, there is a duty or responsibility on the part of the physician to rule out the life-threatening condition? A. Well, I think that's a potentially very misleading statement that, of course, is germane to the details here. As I have stated several times this evening, there are lots of little nodules on any chest x-ray of any patient with chronic obstructive pulmonary disease. And you could, with your retrospectoscope, when one of those nodules out of 200 turns into cancer Q. May I interject, Doctor? MR. BROOKS: Let him answer the question. 	 A. As I said, your question is an attempt to trap me <i>into</i> making a statement that would undermine my standard of care opinion regarding Dr. Husari. Q. It's not an attempt to do anything, Doctor. If I come to you with chest pains, you're going to tell me I've got gastritis, or are you going to make sure that I don't have a heart attack before I walk out your door and drop over dead? That's all Im asking you. Same principle. A. Let's use your example of chest pain, then. If a patient comes to me with chest pain, I need to make a determination whether that chest pain is cardiac, since cardiac chest pain is potentially lethal. Ineed to make a decision whether that patient has a dissecting aortic aneurysm, whether that patient has a cancer in his or her chest. It is not incumbent upon me to pursue every potential component of the differential diagnosis on every patient would never get out of the office for all the tests that he would have. Q. And one of the things you're going to do to determine if it's lethal or not is consider risk 	
24	the question.	24 determine if it's lethal or not is consider risk	1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.
25	MR. LOUCAS: I want to get	25 factors in our little scenario of chest pain,	1.2010.00141
1 2	99 out of here. Generally speaking. I'm not talking about this.	 wouldn't you, Doctor? Or are you going to deny that, too, today?)1
3 4 7 6	A. Please let me fiiish. You could look with your retrospectoscope at that noduir that has turned into cancer and say. just as you did now, well, wasn't it possible that	 A. Sir, I don't appreciate your sarcasm. That's not the tone that your colleague used in the deposition earlier this evening, and I'd prefer that we conduct this in a different manner. 	
7 8 9 10	that nodule was a benign granuloma, but wasn't it possible that it was a cancer'? And therefore, in direct response to your question, cancer was one of the two possibilities, and was it incumbent upon	 7 Q. I'm not my colleague, so please answer the 8 question. 9 You are here to answer my questions. 10 THE WITSESS: Please repeat 	
11 12 13 14 15	that physician to pursue that? Of course not.Q. So, no, if a patient presents with a sign, symptom, or laboratory finding which may be consistent with two different disease states, one of which is life-threatening, there is no duty on the part of	 the question. (Thereupon, the record was read.) A. As I said, when a patient presents as I think we're talking about a theoretical arena rather than the specifics of this case. 	
16 17 18 19 20	 the physician to rule out the iife-threatening condition? That's what you just said, correct? A. I think that your question is extremely misleading, whether one answers it in the affirmative or in the 	 When a patient presents with <i>any</i> particular sign or symptom, there's generally an extensive differential diagnosis that's associated with that. And I think that it would be overly rigid and, in fact, absurd, to say that the standard of care 	60 . M.Stud 3 10
20 21 22 23 24	 Whether one answers it in the aritrmative or in the negative. It's a distortion. Q. Okay. That's the entire principle behind a differential diagnosis, isn't it, what I just 	 20 fact, absurd, to say that the standard of care 21 would dictate that a physician would have to pursue 22 every component of that differential diagnosis each 23 time a patient presents with a particular 24 complaint. 	
25	said?	25 Q. So my question was, would you consider risk factors	

26 (Pages 98 to 101)

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1	in the patient who presents to you with chest pain	1	a very simple question. I don't thirk he
2	when you're trying to work up whether he's got a	2	wants to answer it.
3	dissecting aneurysm or if it's cardiac origin, et	3	MR. BROOKS: So the
4	cetera?	4	question, excuse me, is, "Dr. Levitan, do
5	A. Well, I think that I would consider a whole array	5	you ever use risk factors in working up
6	of factors, including physical examination,	6	diagnoses on patients?" Is that the
7	history, family history. A great many issues would	7	question?
8	be considered.	8	MR. LOUCAS: Let's try that
9	Q. And how about risk factors? Just answer the	9	one. He'll answer yours, I'm sure.
10	question, please.	10	A. That's the question? The answer is, of course.
11	A. What do you mean by risk factors?	11	Q. Okay. Let's talk about Dennis Cowan. Can we do
12	Q. Do you even know what risk factors are if	12	that?
13	somebody presents with chest pain of cardiac	13	A. Ofcourse.Q. Thank you.
14 15	origin? A. Of course there are several risk factors associated	14 15	Q. Thank you. As of September, 1994
15	with chest pain as there are risk factors	15	THE WITNESS: Excuse me,
17	associated with lung cancer.	10	your name is what's your last name?
18	Q. Coronary artery disease, what are the risk factors,	17	MR. BROOKS: George Loucas.
19	Doctor, so you can tell me whether or not that is	19	THE WITNESS: Mr. Loucas,
20	something you would consider with a patient who	20	I've been deposed a number of times over the
21	presents to you with chest pain?	21	years, and let me just go on record as
22	A. I'm afraid I don't understand what your question	22	saying, every attorney who has ever deposed
23	is.	23	me has been a gentleman. And your tone and
24	Q. It's very simple.	24	demeanor I find offensive and are
25	MR. BROOKS: Excuse me, I'm	25	unprecedented, in my experience.
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	103		105
1	103 going to object. You're asking a chest	1	MR. LOUCAS: And please, I
1	going to object. You're asking a chest oncologist about coronary artery disease.	1 2	MR. LOUCAS: And please, I don't want to take myself down to your
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1	actually like to take a break for about two	1		prominent.
2	or three minutes, if we could.	2	О.	
3	MR. BROOKS: Okay.	3	ح.	noted earlier, that it resolved more than one time
4	THE WITNESS: Thank you.	4		during that time period.
5	(Thereupon, a short recess was taken.)	5		Am I correct in paraphrasing something to that
6 BY	MR. LOUCAS:	6		effect, that that's how your testimony went
7 Q.	Doctor; I'm going to take your attention, please,	7		earlier?
8	back to September 23 of 1994.	8	A.	What Im doing is putting myself in Dr. Husari's
9	May we agree that the left upper lobe	9		shoes looking at the chronology of x-ray reports
10	abnormality as found on the x-ray was an incidental	10		that are available to him.
11	finding?	11		And on a couple of occasions, there was a
12 A.	Mr. Loucas, I'm not sure what you mean by an	12		questionable abnormality. And then, with
13	incidental finding. We know that multiple serial	13		appropriate follow up, that seems to go away, or at
14	x-rays were obtained thereafter, and the small area	14		the very least, to stabilize.
15	ofincreased density identified on the 9-23-94 scan	15	Q.	
16	seems to go away.	16		of care have been?
17 Q.	Do you know why the x-ray was taken September 23,	17	A.	Well, when we're diagnosing lung cancer based on
18	'94?	18		abnormalities on x-ray, a lesion which either
19 A.		19		resolves or fails to grow is one that we tend not
20	pneumonia, so it was done to rule out pneumonia.	20		to pursue. Whereas one that persistently enlarges
21 Q.		21		over time is behaving like a malignancy. And those
22	March of 1995, Doctor, the left upper lobe	22		are ones that we would work up with further
23	abnormality re-appears, is that a fair statement?	23		testing.
24 A.	Well, on March 28th, 1995, an abnormality is seen	24		As we look at the series of x-rays here, the
25	in the left upper lobe peripherally. We don't know	25		radiologists look at multiple films over time. And
	107			109
1	that it's the same exact area or that it is the	1		on several occasions they conclude that something
2	same etiology. But there is another abnormality	2		that was seen previously is really of no further
3	seen within the left upper lobe.	3		concern.
4 Q.	Have you ever made a determination, in reviewing	4	Q.	Was cancer ever within the differential diagnosis
5	the records in this case, and based upon your	5		of Dennis Cowan, in your opinion, ever, with that
6	knowledge and experience, many years of training,	6		left upper lobe abnormality?
7	as to whether or not the left upper lobe	7	A.	Well, we discussed this before, Mr. Loucas. There
8	abnormality found September 23 of '94 was the same.	8		is a very broad differential diagnosis for any
9	in fact, on April 4 of 1998?	9		finding on chest x-ray. And it is only when an
10 A.	2	10		abnormally appears io enlarge over time, that is a
11 Q.		11		subtle abnormality, or when something is an obvious
12	was one identified on several occasions rhroughout	12		mass, that further work up is required.
13	that time period between September of '94 through	13	Q,	
14	April of 1998?	14		presented and I'm not going to concede that it
	Yes, there are several abnormal findings that come	15		first presenied in September of '94, but I'm going
16	and go in the left upper lobe.	16		to assume for purposes of this question, if you
17 Q.		17		would agree with me and assume with me September of
18	abnormality was in Dennis Cowan?	18		'94 was the first appearance of this left upper
	Well, as I said a minute ago, in retrospect, one or	19		lobe abnormality, there was a duty on the part of
20	more of these prior films probably, or at least	20		Dr. Husari or anybody else to consider cancer
21	possibly, reflected the abnormality that we finally	21		within the differential diagnosis, is that your
22	see on 4-6-98 on the chest x-ray.	22		testimony, sir?
23	And we both know that the radiologist who	23	A.	· · · · · · · · · · · · · · · · · · ·
24	read the 4-6-98 film does say this has been present	24		times tonight. I feel like, with all due respect,
25	on films dating back to 1995, but is more	25		this is the same question that has been asked

28 (Pages 106 to 109)

1before.12And in the real world, in view of the fact that23most of his patients with chronic obstructive34pulmonary disease had, we can assume, one or more45areas of scarring or nodular findings or granulomas56or something on the x-ray that could theoretically,67'over time, actually grow and ultimately turn out to78be a cancer, having said that, in the real world,8	Cowan. What risk factors did he have that would increase the index of suspicion or the likelihood that that may be cancer?A. Well, probably, like almost every one of Dr. Husari's patients, I would hazard a guess, he was probably a smoker he was a smoker. And smokers get chronic obstructive pulmonary disease, and smoking is a risk factor for lung cancer.
9it's absurd to think that one is obligated to910follow up on every little nodule just because,1011theoretically speaking, the differential diagnosis1112includes cancer. You can't do that.1213And to look back in retrospect, not at the data1314available to the doctor at that time, not at the1415environment in which the doctor practices, but to1516say, there's a cancer in 1998. There was a little1617ditzel in 1994. It's theoretically possible that1718that could have been a cancer. Therefore, the1819standard of care would dictate that he pursue that1920with a CAT scan, that's ridiculous.2021Q. Okay.2123within the differential in September of '94, is2324that a fair statement? That's what you're telling24	 Q. What are his other risk factors at that moment in time, September of '94? A. To my knowledge, that is his principal risk factor. Q. Any others? A. I don't know any details about his occupational history, so I don't know whether he was exposed to nickel, cadmium, asbestos, et cetera, etcetera. So I would again say that, to my knowledge, smoking wes his principal risk factor. Q. How about the frequency of smoking when he did smoke, is that relative at all to increasing the indicia or the likelihood of the risk factor that it may be cancerous? A. At this moment, I'm not recalling when and if he quit smoking. Perhaps you could supply me with that detail, and then I could answer your
1A. No, I don't think that's what I said.12Q. Are you able to say whether or not cancer should23have been ruled out at all as a result of the34abnormality that arose in the left upper lobe in45September of '94?56And if so, how do you go about ruling it out?67That's all I really want to know78A. Right.89And rhe best way I can explain that to you is,910once again, to say that, strictly speaking, any1011tiny nodule on any of these films that belong to1112any of Dr. Husari's patients could include cancer1213as a differential diagnosis. But by no means is1314Dr. Husari required to get CAT scans on all of his1415patients with a chronic obstructive pulmonary1516disease just because, theoretically speaking, each1617of those little ditzels could be cancer.1718Q. So in this instance, the abnormality could have1819been cancer, but it didn't rise to the level or1920raise your index of suspicion enough to say it was2021standard of care to rule out cancer, is that a fair2122statement?2223A. I think that is a fair statement.2324Q. Okay.24	 knowledge of the facts in the case. How about the frequency, that was my question? Does that matter at all in evaluating a risk factor for whether or not a first presenting abnormality is cancerous or not? A. I don't understand your question. Q. I just want to know whether the frequency of smoking is a risk factor in and of itself; you know, whether you are a half pack a day or a pack a day smoker'? A. To some extent?sure, There is a dose response relationship between smoking and the risk of developing lung cancer to some extent. It's not linear, but people who do smoke more do have a higher risk of developing lung cancer. Q. Now, considering the risk factors for Dennis Cowan, did that raise at all the index of suspicion in the differential diagnosis that would cause one to rule in or rule out cancer as of September of '94? A. Well, I thirk that I've answered that question. Q. No, no, this is a new question.

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	114			116
1	A. Well, as I said, in a pulmonary practice, dealing	1	A.	Well, I have prepared carefully for this
2	with chronic obstructive pulmonary disease, most of	2		deposition, Mr. Loucas. But I think this is not a
3	those patients are smokers. And most of those	3		memory test. This is really an inquiry into my
4	patients have abnormalities on their chest x-ray.	4		professional opinion regarding this case. I didn't
5	So, in fact, while it is certainly true that	5		commit to memory every word of these requisitions.
6	anyone who was a smoker is at a higher risk for	6		But if you'd hold on just a minute, I'm happy to
7	-developing lung cancer than one who is not,	7		answer this question by looking through the
8	returning to the real world in which Dr. Husari is	8		reports.
9	practicing where all these patients have	9	Q.	I have a new question.
10	abnormalities on their x-rays and all of these	10		MR. BROOKS: Or you can
11	patients smoke, that's some hyperbole, of course.	11		withdraw it, because we all know how many he
12	But the point is true. It doesn't help him very	12		ordered and how many he didn't order.
13	much.	13		MR. LOUCAS: You know. I
14	And what he really has to do is rely on looking	14		know. She knows. I just wanted to know if
15	at serial chest x-rays and to use the principle	15		the doctor knows.
16	that, if a nodule enlarges over time, that's reason	16	ΒY	MR. LOUCAS:
17	to worry about cancer. Whereas, if it remains	17	Q.	
18	stable over a long period of time or seems to	18		refresh your recollection by going over the charts
19	decrease in size or disappears, the likelihood of	19		rightnow?
20	that being cancer is considerably less.	20	A.	Your question is, Mr. Loucas, among the 18 chest
21	Q. Let's assume for a moment a hypothetical using what	21		x-rays ordered here, can I tell you exactly who
22	you said, the question of a benign granuloma or a	22		ordered each one without looking at the report?
23	carcinoma.	23	Q.	No. I just asked you a new question, and that was,
24	What are the diagnostic approaches to make that	24		is it fair to say you don't know the number unless
2s	determination?	25		you now go through the medical record to refresh
	115			117
1		1		
1	A. Well, largely those that I just explained.	1 2		117 your recollection? Is that a fair statement?
2	A. Well, largely those that I just explained. I mean, to some extent, the radiologist can	2	A.	your recollection? Is that a fair statement?
	A. Well, largely those that I just explained. I mean, to some extent, the radiologist can help us make that determination based on certain	2 3	A.	your recollection? Is that a fair statement? A s I said
2 3	A. Well, largely those that I just explained. I mean, to some extent, the radiologist can help us make that determination based on certain radiographic features, and I defer to the	2 3 1	A. Q. A.	your recollection? Is that a fair statement? A s I said It's not a memory test, is that a fair statement?
2 3 4	A. Well, largely those that I just explained. I mean, to some extent, the radiologist can help us make that determination based on certain	2 3	Q.	your recollection? Is that a fair statement? A s I said It's not a memory test, is that a fair statement?
2 3 4 5	A. Well, largely those that I just explained. I mean, to some extent, the radiologist can help us make that determination based on certain radiographic features, and I defer to the radiologist in that regard.	2 3 1 5	Q.	 your recollection? Is that a fair statement? A s I said It's not a memory test, is that a fair statement? As I said. there are 18 chest x-rays here. And in
2 3 4 5 6	 A. Well, largely those that I just explained. I mean, to some extent, the radiologist can help us make that determination based on certain radiographic features, and I defer to the radiologist in that regard. And again, it's the issue of change over time. 	2 3 1 5	Q.	 your recollection? Is that a fair statement? A s I said It's not a memory test, is that a fair statement? As I said, there are 18 chest x-rays here. And in preparing for this deposition, it did not seem to
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30 (Pages 114 to 117)

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118	120
 time with x-rays. Are you familiar with other approaches to make that determination? A. Well, one could certainly do a needle biopsy, a bronchoscopy, a thoracoscopy, a thoracotomy, a fluoroscopy, a positron emission tomography, and others. There's a whole variety of modalities available to pursue an abnormality on chest x-ray, which, over time, exhibits features that are sufficiently womsome to justify that kind of intervention. Q. How about CT scan, is that one, also? A. Yes, of course. Q. With CT scan, you mentioned before radiologic features that you look at to determine a change over time. What are those radiologic features in an abnormality of the left upper lobe? A. Well, again, I rely on my radiology colleagues to interpret the film, interpret those radiographic features, and tell me when it's sufficiently worrisome. But broadly speaking, progressive enlargement over the period of serial films rather than stability or resolution is what would lead me to be concerned. 	 about than simple x-ray? A. Well, it might. But again, you can't get CAT scans on everybody. You have to really rely on your radiology colleagues to tell you which subset of patients has an abnormality on chest x-ray sufficiently womsome to merit a CAT scan. Q. Let's talk about those that do merit CAT scan. May we agree CAT scan is a better imaging source to help one look at the architecture of an abnormality in a lung than simple x-ray imaging? Very general question. A. Your question is MR. LOUCAS: Could you please read my question back? (Thereupon, the record was read.) A. Yes. Q. What is the best imaging source for visualizing a posterior left upper lobe abnormality? A. Well, one can do a lordotic film, but if there's sufficient concern raised by the radiologist about that lesion or any other lesion, and the radiologist recommends CAT scan, a CAT scan is a better modality than any particular view of a plain chest x-ray. Q. Other than the PA and the lateral, are there any
 1 Q. How about anything else, specifically with the architecture of the abnormality? 3 A. You know those kinds of findings are ones that I rely on my radiology colleagues to discern. Q. And are you familiar with what those architecture criteria are, though, in determining wherher it's more consistent with benign or malignant? 8 A. Again, not being a radiologist. I rely on my radiology colleagues for that recommendarion. Q. I'm asking, as an internist who is here giving pulmonary testimony on standard of care today, what the architecture and those criteria are in determining whether it's more consistent with benign or cancerous, Doctor? A. Well, certainly a nodule that is calcified is less likely to be malignant. One that is dense is more suggestive of malignancy as opposed to something of lower density. Something that is smooth and rounded is often less likely to be malignant. And there are other features. But, again, I don't make these determinations myself. I utilize my radiology colleagues for that purpose. Q. May we agree that a CT scan better helps one visualize those types of things that we just talked 	 other x-ray views that you are familiar with that help one visualize more adequately the left upper lobe posterior left upper lobe abnormality? A. You know, at our institution, we don't tend to use anything other than plain chest x-rays under most circumstances, and CAT scans. In this day and age, our radiologists tend to use special views less often and to go to CXT scans. I'm not saying that is the only way to do it, but, in my experience, we seldom use those additional views. Q. Do you have any opinions as to whether this was, in fact, a carcinoma more likely than not with Dennis Cowan? A. I have no opinion in that regard. Q. Do you presently have plans to testify in Clarksburg, West Virginia in this case? A. Yes. Q. What date will you be going? Have you made your travel arrangements? A. Yes. M. Yes. M. Mednesday, October 4th. MR, BROOKS: That's before

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1	you told me you were going to take a week to	1
2	put your case on. And you represented to	2 3
3	the Court you would accommodate.	3
4	MR. LOUCAS: I have no	4
5	further questions, Doctor. Thank you.	5
6	MR. BROOKS: In light of	6
7	the time factor, I'm not certain we'll be	7
8	able to read and sign, so we'll waive	8
9	that.	9
10		10
11		11
	(DEPOSITION CONCLUDED)	12
12	(DEFOSITION CONCLUDED)	
13		13
14	(SIGNATURE WAIVED)	14
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23 24 25 1 2 3 3 5 2 6 6 7	IN THE CIRCUIT COURT OF HARRISON COUNTY WEST VIRGMIA CERTIFICATE I, MICHELLE R. HORDINSKI, a Registered Merit Reporter and Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness. NATHAN LEVITAN,	24
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