IN THE CIRCUIT COURT OF HARRISON COUNTY
WEST VIRGINIA

- - -

KRISTEL F. COWAN, Executrix:
For the Estate of DENNIS :
MONROE COWAN and
Individually as the wife of:
the decedent,
Plaintiff,

vs.

AHMED HUSARI, M.D., et al.,:
Defendants. : NO 98-C-554-2

- - -

THURSDAY, AUGUST 31, 2000

- - -

Oral deposition of SCOTT MANAKER, M.D., Ph.D., taken on behalf of the Plaintiff, held in the offices of Capital Court Reporting at 1321 Arch Street, 6th Floor, Philadelphia, Pennsylvania 19107, commencing at 3:50 p.m. on the above date, before Celeste E. Gazzara, a Court Reporter and Notary Public.

CAPITAL COURT REPORTING
1321 Arch Street
6th Floor
Philadelphia, Pennsylvania 19107
(215) 636-9800

A P P E A R A N C E S:

BY: MICHAEL M. DJORDJEVIC, ESQUIRE
17 South Main Street
Suite 201 at Maiden Lane
Akron, Ohio 44308
(330) 376-6766
Counsel for Plaintiff

BY: CATHRYN N. LOUCAS, ESQUIRE
1307 Ontario Street, Suite 1700
Cleveland, Ohio 44113
(216) 622-1234
Counsel for the Plaintiff

FLAHERTY, SENSABAUGH & BONASSO, P.L.L.C.
BY: STEPHEN R. BROOKS, ESQUIRE
7000 Hampton Center, Suite 1
Morgantown, West Virginia 26505
(304) 598-0788
Counsel for Defendant, Ahmed Husari, M.D.

- - -

I N D E X

- - -

E X H I B I T S

- - -

- - -

PROCEEDINGS

- - -

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

- - -

E X A M I N A T I O N

- - -

MR. DJORDJEVIC: Michael Djordjevic on the record for the Plaintiffs in this case, It is a few minutes before 4:00 p.m. on August the 31st, 2000.

This depcsition of Dr. Manaker was originally scheduled to begin at 1:30 this afternoon. And unfortunately, apparently Mr. Brooks had some problems with connecting flights and had been delayed by about two and a half hours.

We have no problem in commencing the deposition at 4:00 as opposed to 1:30. Unfortunately, both Ms. Loucas and I must leave Philadelphia today tonight. The last flight out

of here is a little after 7:00.

So, we're going to have to adjourn at 6:30 at the latest this afternoon. We would reserve our right to reconvene the deposition if we don't finish today at a mutually agreeable time and place in the future.

And the only reason for that necessity to reconvene is the late start today.

MR. BROOKS: I agree with that.

MR. DJORDJEVIC: That being the case, why don't you swear the witness.

- - -

SCOTT MANAKER, M.D., Ph.D., after having been first duly sworn, was examined and testified as follows:

- - -

E X A M I N A T I O N

- - -

BY MR. DJORDJEVIC:

Q. Dr. Manaker, you heard my name is Mike Djordjevic. I introduced myself to you briefly before the deposition here this afternoon.

What I am going to be doing here this afternoon is to ask you some questions under oath as if

on Cross-Examination.

My questioning isn't designed to trick you in any way. You have been identified as an expert in this case. And by virtue of the rules of procedure, I am entitled to discover what your opinions are, what the basis of your opinions are in this case together with the training, education and experience that enable you to draw those opinions.

I am going to ask that you follow two simple rules during the course of deposition.

First, we need all of your answers to my questions to be verbal and out loud. The court reporter can't take down an uh-uh or an uh-huh or a yeah or a nah. So, please speak up.

Secondly, let me tell you that we all work under the premise in these proceedings that if I pose a question and you answer the question that you understood the question, gave the best possible reply.

So, if you are confused by any question, if you don't understand it, don't guess at it. Stop me. I will rephrase it. It's important that we communicate.

Fair enough?

A. Very fair.

Q. All right. Doctor, why don't you start by stating your full name and spelling your last name for the record, please?

A. Sure. It's Scott Manaker, M-A-N-A-K-E-R.

Q. And your Social Security Number, Doctor?

A. Is 081-54-8449.

Q. And your date of birth, Doctor?

A. 8/23/60,

Q. Okay. Doctor, I have had the opportunit to just examine very briefly your CV dated August of 2000. I have been provided with a previous CV dated April of 1998.

Can you tell me what addition or changes there have been between April of '98 and August of 2000, please?

A. Without doing a line by line comparison?

Q. Sure.

A. I am not quite sure, but I would say the general and most important features over the past two years are I have been promoted academically. I am now an associate professor of medicine in pharmacology.

I have been promoted administratively to first associate chair. And I am now the interim vice chair of the department of medicine at the University

of Pennsylvania for clinical affairs and for quality.

Other salient differences since 1998 would be the winning of a teaching award in 1998 for bringing basic science to the clinical bedside. That would be the Leonard Berwick Memorial Teaching Award.

And since 1998 I have continued probably all of my professional societies and committee work as listed on the document you previously had.

Q. All right.

A. I have continued to serve on a number of, increasing number of hospital and health system committees, especially focusing on quality improvement programs and also given many, many talks on a variety of clinical and administrative topics.

Q. And we'll discuss that a little bit more in detail as we go.

Also, just on the front page of your CV apparently you have changed both your home address and your office address?

A. Yes.

Q. Between '98 and the present time; is that correct?

A. Yes. I was speaking with Ms. Loucas about that earlier. I have changed home residence when our

children were born and I changed academic administrative offices with my promotions.

Q. Doctor, have you ever submitted to deposition before today's date?

A. Yes.

- - -

(Whereupon, a Curriculum Vitae was marked PX-1 for identification by the Court Reporter.)

- - -

BY MR. DJORDJEVIC:

Q. And before we discuss that, Doctor, let me show you what's been marked as Plaintiff's Exhibit-1 and see if you can identify that on the record for us on the record?

A. Yes. That looks like one of the copies of my CV dated August 2000.

Q. That would be the most complete and up-to-date current CV that you have?

A. Yes. That would be the most complete one. There may very well be another one dated August floating around from earlier in the month.

My secretary usually updates it on average once a month, sometimes twice depending on the volume of things changing.

Q. Okay. Going back to what I had started to ask you about, you have had your deposition taken in the past?

A. Yes.

Q. And can you give me an idea of how many times that's happened?

A. I could give you a range. Somewheres on the order of two to eight times a year depending on the year.

Q. Over what length of time?

A. Since I was appointed to the faculty. It took me a couple of years to really establish a practice and see enough patients that people would be interested in what my opinions were.

So, probably starting since 1992 to 1994 I would say.

Q. All right. So, from 1992 to 1994 until the present date, you have testified by way of deposition two to eight times a year?

A. Something like that.

Q. And if my math is correct, that would be a minimum of 6 to a maximum of 64 depositions, something on that order?

A. Yeah. If you were going to multiply it up I

would say --

Q. I guess 12?

A. On the lower end than 64. Probably somewheres in the 30 to 50 range.

Q. All right. And can you tell me in which context you have given deposition testimony in the past?

A. Sure. Either deposition or Affidavits or live testimony. It covers a range of things from malpractice work, both plaintiffs and defense; disability work plaintiffs and defense, and even as an expert on clinical trials in some securities fraud cases.

Q. Let's see if we can break that down a little bit.

You have testified in other medical

A. Yes.

Q. Besides the present one; is that right?

A. Yes.

Q. Can you give me your best estimate, and I appreciate it's only an estimate, as to how many other medical malpractice cases you have testified in?

A. To be honest I have no idea what the relative

range would be among the three.

Q. So, it would be in the range of you couldn't even guess?

A. If you said roughly a third for each it probably wouldn't be too far off from truth.

Q. So, roughly a third as an expert in medical malpractice cases; correct?

A. Yeah. Maybe a little less than a third for clinical and a little more than a third for the other two.

Q. When you say for clinical, what do you mean by clinical?

A, I meant as an expert regarding clinical trials and the conduction of conductive research.

Q. And what was the third category that you discussed with me? We've got medical malpractice --

A. Disability and clinical trials.

Q. And roughly a third for disability hearings of some sort?

A. Right.

Q. Do you know how it is that attorneys became aware of your availability to review cases for medical malpractice or for clinical trials or for disability?

A. A variety of sources. Sometimes it's because

I'd seen the patient in the context of clinical care. Sometimes it's because they found me hunting around talking to friends, colleagues, neighbors, acquaintances.

Sometimes they found me by hearing of my testimony or presentation at other trials or depositions, but again by word of mouth.

Q. Have you ever or do you currently advertise your availability as a potential expert witness?

A. I do not advertise.

Q. Have you ever in the past?

A. I have not advertised.

Q. And that would go all the way back to 1992, you have never listed your name with an expert service?

A. I am listed with a couple of services.

Q. All right. Which services are you listed with?

A. I think I am listed with Expert Resources.

Q. And where is that from?

A. In Illinois in a suburb of Chicago. I think they are in Peoria.

Q. Any other services that you are listed with?

A. I believe I am also listed with Med Quest in New York

Q. All right. Is that Dr. Lerner's service by any chance?

A. I believe that's right.

Q. And how did it come to pass that you became listed with Expert Resources in Chicago and Med Quest in New York?

A. One of my colleagues recommended Expert Resources and I -- and gave me some information about them. And so, I sent my CV into them.

Med Quest was a referral of a friend. It turns out one of the medical residents at the hospital one of my trainees was a college friend, and perhaps it was Dr. Lerner or somebody else associated with Med Quest, and was looking for individuals who would be interested and solicited me.

I said, sure. I am always happy to hear about cases, see patients.

Q. All right. And have you gotten cases for review as a consequence of your being a party to these referral sources?

A. Yes.

Q. Can you give me an estimate as to how many cases you have reviewed as a consequence of being associated with Expert Resources in Chicago or Peoria?

A. I would say to the best of my recollection it would be less than five or six from each.

Q. All right. And would those all be medical malpractice cases?

A. All of those cases were medical malpractice for plaintiffs,

Q. And those cases were all cases that you reviewed for plaintiffs? Am I understanding you correctly?

A. Yes.

Q. Do you recall any of the issues involved in any of the cases that you reviewed for plaintiffs from either Expert Resources or Med Quest in New York?

A. It depends what you mean by issues. I am not sure your use of the word issues would be my use of the words issues.

Q. Let's start about medical issues?

A. You mean medical problems, medical diagnoses and conditions?

Q. Sure. That's fine. I can live with that.

A. Okay. Pneumonia, pulmonary emboli, plural effusions. It's been many years.

To the best of my recollection that would kind of be the range.

Q. Now, in the cases that you reviewed from the services that we're discussing on behalf of plaintiffs, did you find merit in those cases or not find merit in those cases?

A. Yes.

Q. Which is it? You yes --

A. Some of them I found merit and some of them I didn't find merit.

Q. And what was the breakdown between mer tless cases and meritorious cases?

A. Probably 50/50. Again, I am roughly speaking.

Q. Now, how do the cases come to you from one of these referral sources? Does someone from the corporate office contact you?

A. Yes.

Q. And then what's the next step?

A. They ask if I am still interested in reviewing cases and I say yes or no.

Q. All right.

A. And then they say, do you mind if we contact such and such an attorney, such and such a firm? And I say, no, unless there is some reason I wouldn't want them to be contacting me.

And then they gave me a call at home, tell me a little bit about the case and send me the records.

Q. Then do you make a contract or a deal for your charges with the attorney directly, or is that in some way --

A. It goes through the services.

Q. So, the services have a standard charge? Is that how it works?

A. I tell them what my charges are.

Q. And does a check then come to you from the lawyer or the law firm, or does it come to you from the referral corporation be it Expert Resources or Med Quest?

A. It comes from the corporation.

Q. And do you know what those corporations charge for their services to lawyers?

A. I do not.

Q. Do you currently have any cases that you are working on for either Expert Resources or Med Quest?

A. What do you mean by working on?

Q. That you are reviewing, that you are in the process of formulating opinions on, that you have testified by deposition for already, waiting to --

A. Well, that's now three questions.

Q. I am trying to give you a definition of what I mean. Any of those would qualify as working on?

A. There are none that I am currently working on reviewing. There are none that I am scheduled to testify for, There are one, maybe two that 1 have issued reports that have been out there for years and are as best I know still pending. I haven't heard for years.

Q. So, there are one or two cases that are outstanding? Is that a fair way of putting it?

A. Yeah. Outstanding would be a reasonable way of describing it.

Q. And are those outstanding cases here in Pennsylvania or in other states?

A. Other states.

Q. Do you receive -- would it be fair for ne to say you received cases to look at from these referral sources from all over the country?

A. Yes.

Q. And do you testify all over the country as well?

A. I have not needed to, but I would be willing.

Q. Now, in addition to obtaining cases from referral sources, you said that you obtained a

percentage of the cases that you review in the context of medical malpractice litigation from word of mouth or for reasons that you don't really know how the attorneys get your name.

Is that fair?

A. Yes.

Q. And of the medical malpractice cases that we're talking about, what percentage of those would you say come from the referring corporations and what percentage come by means of some other mechanism?

A. Probably a quarter -- let's see. I don't know.

Q. Well, let's ask it this way. Would more of the cases, again limiting ourselves to the context of medical malpractice, would more of the medical malpractice cases come from referral corporations like Expert Resources and Med Quest or would more come by other mechanisms?

A. More would come by other mechanism.

Q. Do you know how it is that Mr. Brooks came to get your name in this case?

A. Yes. Mr. Brooks got my name from several of his colleagues at their firm, Flaherty, Sensabaugh and Bonasso.

Q. And do you know how it is that Mr. Brooks' colleagues at the Flaherty law firm knew of you and your ability to review medical/legal cases?

A. Yes. I was asked to review a case for another firm in West Virginia. That other firm and Flaherty, Sensabaugh and Bonasso were each defending different defendants in that matter.

And so, I met one of Mr. Brooks' former colleagues at that time.

Q. I see. As a codefendant?

A. Yes.

Q. Or as an attorney for a codefendant?

A. No. He was an attorney for codefendant.

Q. And what was the outcome of that particular case, do you recall?

A. I believe it was a defense verdict.

Q. And you offered testimony in that case on behalf of a pulmonologist or some other specialist?

A. I believe it was a family practitioner.

Q. So, we know that on one occasion you offered expert testimony on behalf of a family practitioner; correct?

A. Yes.

Q. I presume that in other cases you have

offered expert testimony on behalf of pulmonologists?

A. Yes.

Q. Have you offered expert testimony on behalf of internists in the past?

A. Yes.

Q. Have you offered expert testimony on behalf of critical care physicians in the past?

A. Yes. Recognizing that there is substantial overlap between critical care and several of the specialties you have previously mentioned.

Q. Have you offered expert testimony on behalf of emergency physicians in the past?

A. I may have. I don't recall.

Q. All right. You do recall family practice, pulmonology, internal medicine, critical care.

What other subspecialties or specialties of medicine do you recall offering testimony on in the past?

A. Surgery or surgical subspecialties when it overlapped with areas within my field of expertise.

Q. *Any* others?

A. Not off the top of my head, but I wouldn't exclude it.

Q. How about radiology?

A. I would say that radiology is an important subset of my field and that in cases that I have reviewed and testified for radiologists have been involved as codefendants.

I don't recall specifically being asked to speak on behalf of the radiologist, but, of course, there would be overlap.

Q. Let me see if I can make my question a little more focused and narrow and it might be easier for you to answer.

Have you in the past rendered standard of care opinions relative to standard of care to be followed by radiologists?

A. No.

Q. Do you intend to do so in this case?

A. I would not be able to speak to -- well, I would not be able to speak to the standard of care for radiologists.

I would be able to speak to my expectations of my expectations from radiologists in the field of medicine that I practice.

Q. As consulting physicians?

A. Correct.

Q. All right. So you and **I** can agree and **I** can

safely go back to Northeast Ohio this evening, assuming we get out of here, with the understanding that you will not be offering standard of care opinions concerning any radiologists in this case?

A. Correct.

MR. BROOKS: And I will reinforce that, Michael.

MR. DJORDJEVIC: All right.

MR. BROOKS: He will be offering standard of care testimony only with regard to Dr. Husari.

MR. DJORDJEVIC: Very good.

BY MR. DJORDJEVIC:

Q. Okay. Now, in addition to medical malpractice litigation you had been involved in clinical trials testimony; is that right?

You have got to verbalize for the court reporter.

A. Yes.

Q. And can you explain to me a little bit about what your involvement is in this clinical trials?

A. Certainly. There were aspects of clinical trials, clinical research trials for development of new products that would raise certain questions among plaintiffs attorneys.

They asked me to review the data, be it basic research data or clinical data, and comment on the structure of the trial or the experiments, the validity of the data, the validity of the data interpretations, the conclusions that could be drawn and whether or not statements made by various individuals were or were not supported by the scientific data.

Q. These, as I understand it, clinical trials involve the marketing of pharmaceutical products? Am I understanding you correctly?

A. I would say with the ultimate goal. Some of the issues that I have been asked to look at did not relate to trials that had made their way to clinical development. They were still in the animal phase

Q. Are there any particular products that you were involved with, generic names or --

A. Yes. One would be Centoxin, C-E-N-T-0-X-I-N. The product which, in fact, was never -- was ultimately never approved.

Q. And you were hired by whom in that particular matter to review the clinical trial data?

A. The name of the attorney?

Q. Well, why don't you explain to me, first of all, what the interest was of the party who hired you

in that situation?

A. Plaintiff.

Q. All right. And what was the plaintiffs objection to the Centoxin medication?

A. I don't think they objected to the medication. I think their objection was to statements issued by officers of the company in regard to the validity or utility of the product and the interpretation of the clinical trials stemming from trying to get the product to market.

Q. And which company was that that was attempting to get Centoxin to market?

A. At the time it was Centocor, C-E-N-T-0-C-0-R.

Q. And where was this particular litigation filed? Where was it pending?

A. It was filed in federal court and I don't know.

Q. There's lots of federal courts. Can you help me with a little more specificity?

A. I honestly can't tell you which district federal court it would have been.

Q. Was the plaintiff in the Centoxin matter a corporation or an individual?

A. Corporation.

Q. And which corporation was that?
A. Centocor.
Q. So, Centocor was the plaintiff?
A. I am sorry, Centocor was the defendant.
Q. That's what I thought. Who was --
A. I am sorry. I obviously misunderstood the question
Q. That's fine. And please, if it becomes obvious to you that we're not communicating as I told, stop me and we'll try and re-connect.
Who was the plaintiff in the case?
A. It was a class action suit. So, I imagine there were a class of plaintiffs.
Q. All right. And do you recall who plaintiffs counsel was in that case?
A. The woman who asked me to review the records was an attorney named Carol Broderick, B-R-O-D-E-R-I-C-K.
Q. And where is Attorney Broderick from?
A. She is here in Philadelphia. And the name of her firm is Berger, B-E-R-G-E-R, Montague, M-O-N-T-A-G-U-E.
Q. Other than the Centoxin case or litigation that we've discussed, do you recall any of the other

cases that you have reviewed in the clinical trial aspect of your previous history of testifying?

A. I am sorry, do I recall --

Q. Do you recall any of the other matters that you reviewed in the subset of cases that you reviewed dealing with clinical trials testimony?

A. Yes.

Q. And what else, what other cases or issues do you recall?

A. There was another similar case for another product.

Q. All right. Do you recall which product that was?

A. It was the Interleukin-1. Would you like me to spell Interleukin? I-N-T-E-R-L-E-U-K-I-N, hyphen, 1. Receptor antagonist.

Q. And on whose behalf did you review the matter involving Interleukin-1 inceptor antagonist?

A. The class of plaintiffs.

Q. And what was the substance of your testimony or your opinion in that matter?

A. I don't recall the specific details at this time. But once again, had to do with whether or not the trials were properly conducted and the conclusions

drawn from the data were appropriate and consonant with statements by officers of the company,

Q. And it was your opinion that the data were not valid, is that --

A. I forget what exactly my opinions were, but it would suffice to say that the data obtained somewheres along the line downstream did not match up with either the conclusions drawn at the time or the statements made by officers of the company.

Q. Any other cases or matters that you can recollect specific regarding in talking about the subset of your testimony dealing with clinical trials?

A. Not off the top of my head.

Q. And as I understand it, the third area in which you offer testimony is in the area of disability?

A. *Yes.*

Q. All right. And can you tell me about that? In which contexts do you offer disability testimony?

A. Sure. Sometimes it's following my providing clinical care for a patient. My evaluations and care of them come to light and an attorney will ask me to speak either on behalf of them or against the concept of disability compensation.

Q. So, patients are sent to you for a

medical/legal examination? Is that --

A. That would be the second group. The first group would be patients that I am just seeing for routine care. They come to me for clinical care, other physicians send them to me for a consultation.

I might care for them in the course of their hospitalization and then at some future point, be it months or more commonly I guess years later, someone decided that I might be an appropriate individual to speak either for or against the concept of disability compensation.

Q. So, your testimony in that case in part of the disability subset of matters that you review would be incidental to your pre-existing doctor/patient relationship?

A. Correct.

Q. There is another subset of the subset in which attorneys or other entities send you patients for evaluation, either for defense medical examinations or for plaintiffs medical examinations. Is that fair?

A. Correct. I see patients and provide a disability evaluation either for plaintiffs or defendants.

Q. And where do you conduct those examinations,

Doctor?

A. Those are done at the hospital.

Q. And what would be the breakdown, again, I understand we're dealing in rough numbers, between examinations conducted at the request of plaintiffs attorneys versus examinations conducted at the request of defense attorneys?

A. I would say it is more common at the request of defense than plaintiffs.

Q. And are these disability determinations made for Social Security, for governmental agencies of that nature by and large, or for other private insurers, or don't you know?

A. To be honest, I wouldn't know. I would suspect it's more common for Social Security disability, but I know that there are clearly for other disability policies by private insurers as well.

So, I could not give you the breakdown.

Q. And when is the last time that you performed a disability examination that originated from an attorney, be it a plaintiffs lawyer or a defense lawyer?

A. I would say I did one in July.

Q. Last month?

A. Yes.

Q. Would you see those with some -- would you see individuals whom you would examine with the purpose of determining disability on a regular basis?

A. Yes.

Q. One a month on average? Is that fair?

A, I would say for disability purposes not even one every two or three months. It's a fairly uncommon.

Q. Now, Doctor, you've in discussing your current Curriculum Vitae with me pointed out that you have had a promotion in academic rank between 1998 and the present time; is that right?

A. Yes.

Q. And what is your current academic rank?

A. Associate professor.

Q. And you hold that rank with which institution?

A. The University of Pennsylvania.

Q. Is that rank held with the medical school of the University of Pennsylvania or the University of Pennsylvania itself?

A. I think the answer is yes to both of those entities.

Q. So, you hold associate professorship with the

University of Pennsylvania and with the medical school?

A. Yes.

Q. I guess the question -- and I have reviewed your previous CV. I know that you are an M.D., Ph.D.

Do you teach both in the medical college and in graduate school of biology at the University of Pennsylvania?

A. I do not presently teach in the Graduate Hospital of Liberal Arts, what they call the school of Arts and Sciences where the department of biology is.

Although, what I imagine you are referring to is that my Ph.D. Was given from the biology department.

Q. That's correct.

A. Yeah.

Q. Have you been in the past taught the pure science aspect of the biology as opposed to teaching medical students in terms of residents?

A. Not formally. I am trying to remember if I have ever been asked to give an ad hoc lecture in biology and I would say no.

I have given basic science lectures in the pharmacology department, but that would be a basic science department in the medical school, not the school or Arts and Sciences.

Q. You're currently involved in didactic lecture of medical students at the medical school affiliated with the University of Pennsylvania?

A. I am,

Q. And do you teach certain courses at the medical college?

A. I did. I just gave up supervising the entire respiratory module this year because of my other academic and administrative duties.

Q. All right. Are you currently still involved in .didactic lecturing of medical students --

A. Yes.

Q. -- on an ongoing basis? Can you give me an idea of topics that you lecture on, Doctor?

A. Sure. I lecture on tuberculosis, on tuberculosis skin testing PPD, sepsis, control of breathing, sometimes pulmonary function testing.

Q. Anything else?

A. Off the top of my head that's it. Those would be formal lectures that I am asked to give at various times.

It would be lots *of* informal lectures in the course of teaching rounds at the hospital where both medical students and house staff, meaning interns and

residents in internal medicine, as well as rotating residents from other specialties and fellows in pulmonary and critical care.

Q. In the classroom, however, you teach primarily about tuberculosis, tuberculosis skin testing, pulmonary function testing and what else did you say? Did I cover them all?

A. Did you get the control of breathing.

Q. No. That's the one I didn't get.

MR. BROOKS: He also said sepsis.

THE WITNESS: Sepsis.

BY MR. DJORDJEVIC:

Q. I am sorry.

A. And then in addition as the coordinator or leader of what you used to be the pulmonary pathophysiology course and then the subsequent redesigned curriculum of the entire respiratory module, I would teach in a normal classroom setting on a much broader range of topics depending on who didn't show up this for this small group session.

I would kind of be responsible for knowing and picking up.

Q. You're using a team that clearly has meaning to you. I don't know that it has any meaning to me,

respiratory module.

What do you mean by that?

A. Through 1997 the medical school curriculum at the University of Pennsylvania was divided up along classic disciplines where students took individual courses in biochemistry, genetics, physiology, pharmacology, and pathophysiology.

I apologize if I am going too fast for you.

In approximately 1997 the curriculum was redesigned and entitled curriculum 2000 using a model very similar to Case Western Reserve and Harvard where all of the didactic material was divided up not along classic scientific disciplines, but along cording structures.

So, rather than a year to two years of disciplinary basic sciences, the students received a rapid six-month introduction to general principals. And then for the next year to year and a half they received all of the individual disciplines chopped up along the teams of individual organs.

So, first, for example, they would get brain and behavior. They'd get the anatomy of the brain, the spinal cord, the physiology, the pharmacology, the pathology and the pathophysiology including some basic

introductions to clinical neurology and clinical psychiatry.

Then they would move on to the next organ say the heart. They would have the basic anatomy of the heart.

Q. 1 think I follow.

A. Followed by histology, by chemistry and so forth.

So, I went from running the pathophysiology course in the old-style curriculum to running the entire respiratory module for all of the disciplines.

Q. So, in terms of your professional time, a percentage of your professional time is consumed by your teaching responsibilities? Fair?

A. It was. I had to markedly reduce that because *of* my other administrative responsibilities.

Q. What currently would you say the percentage of your professional time devoted to teaching would be?

A. Less than five percent with the caveat that when I am on clinical service rotating in the intensive care unit, the pulmonary consults of the advanced lung disease service or even in the outpatient practice, much of the clinical care that I render is done simultaneously with clinical teaching.

Q. Now, in addition to teaching you said that a larger portion of your professional day is now devoted to administrative chores. Is that --

A. Yes.

Q. Am I understanding you correctly?

A. Yes.

Q. What type of administrative chores occupy your time currently?

A. As the interim vice chair I am responsible for overseeing aspects of the credentialing and enrollment process.

MS. LOUCAS: I am sorry, what process?

THE WITNESS: Credentialing and enrollment. Some physicians have to be appropriately credentialed by the hospital, appropriately licensures.

They have to be enrolled with Medicare or other insurers and the proper payments to be made by oversight of much of the practice, some aspects of the practice, operations.

I am also responsible for quality improvement within the department of medicine.

BY MR. DJORDJEVIC:

Q. And what percent of your professional time do

those administrative tasks occupy?

A. At this time it's about 50 percent.

Q. All right. And if my math is correct, that would leave you with about 45 percent for active clinical practice?

A. It's more like 50/50 or -- greater than 47.5 and greater than 47.5 and that leaves you less than five percent for your normal didactic classroom teaching as we have been describing.

Q. So that the record is clear, somewhere around 47.5 percent is for administration, somewhere about 47.5 is for active clinical practice, somewhere about five percent is for didactic teaching?

A. Roughly.

Q. Is that a fair way of putting it?

A. Plus or minus a few percent that would be a reasonable representation.

Q. Now, Doctor, do you maintain any type of an office practice?

A. Yes.

Q. Describe for me the kind of office practice that you have?

A. I am one of the 30 physicians, 30 attending physicians in the pulmonary and critical care

division.

We have a group practice ourselves which is a subset of the group practice in the department of medicine which is a subset of the group practice of the University of Pennsylvania.

Q. Is the pulmonary practice group, can we call it that?

A. Sure, or the pulmonary division.

Q. Is the pulmonary division a corporation of some sort?

A. No.

Q. Are you employed by anyone when you are seeing patients?

A. Yes.

Q. By whom are you employed?

A. The clinical practices of the University of Pennsylvania.

Q. So, would it be fair for me to say that you are an employee of the University of Pennsylvania?

A. Yes.

Q. Would it be fair for me to say that you are not in private practice?

A. Yes.

Q. Have you ever been in private practice?

A. No.

Q. And as a consequence of being employed by the University of Pennsylvania, I take it that you see patients of the University of Pennsylvania?'

A. I am not sure I understand the question.

Q. Well, do people, do patients come to you because they want to see Dr. Manaker, or do they come to you because they are aware of the pulmonary division of the University of Pennsylvania, or is there some element of both?

A. Both, and many other means. They come because they've heard of me, they come because they've heard of the division, the department of the hospital, the institution University of Pennsylvania, they come because they've been recommended, they find us off the internet, they find things we have written or spoken about.

Q. Now, in reviewing your old Curriculum Vitae it's become clear to me that you're board certified in three areas; internal medicine, pulmonary medicine and critical care?

A, Yes.

Q. As between those three areas, how do you split your time?

A. Of my clinical work I would say probably 50 percent is critical care and 50 percent is pulmonary medicine.

Q. So, on the typical day, your average week, you would spend 50 percent of your time in critical care medicine and 50 percent of your time in pulmonary medicine?

A. No. It would depend on what week it was. Some weeks would be devoted to more pulmonary medicine, other weeks would be devoted toward more critical care recognizing that many weeks there would be substantial overlap.

But in general, it's going to be one or the other.

Q. So, if we wanted to get to the 50/50 breakdown, we'd expand our time horizon if you analyzed a given year it would probably work out --

A. 20-odd percent critical care, 20-odd percent pulmonary disease recognizing again that there is overlap between the two.

Q. You said 20-odd percent. Do you mean 50 percent of the active clinical practice?

A. Of the 47.5 roughly speaking that we were talking about, something greater than 20 percent would

be in the pulmonary portion. Something greater than 20 percent would be in the critical care recognizing that these are very roughly approximations that I am making off the top of my head and there is substantial overlap between pulmonary and critical care.

Q. You and I can agree, and again we're speaking roughly, and I understand that, that about one-fifth of your professional time currently you devote to pulmonary practice?

Is that a fair way of putting it?

A: No.

Q. Okay. What's -- where did I go wrong?

A, I would say that for my practice there is really a continuum between pulmonary and critical care. And it would not be fair to say that it was only 20 percent pulmonary of the 47.5 percent that we agreed upon earlier.

It could be as much as 40 or 45 percent could be interpreted as within a spectrum of pulmonary disease and probably 30 to 40 percent could be in terms of in the spectrum of critical care depending on how you wanted to define it.

That's what I was trying to describe earlier when I said there is really substantial overlap between

the two specialties.

Q. Let's see if we can hit upon something that you will agree is fair.

We can agree, can't we, Doctor, that the bulk of your time, more than 50 percent of your time, is isn't spent -- more than 50 percent of your professional time is spent in areas other than pulmonary medicine; right?

A. Yes. And I would make that statement -- I would agree with that statement based on something less than 50 percent administrative and a small percent teaching.

Q. I am not trying to break it down, but we can agree using broad strokes that less than half your professional time is spent in the practice of pulmonary medicine; right?

A. Yes.

Q. Okay. Now, are you, for example, assigned as an attending to an intensive care unit from time to time? Is that how you get involved with the critical care aspect of your practice?

A. Yes.

Q. Do you attend at a certain intensive care unit, a surgical intensive care unit, a cardiology

intensive care unit, or do you float amongst various ICUs?

A. It's primarily -- well, how can I answer that?

My primary assignment when I'm assigned to the medical intensive care unit is to see patients there.

In the context of covering our group practice, serving as a pulmonary consult attending, I frequently see patients in the cardiac unit, the surgical unit and the neurology unit.

Q. So, it is not uncommon for you to see patients as an attending in any of a number of intensive care units?

A. Yes.

Q. At the hospital? And are you involved in an intensive care rotation now, or are you on pulmonary part of your practice as we sit here today?

A. As we sit here today right now?

Q. What are you doing as we sit here today?

A. Today was administrative time.

Q. Let's expand the horizon from today to this week.

Are you this week on an ICU rotation or a

pulmonary practice rotation?

A, This week I am doing pulmonary. So, I have my three half days of outpatients.

Q. Do you have any patients admitted to the hospital as we speak?

A. No.

Q. Do you generally have patients that you're attending as the admitting physician in-house at the hospital?

A. When I am on service.

Q. And when is the last time you were on service?

A. July.

Q. Last month?

A. Yes.

Q. And last month, how many patients would you have admitted on the pulmonology floor that you were serving as the attending to?

A. Do you mean at any given day on average?

Q. On average?

A. Or over the course of rotation?

Q. On average is fine?

A. Somewheres between 10 to 15 patients a day.

Q. You would be rounding 10 or 15 patients a day

last month?

A. Weekdays. More patients on the weekends when I would also cover the advanced lungs disease service.

Q. Now, Doctor, *you* have, I believe, established that you're board certified in internal medicine, pulmonology and critical care medicine.

Was it necessary for you to take any of the certification exams on more than one occasion for any of those?

A. No.

Q. ***So,*** in other words, you passed each of those on the first attempt?

A. Yes.

Q. Doctor, let's review your education a little bit. And thank you for providing your CV. That should shorten the process of that.

Apparently you obtained an M.D., Ph.D. from the University of Pennsylvania in 1985; is that right?

A. Yes.

Q. Was that as part of some kind of combined program?

A. Yes.

Q. Can you describe for me what that program involved? Is it a joint M.D., Ph.D. program?

A. Yes. I actually received an N.I.H. training award to obtain both degrees.

Q. And were you involved in laboratory research for the Ph.D. aspect of your degree at that point?

A. Yes.

Q. Tell me what kind of research you were involved in?

A. Basic neuroscience including neuropharmacology, neurochemistry and neuroanatomy.

Q. Your undergraduate degree was in neuroscience from the University of Pennsylvania as well?

A. Yes.

Q. And then in 1985 apparently you began your post-graduate education?

A. Yes.

Q. Is that correct? rind tell me what you did in PGY-1, please?

A. I was an intern in medicine at the Boston City Hospital.

Q. PGY-2?

A. I was a resident in medicine at the Boston City Hospital.

Q. PGY-3?

A. I was a fellow in pulmonary and critical care

medicine at the Hospital of the University of Pennsylvania.

Q. All right. PGY-4?

A. The same.

Q. PGY-5?

A. The same.

Q. PGY-6?

A. Assistant professor of medicine at the University of Pennsylvania.

Q. And would that be your last year of post-graduate education PGY-6, or is there a PGY-7?

A. Well, maybe I misunderstood what you meant by post-graduate year.

In 1990 was appointed to the faculty.

Q. Okay.

A. So, one interpretation of what you are saying is that my post-graduate education ended and I was appointed to the faculty. Another interpretation is one is always continuing to be a post-graduate student and continuing to learn and attending courses and so forth.

Q. It's the same in law, Doctor.

A. I am well familiar with CLE programs.

Q. I can assure you. Your formal training in

terms of your fellowship training ended in 1990?

A. Yes.

Q. And is there a particular reason why you chose to go into internal medicine with pulmonology and critical care medicine as opposed to neurology or something more having do with neuroscience?

A. Sure. Actually, applied and entered medical school with the intent of becoming a psychiatrist, but in medical school I found that I didn't enjoy the clinical practice of either psychiatry or neurology. I liked internal medicine.

So, I looked for a field in which I could combine my interests in how the brain controlled physiology and my interest in internal medicine. It seemed that pulmonary disease with control of breathing and with control of respiratory motor neurons seemed like a very natural path for me.

Much to my surprise, as much as everybody else's, when I started on the path of pulmonary and critical care training I found I enjoyed pneumonia, asthma, obstructive lung disease and lung cancer, as well as all the other aspects of pulmonary and critical care medicine.

So, ultimately it turned out to be a very

good fit.

Q. And in reviewing your publications, Doctor, I noticed you seem to have published substantially on septic shock and sepsis and neuromotor response of the lungs and chest.

Are those particular interests of yours?

A. I would say that anything I have written on reflected an interest of mine.

Q. I didn't notice any writings in your 1998 CV having to do with cancer or carcinoma of the lungs?

A: Correct.

Q. Are there any writings or any publications having to do with carcinoma of the lungs in the August 2000 CV?

A. I would say there is no primary peer review publications, nor are there any specific chapters on lung carcinoma.

I would say that lung cancer, lung nodules are probably referred to in many of the textbooks that I have edited.

Q. Let me ask if we can agree that you have authored no publications dealing specifically with the diagnosis of non-small cell lung carcinoma.

Would that be fair?

A. Correct.

Q. Would it be fair for me to say as well that you have authored no publications dealing specifically with the treatment for non-small cell lung carcinoma?

A. Correct.

Q. Again, in reviewing, and pardon me because I didn't have your August 2000 CV, but in reviewing the 1998 CV, I didn't know -- I didn't note, rather, any presentations dealing with the diagnosis of non-small cell lung carcinoma?

A. Correct.

Q. Are there any currently?

A. Not to my recollection.

Q. So, you have made in presentations dealing with the diagnosis of non-small lung carcinoma; am I right?

A. Correct.

Q. And you made no presentations dealing with the treatment of non-small cell lung carcinoma?

A. Correct.

Q. And again, in reviewing your previous Curriculum Vitae, I didn't note or I failed to note that you did any research of any sort dealing with the diagnosis of non-small cell carcinoma?

A. Correct.

Q. Is that true for the 2000 CV as well?

A. Yes, it is.

Q. And again, no research dealing with either the treatment or the diagnosis of non-small cell carcinoma; am I right?

A. Yes.

Q. Doctor, have **you** yourself been a party to litigation over the course of your career?

A. I don't understand the question.

Q. Have you been a party of a lawsuit, either been a plaintiff or a defendant?

A. Let me think for a minute. I have been. I am not sure actually if this is the correct answer to your question.

Regarding plaintiffs I was the victim, my car was the victim of tire slashings. So, in that sense I was the plaintiff testifying against the person that the police identified as the person who slashed the tires.

In terms of being a defendant in a lawsuit, I have been named in two suits to the best of my recollection.

Q. And would those be suits that arose in the

context of medical malpractice litigation?

A. Yes.

Q. Do you recall what the issues were in any of those cases?

A. Yes.

Q. Why don't you tell me about that?

A. Sure. In the first case it was a patient with chronic respiratory failure and who was ventilator dependent and cared for by many years by one of my colleagues.

And the patient and there family were not happy with the outcome of one of the hospital admissions and they sued my colleague.

After several months and some discussions the suit was dropped. I was named along with everybody else who had ever cared for the patient during that hospital admission.

Q. And that case was dismissed against you essentially I take it?

A. I don't know if it actually made it to the point of being dismissed. It was just withdrawn by the family.

Q. That was litigation pending here in Philadelphia County?

A. Yes.

Q. And there was a second case as well?

A. Yes.

Q. And what was that case involved?

A. That was a case of a gentleman with an unusual salivary gland tumor who I had seen and performed a bronchoscopy for hemoptysis.

I, along with every other physician who cared for him, was sued in a medical malpractice case. The case was dismissed on summary judgement.

Q. And that would be pending here in Pennsylvania?

A. I don't think it's pending. I think it's closed several years ago.

Q. That would have been pending in Philadelphia County as well?

A. Yes.

Q. And can you tell me which law firm represented you in those cases?

A. Something Christie, something and Parabue.

Q. That's close enough.

A. I am sorry. It's been several years. I haven't had any contact with them.

Q. And --

A. Morton -- hang on. Mortonson, Christie, something and Parabue, P-A-R-A-B-U-E.

Q. And I take both of those cases arose as consequence of patients that you were seeing while you were an employee of the University of Pennsylvania?

A. Yes.

Q. And the University of Pennsylvania, I take it, provided counsel for you in that case? Is that what happened?

A, Yes.

Q. And does the University of Pennsylvania provide medical malpractice insurance coverage for you as well?

A. Yes.

Q. Do you know who the carrier is by any chance? What the insurance company is?

A. I believe it's PMSLIC, P-M-S-L-I-C. Pennsylvania Medical Society, I guess, Liability Insurance Company.

Q. There is a lot of those in Akron.

A. Yeah. Right. I am not quite sure.

Q. Okay. Doctor, during the course of your career have you had occasion in your own practice to make the diagnosis of non-small cell lung cancer in

your own patients?

A. Yes.

Q. All right. And can you tell me how often you have done that?

And again, let's talk in rough numbers. I am not going to hold you to any specific figure.

A. Greater than a hundred and less than a thousand.

Q. And how have you done that in the past? How have you made the diagnosis of non-small cell lung carcinoma or cancer in the past?

A. 1 would say by obtaining appropriate tissue.

Q. And did something prompt you in those cases to obtain appropriate tissue?

A. Yes.

Q. What, if you would, so that there is no mystery between us, explain to me the sequence of events that would lead you in the course of your treatment of your patients to obtain a biopsy and determine that one of your patients had non-small cell lung carcinoma?

A. Let me try and do this in broad strokes Patients would present with a sign, a symptom, a complaint that would lead to the observation that

something was abnormal be it on physical examination, chest radiographs, be they routine chest x-rays or CT scans.

Sometimes the abnormality might be in a different organ from a metastasis. The appropriate diagnostic plan would be followed **to** get a piece of tissue and make the diagnosis.

Q. All right. **I** made a note in listening to your answer that on occasion, at least, you have launched a diagnostic workup culminating the diagnosis of non-small cell carcinoma as a result or as a consequence of something that you saw on a chest film?

A. Yes.

Q. Am I communicating?

A. Yes, we are.

Q. And with what frequency has that happened in your career where you have seen something on a cliest film that caused to you commence a diagnostic workup?

A. I couldn't begin to tell you.

Q. Has it happened more than a couple times?

A. Yes.

Q. And in the chest films that we're referring to in your own practice with your own patients, would the finding that you see on the chest film be what you

would describe as an incidental finding?

A. Sometimes. Sometimes it's not incidental because I have a good reason to go looking for it.

Q. So, sometimes you request or you 'order a chest film, the indication for the film being to rule in or rule out a lesion of some type in the lungs; is that right?

A. Yes.

Q. And sometimes you order the x-ray and as an incidental finding you see something that eventually turns out to be non-small cell lung cancer?

A. Right. Sometimes the x-ray is ordered for other purposes and it's an incidental finding. Sometimes it's not even a chest radiologic study. It's a study obtained for some other purposes and an abnormality is found within the chest.

An example would be an abdominal CT scan or a lumbar spine scan which will sometimes include cuts of the bases of the lungs and a nodule or mass would be found.

Q. Now, Doctor, once a diagnosis in your patient is made of non-small cell lung cancer, are you still involved in the treatment of that patient, or does that patient go see another specialist at that point?

A. Yes and yes. Yes, I am involved and yes, they will see other specialists.

Q. Explain both to me how are you involved and how does the patient go to see another specialist?

A. 1 am involved on -- I remain involved depending on whether or not the patient would like for me to be involved and I have something to offer.

Usually that's someone with concomitant pulmonary medical illnesses like coexistent asthma, bronchitis, emphysema and so forth.

Other specialists are involved depending on what the appropriate treatment is be it surgery, radiation therapy, chemotherapy.

Q. Can you and I agree, Doctor -- and I am trying to narrow the focus of the questions that I am going to have to continue with you.

Can you and I agree that you ordinarily do not treat patients who have been diagnosed with non-small cell lung cancer for their cancer? Those patients are ordinarily referred either to a medical or surgical oncologist or radiation oncologist? Is that fair?

A. No. I wouldn't characterize it that way. **I** would say all the physicians participating in the care

of that patient are caring for them.

If are you asking me do I perform surgery, I do not perform thoracic surgery. If are you asking me do I perform radiation therapy, I do not administer radiation therapy. If are you asking me do I administer chemotherapy, I do not administer chemotherapy for the purposes of treating lung cancer.

Q. Then explain to me if you would, and I will ask it very open-endedly, what you do in your practice to treat patients in your practice who have been diagnosed with non-small cell lung cancer?

What do you do to treat them?

A. It depends on the patient, it depends on their clinical course.

If they have other concomitant lung disease, I treat them for their lung disease while they are receiving their other treatment. If they are going for surgery, I will often provide ventilator management at the time of surgery and deal with any pulmonary complications

Similarly, I would deal with any pulmonary complications of either radiation therapy or chemotherapy.

I would deal with intercurrent respiratory

illnesses or pulmonary problems while they are receiving their other therapies.

Q. I might be misunderstanding you, and if I am, I am sure you will correct me.

It sounds to me what you are describing is that you will treat the patient for other situations that might be complications of the treatment that the patient is receiving for the lung cancer or other underlying respiratory or pulmonary problems that the patient has?

It doesn't sound to me in the description that you just gave me that you are actually treating the lung cancer itself?

Am I missing something, or am I understanding you correctly?

A. I would say I am not primarily treating the lung cancer itself. I would agree with that.

Q. You and I can agree, and it's fair for me to say that when the diagnosis in this case, we're limiting our discussion to non-small cell lung cancer, is made, the treatment for that particular disease entity is primarily the province of another specialist, and it might be any of the specialists that you have already talked about; right?

A. Yes. With the caveat that there are certain interventions that pulmonary physicians can do to primarily treat lung cancer usually of a palliative nature.

Q. And I would take it because of your qualifier of the palliative nature, those types of modalities are often or most likely offered to the patients who are in advanced stages of cancer?

A. Yes. Yeah. Examples would be photodynamic therapy, laser therapy, stint placement.

Q. **Now,** Doctor, would you consider yourself an expert in the area of diagnosis of non-small cell lung cancer?

A. I would say the diagnosis of non-small cell lung cancers within the realm of pulmonary and critical care medicine. And I am an expert in pulmonary ana critical care medicine.

Q. Do you consider yourself an expert in the treatment of patients who are afflicted with non-small cell lung cancer?

A. It depends on how you want *to* define treatment. If you define treatment narrowly as we just did, if you want to devote it specifically to treating the lung cancer, clearly that is within the realm of

other specialties.

If you say treating patients with lung cancer in the more broad description that we did a few moments ago, then, yes, the treatment of patients with lung cancers is within the field of pulmonary and critical care medicine.

Q. I am trying to get a handle on what you do, Doctor. And that's why I have to ask you these questions.

If a patient comes in and you follow a diagnostic workup that leads you to the conclusion that the patient is a stage one -- you are familiar with the international system for staging lung cancers?

A. I am.

Q. That, as I understand, that is developed by Drs. Mountain and Lipshitz and the M.V. Anderson?

A. I would say that it is an overstatement to say that those two physicians developed the staging system.

And I would say that many other physicians and many other individuals made substantial contributions to the development of the system.

Q. I don't want to make any overstatements. You are familiar with the international staging system,

let's put it this, that's described by Mountain and Lipshitz?

A. They among many have described the system.

Q. Just to make sure we're talking about the same staging system?

A. I think there is only one international staging system.

Q. Under that international staging system, have you on occasion made the diagnosis of a stage one cancer?

A. Yes.

Q. In that situation when you, by whatever workup you follow, arrive at the conclusion or arrive at a high level of suspicion that your patient has a stage one non-small cell carcinoma, do you refer that patient out to another specialty area?

A. Yes.

Q. To whom do you refer that patient?

A. It depends on the patient. I would say that the range would include thoracic surgery and radiation oncology and medical oncology.

Q. Do you make all those options available to the patient, or do you make a recommendation? What do you do?

A. I usually say that there are several choices including surgical therapy, radiation therapy or chemotherapy and I would make a recommendation.

But I usually try to inform the patient of all the various option and choices including the choice of doing nothing, which I usually harshly recommend against.

Q. For the stage one patient that you see, Doctor, do a certain percentage of your stage one non-small cell cancer patients have lung resections?

A. Yes. I would say the majority of patients with a stage one lung cancer non-small cell will ultimately go to a lung resection.

Q. And is it your understanding based on your experience with your own patients or based upon the literature as you understand it, that resection of stage one non-small cell lung cancer patients offers the best chance of cure for those patients?

A. I would say that it will be assuming the absence of any other contraindication to surgery.

Q. Let's make the discussion a little more general.

Are you familiar with either through your own experience with patients, and I think you have already

told me that in your career from time to time you've made the diagnosis of stage one non-small cell lung cancer, for whom you have referred the patient to a thoracic surgeon for lung resection; right?

A. Yes.

Q. All right. Based on your either your experience with that type of patient or your understanding of the literature concerning that type of patient and that type of treatment, are you familiar with any statistics regarding the survival of those patients who undergo surgery?

A. Yes. There are many statistics available.

Q. All right. And what is your understanding of those statistics?

A. Surgery is better than doing nothing.

Q. Is surgery -- does surgery for a resectable non-small cell lung cancer stage one offer the patient more likely than not, greater than 50 percent, five-year life expectancy or better?

A. Let me make sure I understand the question. You are not talking about greater than 50 percent survival? You are saying that resection of a stage one carcinoma more likely than not will give --

Q. Give the -- confer to the patient the benefit

of five years or more survival?

A. I am not sure what the exact percentage is. It would depend on the study. It might be more than 50 percent in some if not most studies, but I am pretty sure there are some numbers out there with less.

Once again, it's going to depend on which population you are looking at, concomitant diseases and so forth. That's the problem with statistics.

Q. Well, let me ask you this in this manner. Go ahead. Were you going to say something?

A. I was going to say if you have a study that you would like to show me.

Q. Well, I want to know what your testimony is going to be, and maybe we can short circuit this somewhat.

Is it going to be your testimony in this case to offer opinions on the proximate cause issue regarding whether or not Mr. Cowan more likely would have survived at any point in time during his treatment?

A. I would have to defer to Mr. Brooks because I don't understand proximate cause.

MR. BROOKS: This witness is a standard of care witness with regard to Dr. Husari.

MR. DJORDJEVIC: All right.

BY MR. DJORDJEVIC:

Q. You are not going to offer any opinions regarding whether or not Mr. Cowan would have been cured of his cancer assuming that his cancer had been diagnosed at a certain time when it was at a certain stage?

A. I am not sure how I can answer that question. It depends on what hypotheticals are asked of me and what I'm allowed to answer.

MR. DJORDJEVIC: But, Mr. Books, you are not going to ask him any *of* those hypotheticals as **I** understand it?

MR. BROOKS: No. Our intention of Dr. Manaker's use at trial is to support Dr. Husari's action with regard to this patient within the standard of care.

MR. DJORDJEVIC: And, Steve, I think maybe the doctor and I are having problems communicating on the legal aspect of thins.

MR. BROOKS: That's right. I am sure he has opinions on those, but those are not what he is being proffered for as an expert witness at trial.

MR. DJORDJEVIC: And you will be asking him

for none of those opinions on your case on Direct I take it?

You will be soliciting no proximate cause opinions from this witness on your case?

MR. BROOKS: That's correct. It's not our intent.

MR. DJORDJEVIC: All right,

MR. BROOKS: I can't imagine that we would go there, obviously.

MR. DJORDJEVIC: Okay.

BY MR. DJORDJEVIC:

Q. Just before I leave this area. Relative to the curability of lung cancer at certain stages by surgical resection, would you defer to your colleagues in thoracic surgery relative to what the survival rates are for patients who are resected?

A. I am not sure what you mean by defer to them for what the survival rate is. And let me explain my answer.

Q. Sure.

A. My answer is there are lots of numbers in the literature. And any one particular number that one specialist might cite I may or may not agree with.

Q. Do you have any numbers based on your

experience that you can talk with me about with your patients, your patients who are resected at stage --

A. I would say that when I take care of patients with a stage one lung carcinoma in the absence of any contraindication to proceeding with surgery that I recommend surgery as the best option for long-term survival.

I don't think that recommending it as a specific percentage of whatever number percent you would like is doing the patient disservice because patients are not statistics. With them the only two relevant numbers are zero percent or hundred percent.

Q. The same with clients. How about stage two?

A. How about stage two? What do you mean?

Q. Have you -- and again, I don't want to go through the whole foundation.

A. In general I recommend surgery as the best option for the majority of patients with stage two.

Q. And by best option, you mean that surgery for stage two non-small cell lung cancers offers the best chance of long term survival for those patients?

A. Compared to the other modalities available and in the absence of other contraindication or complicating factors that might favor some of those

over modalities.

Q. How about the same question for stage three, Doctor?

A. Yes. With the caveat that the decisions among the various options for stage three become very complicated depending on those other factors including simply the patient's age and, for example, the specifics of which lymph nodes are positive and where exactly the lymph node is located.

Q. I follow. All right. Let's digress for a few minutes here, Doctor. I wonder if you could tell me what materials you have been provided to review in this case as the foundation for your opinions?

A. Okay. I can speak broadly without giving you the exact documents. I reviewed records from Dr. Husari. I reviewed documents from several of the other treating physicians. I reviewed literature written by Drs. Mountain and Dr. Lillington provided me by Mr. Brooks and his colleagues.

I read many of the depositions of the individuals involved in the matter. I have reviewed copies of chest radiographs and CT scan.

I would say that's in general the specific documents I have reviewed in preparation for this.

Q. I notice there is a large file of materials to your right?

A. Correct.

Q. Are those the materials that you have received?

A. It's a subset. The other materials have already been returned to Mr. Brooks and his colleagues.

Q. I wonder if I could have Ms. Loucas go through those while we talk for the interest -- in the interest of time. We will do two things at once?

MR. BROOKS: Certainly.

THE WITNESS: Okay by me.

BY MR. DJORDJEVIC:

Q. You have reviewed certain chest x-rays an CT scans; is that right, Doctor?

A. Yes.

Q. And do you recall which chest x-rays you have reviewed?

A. Not off the top of my head, but I can pull out my list.

Q. Do you have a list of chest x-rays that you have reviewed? And while you are digging in there, do you have any other reports, notes, memorandums of any sort concerning this case?

A. I have got my correspondence and I have got my notes. And that's why I am able to -- that's why my usual practice is to return all the original records to the attorneys so I am not warehousing them and because I rely on my notes.

Q. All right. Doctor, why don't we just identify what you are looking at on the record?

And **I** will represent on the record that you have reached down to your left side and you have pulled out a manila folder that seems to have some materials in it.

Is that what just happened?

A. Yes. And this folder contains my correspondence from Mr. Brooks and his colleagues in regard to this matter, my notice of deposition from Ms. Loucas and my notes from the records that I have reviewed.

Q. You have a label on the tap of the manila folder. Can you read that for us?

A. Sure. It says Carol Marunich, M-A-R-U-N-I-C-H. Cowan v Husari for Flaherty, Sensabaugh and Bonasso.

Q. That's a lawyer apparently?

A. Yes. That's one of Mr. Brooks colleagues.

Q. And what's the purpose of that manila folder? Why have you maintained that?

A. To keep papers together in one easily accessible place.

Q. Those would be -- would it be fair for me to that's your fife on this case?

A. Yes,

Q. Is that a fair way --

A. Yes.

Q. -- to describe it? And do you generate that type of a file on every case that you review? Is that what you do as your --

A. Yes.

Q. -- standard routine? All right.

A. Yes.

Q. Why do you do that? What's the purpose of generating a file of that sort in these cases?

A. So I can refer to my notes, refresh my memory, answer specific questions.

Q. And when you generate the contents of the file -- go ahead. Do you want to add something?

A. Yeah. I was going to add I also keep the letters in here because although no one has ever explained it to me, it seems like the letters seem to

be an important part of the file.

So, I made it my routine practice to keep them in there.

Q. Someday when we have some more time **I** will explain it to you if Mr. Brooks doesn't.

Doctor, would it be all right if we were to obtain copies of all of the items in your file concerning this case?

A. Okay by me.

MR. BROOKS: No objection.

MR. DJORDJEVIC: I am not going to do that now. What we'll do, maybe we'll take a break in a little while when the court reporter needs a rest.

You let me know and we'll see if you can make copies of that for us. All right.

BY MR. DJORDJEVIC:

Q. Were the notations that you made -- I can't help but notice that you seem to have different things stapled together and different things paper clipped.

Is there some kind of method to the way you did that?

A. No. I can honestly say that whether it's a yellow pad, a white pad or these bluish-purplish pads

just reflected what happens to be close and handy at the moment.

Whether it's a blue or black pen, on occasions it's even green or purple, doesn't --

Q. Even red I see from --

A. Red -- I will say that I only use red when I am highlighting things that I view as important.

Although, if I don't have red pen handy as is evident in here, I will make such notations of importance in other colors as well.

Q. All right. And let me see if I can understand what you do.

You sit down with the primary records, be they depositions or hospital charts or physician office records, and you read through those and while you are reading through those you make notations of important things that you see in the primary record?

Is that what you do?

A. Yes.

Q. And by reference to your file on the Cowan case, you can tell me which x-rays you have actually seen?

A. Yes. Although, I will tell you that I have notations here, and I believe these notations are off

of the reports rather than the original films.

And only in retrospect thinking about this last night when I was going through the notes, in the context of reading one of the depositions where there was a question as to whether or not an actual x-ray was available did I recognize that there may very well be a notation here of a film from a report when actually that film itself wasn't available able to me and I just made a notation of the report.

I can't distinguish that for you.

Q. What I want to understand and it's important for me to come away from this procedure this afternoon clearly with is can you identify by your notes or otherwise actual films that you put up in front of a view box and looked at as opposed to the reports of those films generated by radiologists interpreting those films at the time they were taken?

A. It's my recollection that I had all of those films available for my view. Those films have been returned to Mr. Brooks.

If at some point in the future someone were to say to me, you know, this one film that you have got a note about isn't there and you never had it, I couldn't dispute that.

But it's my general understanding that I had the opportunity to review the copy films for each of these studies.

Q. And those would be copies or second generations of the films as opposed to the original films?

A. Correct.

Q. When you were look at the films --

A. I believe they were copied films.

Q. Were they -- were the films of sufficient technical quality for you to do whatever you wanted to do with the films?

A, With the caveat that they are copies and copies are never as good at the primaries as Dr. Lillington pointed out in his deposition.

Q. Now, I take it that this is something that you do all the time in your practice as well is review chest films and other films of your patients?

A. All the time.

Q. Would that be a daily occurrence?

A. It just depends if I am seeing patients or not.

Q. But it's certainly something that is well within your ambit of expertise as a practicing

pulmonologist to do, interpret chest films?

A. Yes.

Q. And you felt very comfortable in interpreting the chest films that were done over the years on Mr. Cowan?

A. Yes.

Q. Very comfortable in rendering opinions on what you saw in those films I take it?

A. Yes.

Q. Okay. Could you tell me, sir, what films you believe you reviewed?

A. Sure. If you are going to be provided with copies, do you really want me to read off all these dates?

Q. I have all the dates. So, I will just check them off. You just go through them and I will check them off.

A. I have got notations here for films dates 1/27/86, 10/11/89.

MR. BROOKS: Whoa, whoa, whoa. Mike can't check off that fast.

BY MR. DJORDJEVIC:

Q. Go ahead.

A. I can dictate very quick. So, I apologize.

Q. You should apologize to your transcriptionist, not to us?

A. She is really good. 11/6/89, 8/28/91, 9/10/91, 1/25/92, 10/25/93, 10/28/93, 1/1/94; 9/23/94, 9/24/9 -- excuse me. 9/28/94, 10/27/94, 3/27/95, 3/30/95.

There is a report dated 11/21/95 of a film performed on 10/25/95. 11/22/95, 12/29/96, 11/21/97, 1/3/98, 4/5/98, 4/9/98, 5/7/98, 5/11/98, 5/13/98, 6/24/98, 8/2/98, 9/25/98, 10/1/98, 11/9/98, 11/18/98.

Q. And, Doctor, when did you last review those x-rays?

A. Last year sometime.

Q. You haven't reviewed them preparatory to today's deposition?

A. No, just my notes.

Q. And in reviewing those films, did you review the films with the benefit of the official reports that were dictated by the radiologist interpreting each film contemporaneously, or did you put the films up cold and try to gain your own understanding as to what you saw in the films?

What was your approach to the review of those films?

A. My approach was to review the reports so that I could organize and focus looking at the large number of films.

Then I reviewed the films. And they were ***so*** interesting that there were enough curiosities and questions about them that I actually showed them to two chest radiologists.

Those are not general radiologists, but those are radiologists who have the equivalent subspecialty expertise in chest radiology which they do for a living.

Q. And why did you do that with these particular films?

A. I treat these cases like I treat patients. And patients come to me with outside films, be they originals or copies, with unusual films, films where there are questions. I bring them down and go over them with a chest radiologist to the extent --

To the extent that I can't, all too often patients come and they have only got reports or they only have the report copy films or they have got nothing available, **I** just do the best I can with materials that **I** have available at that time.

Q. All right. ***So,*** in your practice, in the way

that Dr. Manaker practices pulmonology, if you have chest radiographs that you I think described as interesting, amongst other adjectives that I can't recall, you will take those films as a bundle and go down and review them with a radiologist; is that right?

A. At times.

Q. Specifically with a chest radiologist in this institution?

A. Yes.

Q. And I take it that you do that for the benefit of the patient as opposed to any intellectual curiosity that you have?

A. Both. Sometimes it may not be at all relevant to patient care, but if it's unusual or interesting I'll want to learn from my colleagues.

Q. And you will also want to confer to your patient whatever benefit there might be conferred to that patient?

A. Yes.

Q. By reviewing the films with the chest radiologist?

A. Yes.

Q. In reviewing the films of Mr. Cowan that you have already enumerated for us, you took that extra

step of actually going to not one, but two chest radiologists to review the films; is that right?

A. Yes.

Q. Can you tell me who those chest radiologists are, Doctor?

A. One was Warren Gefter and the other was one of the chest radiology fellows whose name I believe is Dan Maki, M-A-K-I.

Q. They are both radiologists **on** staff here at the University of Pennsylvania?

A. Warren is. He is the current chief of the thoracic radiology division. I don't know where Dan is right now.

Q. He was at the time of the review here at the University of Pennsylvania?

A. He was. He was a fellow in chest radiology.

Q. And that raises another interesting point that maybe we can get into at this point in the ball game.

Relative to the ability of a physician to interpret and x-ray, let's talk about specifically of the chest because that's a primary area of interest **1** am sure to a pulmonologist, would you consider your ability to interpret x-rays of the chest equal to,

better than or less than the ability of a general diagnostic radiologist to interpret chest films?

A. It would have to depend on the radiologist.

Q. Some radiologists are better at interpreting chest x-rays than you are?

A. Yes.

Q. Some are worse than you are?

A. Yes.

Q. In your practice here at the University of Pennsylvania, do you know which radiologists you consider to be better than you at interpreting chest x-rays and those that you consider to be not as good as you?

A. It's too general a question given the vast number of radiologists. I can tell you the chest radiologists I would all view as better than I at interpreting chest films and that's who I bring the films to.

Q. In your view of the materials provided to you on the Cowan film or on the Cowan case, is it your understanding that the radiologists that interpreted the studies that you have already enumerated on the record were ordinary general diagnostic radiologists, or were they specialists in chest radiology?

A. It's my understanding they were general radiologists.

Q. Do you know whether or not in this case specifically Dr. Husari had available for consultation with him concerning the Cowan case consultation with a chest radiologist specialist?

A. I do not know.

Q. You don't know if there is a specialist in chest radiology anywhere in the Clarksburg, West Virginia area or what the closest geographic area would be that had a specialist in chest radiology?

A. I don't know what was available in that area. Am I allowed to ask Mr. Brooks a question.

MR. DJORDJEVIC: It's fine with me.

THE WITNESS: Thank you.

MR. BROOKS: Only if it's asked.

MR. DJORDJEVIC: Consider it asked, Doctor.

THE WITNESS: Let the record reflect laughter.

MR. DJORDJEVIC: Where were we? We were talking about --

MR. BROOKS: I think the pending question is whether Dr. Manaker knew whether Dr. Husari had available to him an expert in chest radiology.

BY MR. DJORDJEVIC:

Q. You don't know whether or not Dr. Husari had available to him a subspecialist in chest radiology to review any of these films?

A. I do not know.

Q. Doctor, in reviewing the films yourself, describe to me how you did that? Would you put one film after the other up on the view box, put groups of them up and compare them?

How would you -- how did you review the films?.

A. Yes. I would say one of the nice things about our radiology department is they have a very large room with a great many view boxes.

And when you finally get all the films organized up the way you want them it makes it very easy for you to call someone in and have them take a look at it.

It might take 40 minutes to an hour actually to just organize this number of films. Although, I would say it wasn't the hundreds of films described by Dr. Mountain.

Q. All right. And in reviewing the films for the Cowan case, how much time did you take to do that?

A. I have no recollection.

Q. An hour, less than an hour? Do you have any idea?

A, I am sure it was more than an hour.

Q. And is that the type of time that you would spend in reviewing the films if Mr. Cowan had been a patient of yours as well?

A. Cumulatively, yes. Of course, at any given point in time, one would only be reviewing one or two films.

So, it would then only be a matter of minutes, but it's probably 40 or more dates here. So, 40 or more studies, even if you just a moment at the time of each study, it's going to be 40 minutes.

Q. Now, Doctor, in your practice, do you review all of the chest films on your patients which you order?

A. Usually, but not always

Q. Is it your goal to review all of the chest films on your patients which you order?

A. Yes.

Q. Is it your goal to review all of the chest films available to you in this institution on any given patient if you are trying to evaluate a questionable

process going on in that patient's chest?

A. I would say I would try to review all of the available relevant films.

If I knew that a series of films for five years were normal and in year six there was an abnormality, I might not look at years one, two, three, four and five. I might look at year one and five and year one and three and five.

Q. So that we have a clear record, the way I understand the common method by which x-rays are maintained at a given institution, and let me see if I am understanding this correctly, and if this is how it's done here at the University of Pennsylvania, if Mr. Cowan is a patient of yours and he had certain chest films or other x-rays for that matter that were done at this institution, the University of Pennsylvania, those films would all be maintained by the University of Pennsylvania somewhere in-house?

Is that the way it works?

A. It used to be and then we had problems with warehousing films because of the volume over the years.

I don't know what the policies were in the past at the university. I know that the common methods are now changing with electronic radiographs and

digital technology.

So, for example, those films are no longer even produced. It's all electronic.

Q. Let me then make it specific to this case. Is it your understanding that all of Mr. Cowan's chest films that were ordered by physicians at Stonewall Jackson Hospital were stored on premises at Stonewall Jackson Hospital?

A. I have no idea what the practice is and procedures were at Stonewall Jackson Hospital. I also don't know which of these various films that I saw were performed at what institution.

Q. So, in other words, if Dr. Husari wanted to evaluate something that he saw on a chest film in 1994, you wouldn't know what chest films were actually available to him?

A. That's correct. And I would fondly remember waiting many lengths of time for file room clerks to unsuccessfully locate previous x-rays.

Q. Because you asked them to locate x-rays so you could look at them to evaluate your patient's condition; right?

A. Touche.

Q. We're in agreement; right?

A. We are.

Q. Again, the same question for 1995, 1996, any of those years, you don't know what films would have been available to Dr. Husari in any year starting with 1994 and each calendar year thereafter had he wished to, for whatever reason, put up previous chest films to cry to evaluate what was going on in his patient's chest?

A. True.

Q. Is that fair? If I were to represent to you that those films, at least the majority of them, were maintained by the radiology department at the Stonewall Jackson Hospital, you would have no reason to dispute that, would you, Doctor?

A. I would have no primary knowledge to dispute that.

Q. All right. And in the way that Dr. Manaker practices medicine from time to time with certain patients and certain problems, you will go down to the department of radiology, or wherever the films could be found relative and regarding your patients, and ask to see all of those films; is that right?

A. Yes.

Q. In your review of the records here, do you

know whether Dr. Husari ever did that relative to Mr. Cowan?

A. I do not.

Q. Do you ever -- regarding your factual understanding of this case, do you know whether Dr. Husari at any time prior to 1998 felt that there was need for any additional testing or evaluation or workup concerning anything that he saw in any of the previous chest films?

A. I think your question is a little too broad for me.to answer.

Q. Okay. Tell me what's broad about it and I will see if I can narrow it?

A. It's too long a period of time. I don't know necessarily which of these films were ordered by Dr. Husari and I don't know what was available to him at each period of time.

Q. Okay. I tell you what, let's make it real open-ended. I am going to make it real open-ended for you. I will give you a chance to talk a little bit okay.

Upon your review, on your review of all the materials that Ms. Loucas now knows what they are and I don't, have you been able to gain a factual

understanding of Dr. Husari's involvement in the care and treatment of Mr. Cowan?

A. I would say in general, yes.

Q. All right. Why don't you give me just a narrative statement as to what your understanding is what role Dr. Husari played in Mr. Cowan's care?

Can you do that?

MR. BROOKS: I don't that's objectionable. I am not sure how much information you are going get out of him.

MR. DJORDJEVIC: Well, we're going to find out.

THE WITNESS: I think the care that Mr. Husari rendered to Mr. Cowan was very reasonable and well within the standard of care.

BY MR. DJORDJEVIC:

Q. I understand that's your opinion. My question, sir, is a little different than that.

What is your factual understanding? For example, when did Dr. Husari first come in contact with Mr. Cowan?

MR. BROOKS: There we go. That's getting better.

BY MR. DJORDJEVIC:

Q. All right.

A. I believe it was in January of 1995.

Q. And how was it in your recollection of the facts of this case that Dr. Husari came to see Mr. Cowan?

A. I'm allowed to refer my notes to answer the question.

Q. Refer to anything you want, any of the materials. I am going to ask you that you tell me what you are referring to, but you can refer to --

A. I am just going back to my notes here from Dr. Husari.

MR. BROOKS: Do you want to take a break and get these copied before you go on?

MR. DJORDJEVIC: That would be a good idea.

- - -

(Whereupon, a brief recess was held.)

- - -

BY MR. DJORDJEVIC:

Q. Doctor, before we adjourned for a short break we were talking about your factual understanding of this case.

I think where we left off is you were going to tell me your understanding as to how the initial

contact developed between Mr. Cowan and Dr. Husari?

A. Yes.

Q. All right. And would you explain to me your understanding of how that occurred, sir?

A. My understanding is that Dr. Saba sent Mr. Cowan to see Dr. Husari in the office on January 4th, 1995.

Q. And had there been any contact between Dr. Husari and Mr. Cowan before January 4th of 1995?

A. No. I believe Dr. Husari was asked about a Chest radiograph before that, but there was no contact between them.

There was no doctor/patient relationship.

Q. And who asked Dr. Husari about a chest radiograph before 1995?

A. I will say that I am not sure.

Q. Do you know why Dr. Husari was asked about a chest radiograph prior to 1995?

A. No. There was some discussion of it in the deposition, but it really was unclear.

Q. Do you know what that chest radiograph before 1995 revealed? Do you recall what the dates of that film or films were?

A. I believe it was the November 27, 199 -- I am

sorry. I got my date wrong. Wrong sheet here.

I believe it was the September 1994. Excuse me, one of the films in September 1994, and I am not quite sure if it was the September 23 or September 28.

Q. So, it's your understanding that someone asked Dr. Kusari to review a September chest film done on Mr. Cowan in 1994; is that right?

A. I think that's right. I think as I am looking at this now I'm thinking it was the September 23rd film, but it could have been September 28th.

Q. And do you know which doctor asked Dr. Husari to -- was that a consult did you understand it?

A, No. This is what we refer to in medicine as the curb side. This is the hang on one second. This is the curb side where you are walking along and for some reason somebody says, hey. Come look at this. What would you do?

And you are given two, three, five facts. And you might say, well, this is what I would do, but you are not given the other 25, 35, 55 facts and you are not given the chance to see the patient and do a full evaluation.

Q. All right, Now, is it your understanding that Dr. Husari was solicited for this curb-side

consult.,as you call it, as a result of the fact that he is a pulmonologist?

A. I am not quite sure why he specifically was solicited whether it was because he is a fine physician, because he's a pulmonologist, because he happened to be there.

Q. And is it your understanding that Dr. Husari made any request to do additional evaluation on the patient?

A. I don't know that Dr. Husari made any additional request to evaluate the patient, and I don't know that it would have been appropriate for him to request that.

I don't know the specific details of the conversation or the context in which the conversation occurred.

Q. Have you been in that situation yourself, Doctor, where you have been approached for a curb-side consult?

A. All the time. Walking in the hallway somebody calls you up and pages you and says, hey. What do you think you should do? What do you think I should? What would you do?

Q. And in that situation do you ever say, I

think I need to see the patient?

A, Sometimes.

Q. So, one of the appropriate responses for the physician performing the consult is to request to see the patient?

A. Whether or not it's appropriate would be a judgment decision, but I would just say it's one of the potential options.

Q. I am having difficulty envisioning a circumstance in which it would be inappropriate for the consulting physician to say I'd like to see the patient?

A. If it's superfluous and unnecessary as perceived by either the patient and/or the person making the request.

Q. In any event, do you know what the outcome of that curb-side consult, apparently as you understand it that occurred back in September of '94?

What was the outcome of that curb-side consult?

A. I don't know which of the subsequent events could be determined a specific direct outcome of that conversation.

I don't know if that conversation affected

anything that subsequently occurred.

Q. Do you recall reviewing the films -- we can agree you and I that there were some films that were done September the 23rd of 1994?

A. Yes.

Q. And September the 28th of 1994?

A. Yes.

Q. Correct? Do you recall reviewing those films?

A. I have my notes here from my review.

Q. All right. And could you tell me -- and again, refer to your notes -- what those films revealed?

Why don't you tell me what you are looking at so I can find it in the copy here, Doctor?

A. About the first page of the set of notes that's entitled Dennis Cowan v Ahmed Husari, Circuit Court Harrison County. It's page one.

Q. Okay.

A. Got that?

Q. I have got it.

A. So, on the 23rd Dr. McClane interpreted chest x-rays showing chronic scarring and a small area of increased density in the left upper lung zone

representing a small acute infiltrate not present on previous studies. That was his interpretation.

Dr. Goodwin interpreted a right anterior oblique film in which he could not identify that small area of increased density.

Q. All right.

A. Dr. Goodwin then went on and interpreted the film of September 28 in comparison to the previous films of the 23rd saying there is a minimal infiltrate and it's almost completely resolved.

Dr. Taluxen then looked at the October 27th film and said mild hyperinflation, negative chest.

And when I looked at those films in the context of the sequence and the context of the information available it led to the conclusion that there was an pneumonia, an acute infection, that appeared to be getting better because it went from a left upper lobe density to by report an almost complete resolution to a negative chest.

Now --

Q. Are you finished? I don't want to interrupt you?

A. I will stop there for now.

Q. Okay. There appears to be a notation in red

ink on the original?

A. Yes.

Q. It appears heavier on my copy?

A. Yeah, from October 27th.

Q. Right. That says, okay reading. Can you read that for me verbatim, please?

A. Sure. My handwriting is atrocious. I acknowledge. Okay reading in context of reading many films per day. Only in retrospect do you say the residual infiltrate exists.

Q. What do you mean by that?

A. I mean that on that particular film, and I believe this is the film that many individuals in their depositions questioned about the radiographic technique, there were different standards.

There is the standard for a pulmonologist looking at chest x-rays, there is a standard for a general radiologist looking at x-rays, and there is a standard probably for a chest radiologist different from the general radiologist I would imagine, but don't know for certain because I am not a radiologist.

And my expectation having looked at that copy film and reviewing that report was in the context of a general radiological sitting there reading however many

tens to hundreds of films a day, looking at it that that interpretation was probably okay.

And that only in retrospect could you really say, you know, there is still something here: And I remember fondly Dr. Lillington and Dr. Mountain talking about whether or not you could really see something on that film or not.

Q. I want to get your opinions because your the guy that's seated across the table from me this afternoon?

A. Okay.

Q. What did you see on the film of September the 23rd or the films of September the 23rd?

A. As best I recall, those films showed something in the left upper lobe on the 23rd that appeared smaller on the 28th and that was imperceptible trying to exclude previous knowledge about its existence.

And in retrospect, I could acknowledge there was something there on film on October 27th.

Q. Can you and I agree that in your point of view you were looking at the film from the point of view of a practicing pulmonologist? Is that what you attempted to do?

A. Yes.

Q. And can we agree that from the point of view of a practicing pulmonologist there was something, as you put it, something on those films September the 23rd, September the 28th, October the 27th of 1994?

A. No. I would acknowledge there was something there on September 23rd and September 28th.

What was there on the copy film that I had the chance to review from October 27th was almost imperceptible and it would have been very hard to distinguish it from normal lung markings. And that's the reason for my comments here about only in retrospect and an okay reading in the context of many films.

If you didn't know it was there and you were just blindly reading the film, you could very easily overlook it.

Q. But if you were comparing the October film to the September films you would know it was there and you could see it in October?

A. If you could see it in October and you could see it getting better and you would wonder, is it still there a little residua, or is it completely gone?

And if you ask me to do that blindly five

times in a row, 1 am not sure who would win three to two.

Q. If you were managing the patients or the patient whose chest films you were viewing, what would be your plan of treatment, if any, as of October the 27th of 1994?

MR. BROOKS: Excuse me. I don't really like to object, but implicit in that is the assumption that Dr. Husari was managing the patient.

And I think it was very clear that he was not, but having said that, go ahead.

MR. DJORDJEVIC: I don't dispute that.

THE WITNESS: What I would do would depend on the particular details of the patient that I knew.

Two reasonable options would be to say there is still something there. Let's get another film in two months, three months, four months to see if it goes completely away or if there is a residual scar.

A second reasonable approach would be to say if there is a residual scar, that's fine or if it goes completely away, that's fine, I don't really need to know either of those. And that another film should be gotten only on an as-needed basis

as other aspects in the patient's clinical care dictated.

Either one I would say would have been a reasonable procedure for the physicians caring for him at that time.

BY MR. DJORDJEVIC:

Q. The next chest film that you discuss on your handwritten note chronology is a chest film of 3/27/95; is that correct?

A, Yes.

Q. Now, as of 3/27/95 and your factual understanding of this case, was Mr. Cowan at that time a patient of Dr. Husari?

A, Yes.

Q. So you and I can assume that -- you and I can agree that as of 3/27/95 Dr. Husari was the physician who was treating Mr. Cowan? Can we agree?

A. Yes.

Q. And as such --

A. In fact, I would say he saw him in the office on the 27th.

Q. And as such she had a certain responsibility to Mr. Cowan, can we agree, as the treating physician?

A. As of March 1995, yes.

Q. And how or why was the March 27th, 1995 chest film obtained? Why was it ordered?

A. It was ordered because Mr. Husari -- Mr. Cowan had seen Dr. Husari in the office complaining of shortness of breathe and cough. He had an abnormal chest examination.

Dr. Husari's clinical impression was of a flare of chronic obstructive pulmonary disease. He started therapy with Prednisone and antibiotics and ordered the chest x-ray to evaluate the chest.

Q. And that ordered chest x-ray to evaluate the chest is represented by the March 27th, 1995 film; is that right?

A. Yes. I believe so.

Q. Is it your understanding that Dr. Husari himself reviewed that actual film?

A. Without making this into a memory test I remember Dr. Husari commenting that it's his usual practice to review the films that he ordered and I would assume that he saw him.

Q. If it was your patient and a film that you ordered, would you review the film?

A. Yes.

Q. You, in fact, reviewed the March 27th, 1995

film; is that correct?

A, Yes.

Q. Is it your understanding of the facts of this case that when Dr. Husari reviewed that film he had previous chest films to compare it to, or he didn't?

A. I don't believe he had previous films to compare to at that time, but he may have.

It's my general understanding that at that time there weren't many of the previous films available.

Q. Now, did the standard of care in your opinion, Doctor, require that Dr. Husari make some attempt to learn whether or not there were previous films available for comparison?

A. No. As long as he had the information that there was something there previously. Access to the information, be it in a report, either written or verbal, then there was no obligation or necessity for him to go pull the old original films.

Q. And is it your understanding of the facts in this case that the information was available to Dr. Husari, and we're going to have to quit after this question, relative to the radiology reports of the '94 September and October films?

Was that information that Dr. Husari had?

A. I would say that as of January at the initial visit he received the report that the follow-up chest x-rays had been negative.

And I am not quite sure what information was available to him at that time other than the -- yeah. I mean, I am just not sure what else was available to him in his records or by reports regarding previous specific films.

Q. Now, you note in your handwritten notations that apparently Dr. Lopez interpreted the 3/27/95 film as suggesting an infiltrate; is that correct?

A. That's correct.

Q. Would that infiltrate or density be in the same area in which it had been previously reported in the September of '94 film?

A. I think there is no way to know that from the report. It's unclear if there is any way to know that without putting up the films one next to each other.

And you would have to acknowledge that because it's such a subtle finding, they might actually be right next to each other, but appear to be in the same place.

Fortunately, another chest x-ray was ordered

three days later and at that time the previous films were available for review because Dr. Thrush in his interpretation noted a comparison to the previous studies of September '94. There was no change.

So, he had put in his interpretation presumably representing a scar. And that would make clinical sense if it was, in fact, in the same place.

1 would add at this time clinically it matches to Mr. Cowan's symptoms because his wife called the office on the 28th to say he was feeling better and hardly wheezing.

So, I think it was a very reasonable clinical interpretation for someone to have made that boy, you know, he had this pneumonia the previous fall. Got mostly better. He has got a scar. This is the acute detection of a chronic scar coincidental and unrelated to a COPD flare which is responding appropriately to therapy.

Q. You and I can agree that you have seen -- and we're now discussing films up through March 30th of 1995?

A. Right.

Q. You and I can agree that there is nothing that you see in any of those films that would enable

you or any other pulmonologist to rule out neoplasm?

A. One can -- even a normal x-ray does not allow a pulmonologist or anyone to review out neoplasm.

Q. I want us to communicate. We can'agree that these weren't normal x-rays?

A. We can.

Q. We can agree that these x-rays showed abnormal findings?

A. We can.

Q. That those abnormal findings were densities that were described in the left lung?

A. Yes.

Q. Correct? And we can agree that nothing that we've seen thus far from '94 to '95 would enable Dr. Husari, you or any other pulmonologist to rule out neoplasm as the cause of that particular density, can we?

MR. DJORDJEVIC: Let me just get this.

- - -

(Whereupon, a brief off-the-record discussion was held.)

- - -

BY MR. DJORDJEVIC:

Q. All right, Doctor, do you want --

A. No. I think the most concise answer I could give you is the report that there was no change in comparison to September 1994 says that there is no change in a stable lesion for six months which makes the likelihood of a malignancy much lower.

Q. I want to make sure we're communicating, because I am not using the term likelihood or lower or percentage. I am using the term rule out.

Can you and I agree that there is nothing that we see on the films of '94 now going into '95 that would enable you Dr. Husari or any other pulmonologist to rule out neoplasm?

A. I would say that there is never anything on the film that allows you to rule out a neoplasm. It doesn't matter what's there.

Q. Can we agree that neoplasm would be in a differential diagnosis in all of the films that we have discussed so far?

A. It's always something that one could consider in the differential diagnosis, yes.

Q. So, specifically in the case of Mr. Cowan, we can agree that starting in September of 1994 and now going up to March of 1995, there is a finding that is abnormal on chest films; correct?

A. Yes.

Q. And that one possible explanation as to what that finding is or may be is cancer?

A. Yes.

Q. And that none of the chest films that we have seen thus far rules out cancer as an explanation for that finding; right?

A. Right.

MR. DJORDJEVIC: Okay. That is a good place for us to stop. All right. Okay. Thanks.

- - -

(Whereupon the deposition concluded at 6:15 p.m.)

- - -

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

I, Celeste E. Gazzara, a Court Reporter and Notary Public, do hereby certify the foregoing to be a true and accurate transcript of my original stenographic notes taken at the time and place hereinbefore set forth.

Celeste E. Gazzara
Court Reporter
Notary Public

DATED: September 7, 2000

(The foregoing certification of this transcript does not apply to any reproduction of the same by any means, unless under the direct control and/or supervision of the certifying shorthand reporter.)