D102CV921651

ELIZABETH *ANN* **DYXES AND** JOE **G. DYXES, JR.**	*	**IN THE DISTRICT COURT OF**
VS.	*	**BOWIE COUNTY, T E X A S**
COLLOM & CARNEY CLINIC, JOHN **D. FISHER, M.D. AND ERIC** HALL, **M.D.**	*	**102ND JUDICIAL DISTRICT**

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DEPOSITION OF
NEILL LONGLEY, M.D.
October 18, 1993

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Dep. 271

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DEPOSITION OF NEILL LONGLEY, M.D.

taken on the 18th day of October, 1993 between the hours of 6:45 p.m. and 7:50 p.m., before Janet M. Canton, a Certified Shorthand Reporter and Notary Public in and for the State of Texas, at the offices of Giessel, Stone, Barker & Lyman, 2700 Two Houston Center, Houston, Texas, pursuant to Notice, the Texas Rules of Civil Procedure and the stipulations of counsel.

APPEARANCES:

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PRELIMINARY PROCEEDINGS

MR. ONSTAD: It's by agreement.
MR. BARKER: Do you want to read and sign it?
THE WITNESS: No.
MR. ONSTAD: We are going to go to trial so dadgum fast.
No, we'll just -- if I see something that looks out of line, I'll let you know.

(Exhibit Nos. 1, 2 and 3 were marked for identification by the reporter.)

NEILL B. LONGLEY, M.D.,
having been first duly sworn, testified as follows:

EXAMINATION

BY MR. BARKER:
Q. Your name, please?
A. Dr. Neill Longley.
Q. You're a radiologist by profession?
A. Yes, sir.
Q. You practice medicine in Houston, Harris County, Texas?

A. Yes, sir.
Q. You have been hired by Mr. Onstad to assist him in the Dykes case?
A. Yes, sir.
Q. All right, sir. Your curriculum vitae has been marked as exhibit what?
A. One.
Q. Is that a current curriculum vitae, Doctor?
A. Yes, sir.
Q. All right, sir. Would you be kind enough to hand it to me for just one second while I glance at it?

You are not an oncologist?

A. No, sir.
Q. You don't specialize in the diagnosis or treatment of cancerous conditions?
A. Yes, I do. As far as the radiographic or mammographic cancer -- evaluation of cancer. This is our primary duty. We don't treat as an oncologist does, however, make diagnoses of cancer by x-ray.
Q. All right, sir. When were you first retained by Mr. Onstad to assist him in the case?
A. I think within two or three days of this report that I have given. Mr. Onstad came to my office

and brought these films to me to read holding them in his hand because he didn't want to lose them. So he brought those to me and I reviewed those and dictated a report while we were there. And I think this was February the 17th of 1992 that we did this.

Q. You've rendered only one report in the case. The report is dated February 17, 1992?

A. Yes, sir.

Q. And it's marked as exhibit what?

A. It's Exhibit No. 17.

Q. You were retained by Mr. Onstad on or about February 17 of 1992?

A. Yes, sir.

Q. Now, since being retained by Mr. Onstad, what have you done other than to meet with him on February 17th and review certain mammographic slides and then write this report?

A. I've had a couple of telephone consultations with Mr. Onstad.

Q. Have you done anything else?

A. No, sir. Nothing written; haven't written anything additional except I found some additional medical information concerning clarification of mammographic reports.

Q. Let me make sure that we're communicating. You met with him on or about February 17, 1992 for the first time?
A. Yes, sir.
Q. On that occasion you took your assignments, so to speak, from him in this case.
A. Yes, sir.
Q. That is, listened to what he wanted you to do?
A. Yes, sir.
Q. What he wanted you to do is to read these films, give your opinion concerning them, and you did that by rendering your report of February 17 of 1992?
A. Yes, sir.
Q. Since that time you've done some other things?
A. Yes, sir.
Q. That is, you've engaged in a couple of telephone conferences with Mr. Onstad. Correct?
A. Correct.
Q. And then you have looked for certain documentation which you brought with you today. Is that true?
A. Yes, sir.
Q. Can you give me the date or approximate date of the first phone conference you had with him

after writing your report?
A. I don't think I can be that specific. I think it was about three months ago that he indicated to me that certain particulars of the case revolved around the clarity of the reports and wanted to know if I had any information which reflected on the proper method of writing a clear x-ray report on a mammogram.
Q. So that was the essence of his request of you in the first phone conference following your having written your report?
A. Yes, sir.
Q. Did anything else take place in that phone conference that you recall?
A. No, sir.
Q. The second phone conference following your report was approximately when?
A. That was about a week later. And I called him to tell him that I had found certain articles which reflected the information he was interested in.
Q. All right, sir. The articles that you mentioned in the first phone conference with him?
A. Yes, sir.
Q. All right, sir. Did you discuss anything else

in your second phone conference other than you're pointing out that you had found certain articles?
A. No, sir.
Q. Have you done anything else on the case since that second phone conference following having written your report?
A. No, sir.
Q. Actually you have. I barely take issue with you and I'm sure that you would agree with me. What you have done is you met very briefly with him this evening before coming into this conference room to begin your deposition. Is that correct?
A. Yes, sir. I didn't know that you wanted --
Q. That's quite all right. No problem at all.
Now in that meeting with him, that is the meeting that you had with him that ended just a few minutes ago, tell me what he said to you.
A. He said that -- I don't remember exactly. He said I want you to go over things, kind of get them correlated. And then he said, I don't know which direction they're going to want to work from, but I think you have all the information you need to work with.
Q. That's all he said to you?

A. Essentially.
Q. Essentially?
A. That's essentially what he said. I don't remember what he said word for word.
Q. All right, sir. Did he say anything to you about what testimony Dr. Lane delivered this afternoon?
A. No, sir.
Q. All right, sir. Did you bring all of the reports with you today that you have found as a result of his request made of you in those phone conferences?
A. Yes, sir.
Q. All right, sir. And they are marked as exhibits, what?
A. Exhibit No. 2 and 3.
Q. All right, sir. What are you charging for your work in this case?
A. $350 an hour.
Q. All right, sir. Does that include travel time?
A. No.
Q. You do that for free?
A. Yes, sir.
Q. All right, sir. What if you traveled to give testimony at the trial of this case?

A. I would have to charge for the time away from work, and essentially, if I spend a day away from work, I'd have to charge an eight-hour day. I probably would have to also -- if I'm flying, you know, flight time's only an hour or so, but I think probably an hour or two for flight time I would have to charge.

Q. Your travel time would be billed at 350 an hour?

A. Yes, sir.

Q. All right, sir. If you were to testify in the trial of the case, that is in person in front of a judge and jury, what would your hourly rate be?

A. $350 an hour. Makes it simple; keep it the same.

Q. So your hourly rate is $350 on this case regardless of the service that you render. Is that true?

A. Yes, sir.

Q. This is not the first time you have given an oral deposition?

A. No, sir.

Q. You've probably done it hundreds of times before.

A. Not hundreds of times, but --

Q. A hundred times?
A. No. I doubt it. Probably 30, 40 times over the years.
Q. All right, sir. In addition to that, have you testified in a court of law?
A. Yes, sir.
Q. Probably an equal amount of times?
A. No.
Q. About how many times?
A. I would say probably one -- one period didn't go to court for a couple of years and then -- then it would average out once or twice a year after that.
Q. If you added them all up, what would your best approximation be of the number of times that you have testified in a court of law?
A. I *guess* it would -- since I've been in practice for 30 years, I'd say I average at least one time a year. So probably 30 times at least.
Q. All right, sir.
A. Maybe more. I don't really know.
Q. All right, sir. I accept your answer as being an approximation.
Have you testified both in the State of Texas as well as in other states?

A. Yes, sir.
Q. Can you approximate the number of states you've testified in either in giving deposition or testifying in court?
A. I've only testified one time outside the State of Texas.
Q. All right, sir.
A. That was in Florida.
Q. Fine. They have nice weather down there as well.
A. Yes, sir.
Q. Can you approximate the number of counties in the State of Texas you have testified in?
A. Probably six; five or six. One in Centerville, and I did one up north of Dallas once. The rest of them have been either Harris or Galveston Counties.
Q. All right, sir. Where was the medicine practiced as you understand the facts of this case, in what county?
A. Oh, let me see. Texarkana. I don't know what the county is.
Q. Have you ever practiced medicine in that county?
A. No, sir.
Q. Do you know on a close personal and close

professional basis any practicing physicians in that county?
A. No, sir.
Q. All right, sir. Have you ever?
A. No, sir.
Q. Have you ever done a survey as to the standard of care that's rendered typically by physicians, radiologists or others in that county?
A. Only what board certified radiologists would be required to have as a standard over the United States, a national standard.
Q. Well my question is --
A. But not specifically in that county, no, sir.
Q. You understand that my question was really a bit different than your answer, don't you?
A. Yes.
Q. All right, sir. My question is: Have you ever attempted to determine what the standard of care and how medicine is typically practiced by radiologists in that county? Have you done any such study?
A. No, sir.
Q. Is this the first time that Mr. Onstad has ever retained you to assist him in representation of a client in a case?

A. I can't remember. I -- specifically he himself, I think this is either the first or the second time he's ever --

MR. ONSTAD: I can't remember whether you gave me a report in the Props case or not, Lucy Props.

THE WITNESS: What's that?

MR. ONSTAD: The Lucy Props case, another case up in Texarkana. I think it settled --

THE WITNESS: I don't remember that one specifically.

A. But I have reviewed cases before that were in Texarkana. I thought -- did I go up there and go to Texarkana and do I have -- have I met the doctors up there? I haven't. But I think that I probably have reviewed two or three cases for Mr. Onstad, but I've never gone to a deposition before with him that I can remember.

Q. (By Mr. Barker) When I asked you whether you had done -- perhaps I don't even recall the wording of my question. Let me revisit the subject with you.

A. Yes.

Q. Is this the first time you have ever been

retained by Mr. Onstad to in any way assist him on a lawsuit?
A. No, sir.
Q. So you have assisted him on other lawsuits in the past?
A. Yes, sir.
Q. Is that a true statement?
A. Yes, sir.
Q. All right, sir. Can you remember what those cases were or what they were about?
A. No, sir. There weren't more than one or two others. I can't remember specifically.
Q. All right, sir. When you were visiting with Mr. Onstad on February 17th of 1992, did you ask him what sorts of things he wanted you to address in your report?
A. No, sir. He just told me to review the information that he had, which was a mammogram report and the mammograms, and to write my interpretation of what the mammograms were, what was on the mammograms and to make an evaluation of the correlation between the reports and the actuality of the films.
Q. At the time you wrote your report of February 17th of 1992, had you reviewed anything other

than the mammograms and the mammogram reports?
A. No, sir.
Q. All right, sir. Have you reviewed any other documents since writing that report up until today's date, other than those same things and Exhibits 2 and 3 to your deposition?
A. No, sir.
Q. Did you have Exhibits 2 and 3 that are attached to your deposition in your office or did you have to go outside your office to get them?
A. We had those available in our office.
Q. In talking, some people have the tendency to use the royal "we" meaning people other than --
A. Relsey-Seybold Clinic had this information.
Q. I want to talk about you.
A. I had it in my office. Yes, sir.
Q. You've had both Exhibits 2 and 3 in your office for some time?
A. Yes, sir.
Q. All right, sir. One of these, if not both of these, were reports I saw that you were reading here before your deposition began. Which was it?
A. This one here, Writing the Mammogram Report.
Q. That's Exhibit 3?

A. Yes, sir.
Q. Why were you finding it necessary to read it before *your* deposition?
A. I wanted to specifically relate this to the statements that I had made in my report.
Q. All right, sir. Is there anything in Exhibit 3 that you think relates specifically to the statements in your report that's marked as Plaintiff's Exhibit 17?
A. Yes, sir.
Q. All right, sir. What specifically do you think relates to the statements?
A. The statements have to do with the report which stated -- indicated densities in both breasts which were thought to partly be -- this is paraphrasing -- which were thought to be partly due to fibrocystic disease and mammary dysplasia. And the report did not state -- the report did state a mass lesion cannot be definitely excluded from either breast and a recommendation for follow-up was not made.
Now --
Q. Pardon me. You were just paraphrasing Dr. Fisher's report?
A. Yes, sir.

Q. All right. Okay. Go ahead please,
A. I think that's accurately -- pretty accurate what he said. But in this article by Dr. Stephen Feig, who is one of the foremost mammographers in the country, he states in this article, the use of fibrocystic disease should be avoided since it will not only cause unnecessary anxiety to the patient, but could place the continuation of her health insurance in jeopardy or raise her insurance premiums since some insurance companies consider fibrocystic disease as a precancerous or high risk condition. For these reasons, use of the diagnostic term fibrocystic disease is discouraged.
Q. All right, sir. I'm sorry. Please go ahead.
A. Okay. Another statement that I thought -- since he used these things in his report --
Q. Who used what things?
A. Since Dr. --
Q. Fisher?
A. Yes. Dr. Fisher used in his report, he stated that there were increase in densities in both breasts thought to be partly due to fibrocystic disease and mammary dysplasia.

Q. Uh-huh.
A. Then in this article it states dysplasia is one such ambiguous term which should be avoided since it may have different meanings to different people; radiologists may consider dysplasia to be a generalized term including fibrocystic conditions such as adenosis, fibrosis, papillomatosis, cysts or fibroadenoma. Yet to a gynecologist, dysplasia of the breast may imply a preneoplastic condition analogous to dysplasia of the uterine cervix. Similarly a misnomer such as fibrocystic disease should not be used. Being prevalent to varying degrees in most women it is not a true disease. The term fibrocystic condition or fibrocystic involvement should be used.
Q. Have you ever used the term fibrocystic disease in a report in your life?
A. I stupidly used those before --
Q. The answer to my question is yes?
A. Yes.
Q. What is the other term that's referenced in Exhibit 3 that you say is in Dr. Fisher's report that ought not to have been used by Dr. Fisher in his report?

A, Dysplasia,
Q. All right, sir. Have you ever used the phrase mammary dysplasia in any report you have ever written?
A. No, sir.
Q. Why?
A. Because I don't think that you can make that diagnosis from an x-ray.
Q. All right, sir. Well, he's not making the diagnosis of mammary dysplasia, is he?
A. Yes, sir.
Q. Oh, he is?
A. In his report he is stating --
Q. Making a diagnosis of mammary dysplasia?
A. Stating that there is evidence of mammary dysplasia.
Q. I see. To you that's a diagnosis?
A. Well, that's his interpretation of it.
Q. Is that a diagnosis?
A. He did not put that as a diagnosis.
Q. Oh, okay. Is there anything else in Exhibit 3 that you think is relevant to this discussion of Dr. Fisher's report which is marked as Plaintiff's Exhibit 17?
A. Yes, sir.

Q. All right, sir. Please go ahead.
A. The report did not make a recommendation €or follow-up and he did say a mass lesion cannot be definitely excluded from either breasts.
Q. All right, sir.
A. So here in the second paragraph -- the last paragraph oR the second page of this report -- writing of the mammographic report, the phrase malignancy cannot be excluded, should not be haphazardly applied to every lesion which has not been unequivocally benign. Although anything can be anything on mammography, it is unlikely that a well-circumscribed, half centimeter mass in a 35 year-old female is malignant. Thus the report should assess possibilities rather than express uninformative warnings, which I considered was made here, uninformative warning also recommend --
Q. Do you think Dr. Fisher has addressed possibilities in his report?
A. Yes, sir.
Q. All right, sir. Go ahead, if you would.
A. Let me see. Once mammographic studies are completed, a final report should be judicious. Rather than applying the phrase malignancy

cannot be excluded to every lesion which is not unequivocally benign, the radiologist should provide appropriate advice, such as mammographic follow-up, ultrasound, aspiration or biopsy based on the degree of suspicion of the individual lesion.

Q. Okay.

A. Those are the faults that I find.

Q. All right, sir. How long have you had Exhibit 3 or the original of it around your office?

A. We've had it --

Q. No, you. I'm asking about you.

A. I've had it for, I think, about a year, year and a half.

Q. Okay. How did you get it?

A. This was given to us as part of a continuing study program by the American Cancer Society.

Q. All right, sir. So did you know of this report's existence before it was given to you?

A. No, sir.

Q. Okay. Did you have a similar sort of guideline, if you will, for reporting mammographic interpretation?

A. Yes, sir.

Q. Before you used Exhibit 3?

A. Yes, sir.
Q. All right, sir. And was that Exhibit 2?
A. Yes, sir.
Q. In other Words, for your purposes, exhibit 2 was the predecessor to Exhibit 3 in your office?
A. Yes, sir.
Q. Now, do you use Exhibit 3 as a guideline rather than Exhibit 2?
A. Well, we use -- we use in practice Exhibit No. 2 --
Q. Uh-huh.
A. -- with Exhibit No. 3 to more polish the reports that we make. But this system here, Simple Classification System for Mammographic Reporting, is what we actually use -- generic "we" is the Kelsey-Seybold Radiology Department.
Q. Let me ask a favor of you, if I might, and it will simply, at least in my judgment, make an understanding of your testimony a bit simpler. If you intend to mean yourself, please say me or I.
A. Yes, sir.
Q. If you intend on meaning other folks, of course use the "we." But if you would, kindly try to keep those separate so I'll know who you're

talking about and I'd appreciate that.
A. Okay.
Q. In any event, I understand what you're telling me and please correct me if I'm wrong: You continue to use Exhibit 2, you have begun to use Exhibit 3 about a year ago when its existence first became known to you when it was given out at a continuing medical education type seminar?
A. I and my colleagues at Kelsey-Seybold Clinic had used the precepts detailed in Exhibit No. 3 for at least five years. I used it before I came to Kelsey-Seybold in 1990. So this was not -- this did not affect my method of reporting because I never used the term dysplasia; and I very closely limited my use of fibrocystic disease because I think that that is a pathologic diagnosis rather than a radiologic diagnosis,
Q. All right, sir, Apparently whomever wrote Exhibit 3 felt it would be useful because a number of radiologists all over the country were doing the sort of things that the author of Exhibit 3 thought they ought not to do, Would you agree with that statement?
A. Well, that's presumptive on anyone's part. I mean --

Q. Surely it is.
A. They hope --
Q. Would you agree with the statement?
A. Well, I don't know whether I can agree with what he was thinking -- Dr. Feig. I'm sure he's a teacher, though, and he would -- I'm sure his attempt is to try to standardize the language of radiologic reports so that they can always be understandable. I don't know what his aim was when he wrote it.
Q. Do you think that a radiologist can practice good medicine and be a good radiologist if they from time to time run afoul of, if you will, the suggestions made by Dr. Feig as set forth in Exhibit 3?
A. Dr. Feig?
Q. Feig.
A. Yes.
Q. Okay, You have bracketed some language in Exhibit 3.
A. Yes.
Q. Did you do that with an eye toward your work on this case?.
A. Yes, sir.
Q. Okay. I understand.

Now, is there anything there, Exhibit 2, that you believe was not followed, if you will, by Dr. Fisher in preparing his July of '89 report? If so, tell us.

A. This is much the same thing in that they're saying this was written in 1987. But their precept in this --

Q. Excuse me. Let me bring you back to my question.

A. Okay.

Q. Is there anything in Exhibit 2 that you're holding in *your* hand that you believe Dr. Fisher ran afoul of in rendering his report of July of '89? If so, tell us.

A. Well, in this article it also states equivalent statements like "cannot rule out malignancy" or "considered biopsy in the right clinical situation" places the physician in a difficult position of deciding whether referral for surgery is indicated, This is just one of the statements, but --

Q. Well, a radiologist doesn't make a decision about whether somebody ought to have surgery, do they?

A. Well, yes, it --

patient management. Under such circumstances clinical signs, symptoms and history may be absent or irrelevant. Biopsy decisions will be based on the mammographic findings alone.

Q. (By Mr. Barker) Have you done anything else on the case -- I'm sorry. Strike that, please.

Doctor, has there been anything else that you found in Exhibit 2 that you believe Dr. Fisher ran afoul of?

A. In Exhibit 2?

Q. Yes. I want you to finish that.

A. In that he didn't do anything according to Exhibit 2, but I wouldn't expect him to because this is not a standard usage, People don't use this classification as a standard over the country. This is just an example of what clear radiologic reporting should be for mammography, we think. That is the generic "we", Kelsey-Seybold Clinic Radiology Department.

Q. How many times, say in a week's period of time, Doctor, do you find it that a treating physician will come to you to visit with you about a radiologic report that you rendered him or her?

A. Oh, many times, Especially for mammography, I usually have at least two to three consultations

They do?

Q.

A. A radiologist, by his actions -- and you can find here -- I can find in here where it states that the radiologist controls whether a person is sent for surgical consultation by his statements.

Q. Oh, surgical consultation. But that's not making a decision for surgery, is it?

A. No. We don't make the decision for the surgery. However, we determine by *our* reports in many instances whether a person is sent to a surgeon or there is further study made, or if the patient is just followed on a routine basis.

MR. BARKER: Let's go off the record a second.

(Discussion off the record)

A. If I might refer back to -- there's a statement in here: Recent interest in mammographic reporting can be attributed to several factors. First, increased use of screening mammography leading to the recognition of nonpalpable abnormalities means that the radiologist rather than the clinician will initiate the course of

week, indeed perhaps multiple times per day?
A. Yes, sir.
Q. All right. Now, on those occasions, is it typical for the doctor to say to you, I'd like to get a little bit more information from you as to what you're talking about here in this written report? Clarification, if you will.
A. They don't ordinarily do that. They ask me, say Row then, what would you do? What should I do? Ultrasound? Should I do --
Q. You've already told me --
A. They don't usually ask me because our -- when I give out our report, it is clear to them what I'm saying,
Q. Have you ever had a doctor come to you and say, I'm not sure I understand what you mean here. I need clarification. Has that ever happened?
A. Yes. In the past.
Q. Sure.
When's the last time it's happened that you can recall?
A. Most of the time was when I was in Galveston.
Q. When's the last time?
A. Probably not since 1950 -- I mean -- excuse me, 1990.

a day usually with surgeons to have them -- they'll come to me to help get the fine tuning on a diagnosis, because I might give them a Class 3 which indicates suspicion.

Q. Let me just ask you to stay with my question.

A. I'm sorry.

Q. Believe it or not, I kind of know where I'm going, You have given me a number.

MR. ONSTAD: I've been quiet, but you are also running over him. You're cutting him off a lot. Let him -- and I know we all want to get out of here.

MR. BARKER: Trying to save time.

MR. ONSTAD: But I don't want the record to appear -- I'm being mostly fair. Let's go.

A. Can you go back to your question so I can be sure I've got it right?

Q. (By Mr. Barker) Absolutely.

What I'm trying to find out, and I believe you gave me an estimate, as to the approximate number of times during any given week a physician to whom you have rendered a report comes to you to talk to you about that report, And I believe you told me it's multiple times a

Q. All right, sir. What doctor do you last recall coming down to you and saying, look, Dr. Longley, I'm not quite sure what you mean here in this report. Can you clarify it a little bit for me?
A. When you're not -- you're not talking about mammogram reports specifically --
Q. Any kind of information.
A. -- we have this all the time. I mean, I thought you meant mammogram reports. No, we have those frequently. Maybe once or twice a week there's a report that doesn't have a word in it that they understand, or they have a precept that's presented to them they don't understand, or there may be a typographical error in the report. So --
Q. Is there an absolute standard that is recognized by all radiologists in the reporting of mammograms nationwide?
A. Only that the diagnosis should be clear, succinct and accurate.
Q. All right, sir. Are the words used to convey those ideas, however, necessarily standard?
A. No, sir.
Q. Okay. They ought to be clear and succinct?

A. Yes, sir.
Q. All right, sir. Is that pretty much the bottom line when you render your reports and your opinions in your reports?
A. Yes, sir.
Q. Okay.
A. And hopefully accurate.
Q. Indeed. I understand exactly what you mean. I believe I do.

Let me hand some of these exhibits to you, if I might, please. I'll hand them all to you, and you can choose those that you feel appropriate to respond to my questions.

Are these the mammographic reports that you reviewed in order to write your report of February 17 of '92?

A. These aren't reports, these are --
Q. I meant the mammograms themselves.
A. Yes, sir.

MR. ONSTAD: For further identification, they're Plaintiff's Exhibits 1 through 8.

MR. BARKER: Yes.

MR. ONSTAD: And of course, just for the record, we may have said this off the

report.
A. That's these here.
Q. And what exhibit numbers are those, please?
A. Those are Exhibits P1, P2, P3 and P4.
Q. All right, sir. In looking at those exhibits that are before you, do you see what you consider to be moderate fibrocystic changes?
A. No, sir.
Q. You see none?
A. No, sir.
Q. You see no fibrocystic changes at all?
A. As I told you before, that's not a radiographic diagnosis.
Q. Do you understand what the term fibrocystic change means?
A. Yes, sir.
Q. All right, sir.
A. I know what some people refer to as dense breasts and with cysts, which this patient does not exhibit and --
Q. She doesn't have dense breasts?
A. -- it would be a misnomer if she did have it.
Q. You don't think she has dense breasts?
A. No, sir.
Q. You don't think she has any cysts?

record, the little red marks that are on those Plaintiff's Exhibits 1 through 8, they weren't on there when you looked at them, were they?

THE WITNESS: No. And I didn't put them on there.

MR. ONSTAD: I understand.

MR. BARKER: I understand. That was my understanding, in any event.

MR. ONSTAD: We've got Dr. Fisher doing it on videotape.

A. Okay. But these are the mammograms, the actual xerographic studies. And I believe these are original records -- yes, these are original records of Collom & Carney Clinic.

Q. (By Mr. Barker) All right. If *you* would, please take those that are the subject of Dr. Fisher's July 25, '89 report, as you understand it -- just set the others aside, if you would.

A. Yes, sir.

Q. All right, sir. Set the others aside if you would, please.

A. All of these were utilized during his report.

Q. I'm asking you to put in front of you those that you believe were the basis of his July 25, 1989

no evidence of dysplasia, which is also not a radiographic diagnosis.
Q. Do you see any patchy densities?
A. Yes, sir.
Q. All right, sir. Do you see them in both breasts?
A. Yes, sir -- no. Only in the right breast.
Q. You see none in the left breast?
A. No, sir. I see only -- I see only normal breast stroma in the left breast and -- but I see suspicious nodules in the right breast.
MR. BARKER: Unresponsive.
Q. (By Mr. Barker) Do you see any mass lesions?
A. Yes, sir.
Q. How many?
A. I see at least one and probably two more.
Q. Exactly where, in which breast and what exhibit?
A. Okay. In Exhibit No. P1, slightly to the outside or lateral side of the nipple line and near the chest wall with streamers extending toward the nipple, I see a stellate lesion which is approximately one centimeter in diameter. And on the side view or the axillary view, I see another mass lesion which corresponds exactly -- that's Exhibit No. P2, which corresponds exactly

A. No, sir.
Q. You don't think she has any fibrocystic changes?
A. No, sir.
Q. Do you think she has any mammary dysplasia?
A. As I said before, mammary dysplasia is also a misnomer and that's always a pathologic diagnosis. I do not think she has any mammary dysplasia because that's a pathologic diagnosis.
Q. Well, what is mammary dysplasia?
A. Mammary dysplasia is a change in the ducts in which there is a thickening of the tissue inside of the duct and which may also have metaplasia. But that's a pathologic diagnosis,
Q. Regardless of what it is, you say she doesn't have any mammary dysplasia?
A. No, sir.
Q. All right, sir. And you say she has absolutely no fibrocystic changes either?
MR. ONSTAD: You're talking about as evidenced by those mammograms?
MR. BARKER: Yes.
A. No, she has no evidence of fibrocystic disease which --
Q. (By Mr. Barker) I didn't ask about that.
A. -- is not a radiographic diagnosis and she had

means indeterminate lesion found, suggestive of possible malignancy.
Q. Are all of the densities the same?
A. No, sir.
Q. Are the densities of similar size however?
A. No. The primary lesion is larger than the other two.
Q. Well, what size is what you define as the primary lesion?
A. Primary lesion is approximately one centimeter in diameter with streamers that go toward the nipple, which are two to three centimeters in length.
Q. What is the size of the next --
A. I would say --
Q. -- smaller?
A. -- there's another one that's approximately a half a centimeter, and another one that's approximately a fourth of a centimeter.
Q. Are they approximately the same in appearance?
A. Yes, sir. They each are stellate in appearance which is characteristic of infiltration.
Q. Do you see any clustered calcifications?
A. No, sir.
Q. Do you see any nipple retraction?

in size and contour to the mass lesion seen in the Exhibit P1.
Q. Is it in exactly the same location in the breast?
A. Well, you -- you use these to triangulate. So it -- it's the same distance from the chest wall.
Q. My question is: Is it in exactly the same location in the breast?
A. It's -- In my opinion, it is.
Q. Is it the same lesion?
A. Yes, sir.
Q. All right, sir. Do you see any others?
A. I see two other nodules which I see only in the side view. And these are stellate in appearance which makes them suspicious.
Q. Are they cancerous?
A. I would say probably, yes, sir.
Q. Do you know for sure?
A. Well, one never knows until they're taken out.
Q. All right, sir. You would not say they're definitely cancerous; you're saying that you think they probably are?
A. Yes, sir. And if I use my classification, I would make them what we call a Class 3 which

A. No. There's --
Q. Do you seen any skin retraction?
A. No, sir.
Q. Do you see any skin thickening?
A. No, sir.
Q. Do you see asymmetry between the two breasts?
A. No, sir, except for the nodulation.
Q. Do radiologists looking at mammograms such as those make a diagnosis of cancer or simply report their findings to the treating physician who upon appropriate report and other findings would make the diagnosis?
A. Well, we don't come right out and put the word cancer on it. We put a classification on it.' That is the generic "we" at Kelsey-Seybold Radiology. But if I give a diagnosis of Class 1, it means normal. If I say a Class 2, there are masses or -- mass or masses present which are probably benign. If I say Class 3, it's an indeterminate lesion found suggestive of possible malignancy. And if I say Class 4, it's probable malignancy.
Q. Are these Class 3s, did you say?
A. Yes, sir.
Q. All right. How old was Ms. Dykes at the time

those mammograms were made?
A. Age 41.
Q. Was she menopausal, or do you know?
A. I don't -- I don't know.
Q. All right, sir. Are you accepting of the phrase, the three-part approach to detecting cancer; that is, breast self-examination, physician examination and mammograms?
A. Yes, sir.
Q. All right, sir. What *are* the sorts of things in mammographic studies such as you see in front of you that can obscure breast cancers?
A. Scars.
Q. What else?
A. The major thing is just not having the lesion within the view of the x-ray beam.
Q. Can you think of anything else?
A, You can have bad screens which can obscure lesions,
Q. What else?
A. Inadequate penetration of the films.
Q. What else? Can you think of anything else?
A. I can't come up with anything, I've probably got four or five more, but I can't think of them right off the top of my head.

Q. I'll give you four hours, one for each.
A. All right. Let me see.
Okay. One thing that could obscure a lesion or make you, you know, confused with it, would be molds on the skin.
Q. What else?
A. Previous radiation therapy.
Q. What else?
A. Previous surgery.
Q. What else?
A. And that's about all I can come up with right now.
Q. Am I giving you all the time you need to tell me?
A. I believe so.
Q. All right, sir. And you can't think of anything else?
A. Not right now.
Q. I don't mean to beat a dead horse, so to speak, but when you say not right now, I don't want somebody to interpret by listening to this deposition that I'm cutting you short and running you off. Am I giving you full opportunity to answer that question --
A. Yes.

Q. -- with everything you can think of?
A. To bring up the dredges of my memory, but I would reserve the right to think of something later on.
Q. I understand that. And I appreciate that you have that right to think of something later.
Do you accept the proposition and agree with the proposition that cancers in the breast are easier to find retrospectively after a second round of mammographic studies?
A. Yes, sir.
Q. why is that?
A. Well, you have the previous one to compare.
Q. Can you amplify on that answer just a bit?
A. Well, if you have you a previous x-ray which shows a perfectly normal appearance, like the left breast in this instance, and you find something later on, then by comparing back to the previous lesion, then it becomes more apparent.
Q. Do you believe that duct dilatation is a non-specific finding?
A. Yes, sir.
Q. All right, sir. Do *you* believe that most of the time that represents a benign process?

A. Ordinarily, yes, sir.
Q. All right, sir. Would you be kind enough with regard to each of those four exhibits in front of you, again those are the July of '89 mammograms, by exhibit number tell us each of the findings *you* see in each of them? In other words, if you would, orally dictate us a report --
A. Okay.
Q. -- for each.
A. I would make this -- I would first dictate Wolf's classification which determines the character of the breast.
Q. Here's what I'd like for you to do. I haven't made my request of you clear. And that's my fault, not yours. What I would like for you to do is to go something like this. Exhibit 1, --
A. Okay.
Q. -- and then literally dictate your report of *your* finding.
A. The way I would dictate this is Wolf's classification P-1 --
Q. You have to give me the exhibit first, please, sir.
A. This is Exhibits P1 and P2.

Q. One at a time.
A. Okay.
A. You said read it as though I was reading. If you want me to read as each individual page -- we have Exhibit P1, Wolf's classification P-1. There is a one centimeter nodule very close to the chest wall with extensions from the nodule toward the nipple which give the mass a stellate appearance and which are highly suspicious for carcinoma of the breast.
Q. Okay. P2?
A. And P2. The axillary view confirms the presence of a nodule in the nipple line very near the chest wall with two additional nodules of similar character which lie above the primary or dominant nodule, all of which are somewhat stellate in appearance and are likewise suspicious of malignancy, Class 3.
Q. P3?
A. Class 3.
P3. P-1 is Wolf's classification. This cancer classification is class --
Q. I'm sorry. I'm asking you to yo on to P3.
A. I'm sorry.
Q. I've read, quote unquote, *your* report on P2.

normal?
A. Yes, sir.
Q. All right.
A. But not nodulation. I see distribution of breast stroma which I consider to be a normal distribution of the density of the breast.
Q. All right, sir. Do you have the 1990 films, Doctor?
A. Yes, sir, I do.
Q. Can *you* take the right breast '89 films and the right breast '90 films for just a moment so I might visit with you about those?
A. Yes, sir.
Q. With regard to the right breast, can you tell beyond any shadow of a doubt that there was a cancer in the right breast in July of '89 as opposed to the cancer developing adjacent to one of the patchy densities during the following 18 months?
A. I'm sorry, would *you* please restate that? I'm sorry, I don't understand exactly what you're asking.
Q. Well, is it possible that what has happened is that there has been a development adjacent to one of the patchy densities during those 18

Please go on to Exhibit P3.
A. Okay. Then P3 shows the Wolf's classification is P-1. No dominant or infiltrating mass, no skin thickening, clumped microcalcification or other evidence of malignancy.
Q. P4?
A. P4, there is -- I'd give that exactly the same dictation, no dominant or infiltrating mass or clumped microcalcification. Diagnosis, Class 1.
Q. All right, sir. In comparing what you have in the four exhibits, how many patchy or nodular densities do you see in each breast?
A. I see in each film or each breast?
Q. Each breast.
A. I only see nodulation in the right breast. I don't see nodulation in the left breast.
Q. Do you see any patchy densities in the left breast?
A. Only what you would term to be normal breast distribution, breast tissue distribution. I don't see patchy densities.
Q. I'm not sure I understand your answer.
A. I see density in the breast which is normal, a normal distribution of breast tissue.
Q. Means you see some, you just consider it to be

probability, this is exactly the same lesion in exactly the same spot.
Q. Don't most all of these densities have irregular margins?
A. No, sir.
Q. Which don't?
A. Well, none of these lesions in the right breast in either 1989 or in 1990 have regular margins. They have stellate margins to my eye.
Q. How is stellate different than irregular?
A. Stellate is star burst appearance. These have a star burst appearance to me. They have fuzzy edges. It's like you take a piece of cotton and Look at it, you see the fine fiber along the. edge opposed to a cancer which has sharp edges. So many of these have cottony margins, to me, both in 1989 and in 1990. The only thing is that the one in 1990 is considerably larger.
Q. So *you* don't think that one could describe a stellate appearance as a lesion with a regular margin?
A. I would think that would be wrong.
Q. Are all irregular densities cancer?
A. No, sir.
Q. All right, sir.

months up until December of '90?
A. Well, anything is possible. However, a stellate density has developed in exactly the same position as the primary nodule seen in 1989.
Q. And would you give us that precise location again by measurement?
A. I don't have anything to measure with, but I would say that in each of the examinations in 1989, the lesion appears to be near the chest wall within a centimeter or so and in the nipple line slightly lateral to midline. In 1990, the lesion is considerably larger but in exactly the same position, near the chest wall and slightly lateral to the nipple line.
Q. Is there a possibility, Doctor -- do you concede a possibility that the cancer could have developed after the '89 study adjacent to one of the patchy densities visualized in the '89 study?
A. I wouldn't think so.
Q. You think that's impossible?
A. Oh, no. There's one or two or three things you never say in medicine and one is impossible or absolutely, always or never. So I can't say those things any time, but I -- within medical

A. That's right. I don't have the lymph nodes in view actually in either of these examinations. I mean, we know there were lymph nodes present; however, they don't show up in the 1990 lesions and they don't show up in the 1989 lesion.
Q. Can you tell strictly by the size of the lesion whether it has spread or not?
A, If it's -- standard with that, if the lesion is over one centimeter in diameter, that it's suspicion that there is spread --
Q. That's not my question.
A. Only by inference -- I can only say by inference that this lesion is at least a centimeter in size originally and certainly much more than a centimeter in size in the second examination,
Q. Nor is that my question, 1 mean, I appreciate --
A. What can you use to say whether it's spread or not? The only way you can do that is by size.
Q. No, sir, Let me bring you back to my question.
A. All right.
Q. Can you tell strictly by the size of a lesion whether it has spread or not?
A. By statistical data, the statistics are that if a lesion is a centimeter or more in size,

A. Almost all stellate lesions are,
Q. What percentage?
A, 90 or more.
Q. In women of this age?
A. Yes,
Q. Where do you get that from?
A. From the American Cancer Society home study course that we've gone through for the last couple of years.
Q. Has anybody described those lesions as being stellate other than you to your knowledge in this case?
A. I don't know. I don't think they have, but I don't know whether they -- I don't remember what was stated about the lesion on 1990. But certainly if they don't describe it as that, they would certainly describe it as an infiltrating lesion.
Q. If you look at what you consider to be the probable cancer lesion in the '89 films, do you know one way or another as to whether or not such a lesion has spread to the lymph nodes at that point?
A. No, sir.
Q. All right. Just something you can't tell?

itself, you can get a double density. I guess that's what you're talking about.
Q. What comments do you have with regard to positioning the patients in these films?
A. The positioning is adequate,
Q. Is it the same?
A, Well, in the second one, there is more of the breast on the craniocaudad view but only marginally. So I would say that they're essentially the same.
Q. Not the same is the answer to my question?
A. Of course, one can never position the breast exactly the same. If we wanted to determine if there's -- if a lesion is exactly the same lesion, we will -- oftentimes all we do is do another mammogram and -- because ordinarily you cannot get exactly the same projection in two separate examinations.
Q. Do you agree that most dilated ducts are non-specific findings and are due to a benign process?
A. Well, it's according to where they are. If you have one right up under the nipple, then the most common cause for that is intraductal papilloma. Those are usually benign up to a

there's a high incidence of metastasis to nodes.
Q. That is it will spread in the future?
A. No. It has already spread by the time it's a centimeter or more in size.
Q. All right, sir. And where did you get that information?
A. This is common from textbooks. I can't give you the specific one. I think that you can find this -- Let me see. I have a textbook that I have at my office which states this specifically, but I can't remember the name of the textbook right now. We have several.
Q. Do you see any dilated ducts?
A. No, sir.
Q. All right, sir. On any of the views in any of these mammograms?
A. No, sir.
Q. All right, sir. What is a fold area on a breast?
A. A what?
Q. Fold area.
A. Fold?
Q. Yes.
A. I guess that's where the breast is flexible like a balloon or something. But if it folds upon

to be deposed before you?
A. No. I believe Dr. Lane is an oncologist, isn't he? Is he at Baylor?
Q. Yes, sir.
A. I think I've heard of him from being over there. I think he's a professor. That's generally what I know. I don't know him personally.
Q. All right, sir. Do you understand that he enjoys a good reputation as a physician?
A. Yes, sir.
Q. All right, sir. It is my understanding from listening to portions of his deposition given today that he has made a charge of $400 per hour for some of the work that he's done and indeed some of the work that he may do in this case will be at the rate of $600 per hour.
A. Yes, sir.
Q. Do you find any fault with those charges?
A. No. I just learned something from them though.
Q. And it's my understanding, Doctor, that you've not reviewed any materials other than what you told me about. Is that right?
A. No, sir. Not for this case.
Q. Obviously that's what I meant.
Okay. I don't have anything else right

point. And if those show up as a nodule, you might pay attention to them. However, they're usually very sharply demarcated and benign, recognize them as being benign because they lead right up to the nipple.

Q. Has Mr. Onstad asked you to do anything in this case that you have not done already?

A. No.

Q. Have you done everything he has asked you to do to date?

A, Yes, sir.

Q. Has he visited with *you* about *the* possibility of any future assignments that he might give you on this case?

A. No, sir,

Q. Has he asked *you* whether or not you'd be available to come to Texarkana to testify at trial?

A. Yes, sir.

Q. You have indicated that you can?

A. Yes, sir.

Q. So long as he pays you?

A. Yes, sir,

Q. All right, Do you know Dr. Lane professionally, either actually or by reputation, that was here

now. Thank you very much.
I assume, perhaps I ought not to -- I ought just to come right out and ask you: Do you believe that I have been polite with you today?
A. Absolutely.
Q. Have I given *you* a fair opportunity in your judgment to answer the questions that I've put to you?
A. Yes, sir.
Q. Do you feel a need to change any of your testimony or are you willing to stick with what you said?
A. Yes. I might still think of one more thing, but -- I would certainly let you know ahead of time.
Q. I understand what you're saying is you want to reserve the right to add something to your answers?
A. Yes, sir.
Q. But are you willing to stick with what you've said?
A. Yes, sir.
MR. BARKER: All right, sir. That's all I've got. Thank you very much. I

appreciate *your* courtesy with me.

MR. ONSTAD: I Will reserve all of my questions until the time of trial.