IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

DOC. 308

SUZANNE BOYD, ET AL.,

Plaintiffs,

-vs-

JUDGE CALLAHAN
CASE NO. 233,783

BERT M. BROWN, M.D., ET AL.,

Defendants.

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Deposition of GEOFFREY MENDELSOHN, M.D., taken as if upon cross-examination before Linda A. Astuto, a Registered Professional Reporter and Notary Public within and for the State of Ohio, at the offices of Mt. Sinai Hospital, One Mt. Sinai Drive, Cleveland, Ohio, at 11:00 a.m. on Thursday, September 1, 1994, pursuant to notice and/or stipulations of counsel, on behalf of the Plaintiffs in this cause.

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Bert M. Brown, M.D.
and Cleveland ENT.

GEOFFREY MENDELSOHN, M.D., of lawful age, called by the Plaintiffs for the purpose of cross-examination, as provided by the Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION OF GEOFFREY MENDELSOHN, M.D.

BY MR. YOUNG:

Q. Doctor, would you state your name and spell your last name for the record, please?

A. Geoffrey Mendelsohn, M-e-n-d-e-l-s-o-h-n.

Q. Perhaps we should have you spell your first name for the record as well as for the reporter.

A. G-e-o-f-f-r-e-y.

a. And Dr. Mendelsohn, you are a board certified physician?

A. Yes.

Q. In what area?

A. Pathology.

Q. And do you have any specialty within the practice of pathology?

A. Well, I specialize mainly in surgical pathology and cytology.

Q. And you are on the staff here at Mt. Sinai?

A. I am Director of Laboratories here at Mt. Sinai.

Q. As Director of Laboratories, what do you do here?

A. I'm responsible for running the laboratories and together with four other colleagues, we are responsible for all the diagnostic tests that are done here in anatomic pathology and between us we take responsibility for the various clinical laboratories.

Q. Okay. As director of the laboratories, do you participate in the quality control within the laboratories here at the hospital?

A. Yes, I do.

Q. And what type of testing is under your direction and control here?

All laboratory testing is under my control.

And what do we mean by that? Can you describe that for the layperson?

All specimens that come to the laboratory for any test, blood tests, blood chemistries, blood levels, immunology, cytology, which includes Pap smears and needle aspirations, surgical pathology, which involves the examination of tissues at biopsy, tissues that are excised from the body. The blood bank is part of the laboratories. I'm in charge of all areas in

which blood work, fluids or tissues is taken from the body and come for testing.

Q. Okay.

A. Are done in the lab.

Q. Are you an employee of Mt. Sinai?

A. No, I'm not.

2. Subcontractor here?

4. I'm a subcontractor here.

Q. Part of an independent group of some sort?

1. Part of a group of pathologists, yes.

Q. What is the name of that group?

A. Mt. Sinai Pathology Consultants.

Q. And how many pathologists are actually within the group?

A. We have as of now four partners and we have one employee, one physician, a young physician whose joined the group.

Q. Five pathologists?

A. Yes.

Q. Are all services of the group rendered here at Mt. Sinai?

A. Yes.

Q. In other words, you don't do subcontracting work for other hospitals in the area?

A. Oh, no. Absolutely not.

Q. Or anything of that sort?
A. No.
Q. Do you take in work from physicians in the area in addition to what's done here within the confines of the Mt. Sinai Hospital?
A. We take in work from physicians. Our laboratory takes in work from dialysis centers and nursing homes. That is exclusively blood work obviously.
Q. And all of the work that is done here within Mt. Sinai you've contracted to handle, I assume?
A. That is correct.
Q. Any specimens taken here actually at the hospital?
A. That is correct.
Q. For what period of time have you been here at Mt. Sinai?
A. Since 1987.
Q. And when you came here in 1987, was it as Director of Laboratories?
A. I came here, I spent a year here on the staff, Dr. Seigler at that time was Director of Laboratories. He was about to retire and I came here with the intention of becoming director.
Q. And was it the same group of pathologists that

had the contract to handle this responsibility at that time when you came here?

A Only one of the original pathologists is still a part of the group, Dr. Seigler, who was director, and is now semi-retired, almost completely retired. He still does some teaching here, but he's not part of the group any more. He doesn't do diagnostic work.

Q But essentially it was the same professional group, there is a continuity of the professional group?

A There's a change in the corporate name which occurred probably around 1984 or '85.

Q All right.

A But essentially it's a continuity of the same group, same contract, yes.

Q Prior to coming to Mt. Sinai, what did you do professionally?

A I completed my residency in 1979 at Johns Hopkins. Following that I spent four years on the staff at Johns Hopkins as a pathologist and as an assistant professor of pathology at Johns Hopkins Medical School.

In 1983 I moved to Cleveland. I was Director of Surgical Pathology and Anatomic

Pathology at University Hospitals and I still have an appointment as an Associate Professor of Pathology at the medical school.

Q. And do I understand that you were Director of Labs there for a period of time?

A. No, I was Director of Surgical Pathology for a couple of years and then became Director of Anatomic Pathology.

Q. Now, does surgical pathology here at Mt. Sinai fall within your responsibility as Director of Laboratories?

A. All laboratories are within it. I have a Director of Surgical Pathology who is responsible for it but I have oversight and responsibility for the lab.

Q. And who is that?

A. Dr. Lash.

Q. For what period of time has he been with Mt. Sinai?

A. I've been here seven years. He's probably been here six years.

Q. For what period of time were you with University Hospitals?

A. Four years.

Q. And was, in that entire time did you deal with

surgical pathology?
A Yes, I did.
Q You came to the city you say in 1983?
A Yes.
Q Doctor, are you insured by PIE?
MR JACKSON: Objection. But you may answer.
A Yes.
Q Okay And do you participate in the business of PIE in any manner?
A No.
Q All right You do review claims for them from time to time or records and matters that come within their responsibility, correct?
MR JACKSON: Objection. You're distinguishing PIE from reviewing them for the law firm who is handling --
MR YOUNG: I am.
MR JACKSON: You may answer.
A I review cases for the law firm of Jacobson, Maynard, Tuschman & Kalur.
Q Have you ever done any review work for people within PIE other than Jacobson, Maynard?
MR JACKSON: Exclusive of claims that are being handled by the law firm?

MR. YOUNG: Exclusive of reviewing claims with an eye towards testimony.

A. I'm not sure that I understand the question, I guess.

Q. Have you ever reviewed claims for Jacobson, Maynard or PIE to determine their defensibility separate and apart from the issue of being retained as an expert with an eye towards being a witness?

MR. JACKSON: Objection.

A. I've reviewed cases for Jacobson, Maynard Tuschman & Kalur. I've been asked to give an opinion on those cases. Do I think this is a breast cancer, do I think this is a this or that.

There have been cases that I've reviewed for them where, you know, I've said that's what it is, a mistake was made. I don't know, I guess I'm unable to distinguish your question PIE from Jacobson, Maynard.

My contact has been with Jacobson, Maynard, with the attorneys at the law firm.

Q. Always an attorney within the law firm would contact you and ask you to review a matter?

A. Correct.

Q. We'll talk about that a little later.

But you've been retained in this case to give an opinion, is that correct?

A. That is correct.

Q. And you've been retained by Mr. Jackson who first approached you?

A. That's correct.

Q. How did he first approach you concerning this case?

A. Again, my recollection is that sometime in 1993, and I don't remember when, but at sometime in 1993 he called me, he had a case, asked if I would look at some biopsies for him.

I looked at those biopsies and then in April of this year he wrote me a letter and asked if I would, he sent me some medical records, sent me the slides and asked if I would review the material and issue a report.

Okay. When you first talked with him in 1993, did he give you any factual background other than simply slides?

A. I honestly don't recall that meeting with any detail. He brought some slides for me to look at and as is my practice, I don't just look at slides. He told me a little bit about the case

and showed me the biopsies, asked me what I thought briefly and said if I want a report from you, I'll get back to you.

Q. Okay. And do you recall what slides he brought with him when he had that meeting with you?

A. My recollection is that it's the same slides I reviewed prior to issuing this report in April which is slides from a biopsy of a tongue or oral lesion.

Q. Did they come from Marymount or Medina or both, if you know?

A. The slides I reviewed were from Marymount.

Q. All right. And in that initial meeting did you also review some slides from Medina?

A. I don't recall.

Q. Have you ever reviewed slides from Medina, to your knowledge?

A. Yes.

Q. And when did you review those?

A. Recently, within the last week or two.

Q. Now, you prepared some report or a report for Mr. Jackson dated June 23, 1994, correct?

A. Correct.

Q. And do you recall what you'd reviewed before preparation of the report?

A. Before I reviewed the report?
Q. Before you wrote the report.
A. I reviewed the medical records and pathology slides representing the biopsy taken from the base of the tongue.
Q. I see in the first paragraph of your report you say "at your request I have reviewed medical records in the case of Allan Boyd."

Do you know what records?

A. I reviewed them very briefly because I didn't, I reviewed only what was pertinent to my reviewing the slides and issuing this report. I reviewed medical records from Medina Hospital and also two admissions to Akron General Hospital from November, 1990 and December, 1990.
2. Okay. You're looking at something here as you say that.

What do you have before you that details what you reviewed? Here we have reference on a letter dated April 27, 1994 from Mr. Jackson to records, hospital records of Marymount and Medina. But there is only a reference to slides from Marymount.

. That's correct.
. At the time that you initially received this in

April, did you have those Medina slides as well?
A. Not to my recollection. I received those after that report. I received those more recently.
Q. And when you say more recently, you're talking about within the last few weeks?
A. I looked at them within the last couple of weeks.
Q. As a result of looking at those slides, have you formed any opinions which are not contained in your report of June 23, 1994?
A. The slides show squamous cell carcinoma of the tongue as well as squamous cell infiltrating within soft tissues.
Q. Do you intend to express any opinion in this case that is not included in your report of June 23, 1994?
A. There may be some issues on which I would express an opinion that I subsequently formulated, particularly after reading the deposition of Dr. Shumrick. So I would have some opinions there.

There might be some other, you know, some other opinions related to this case. I can't think offhand. There may be.

Q. Have you talked with Mr. Jackson about

supplementing this report and any opinions he would like to include in your testimony that were not included in that report of June 23rd?

A. Mr. Jackson has not asked me to issue any other report.

Q. And he has not expressed to you the desire to address any opinions not included in that report?

A. Not at this point.

Q. Doctor, in rendering an opinion in this case, what do you believe your area of expertise to be bearing upon the issues in this case? How do you feel qualified as an expert to render an opinion in this case?

A. I'm an experienced pathologist. I've, I have had an interest in cancer, the pathology of cancer ever since I started my training and certainly the pathology of cancer has been a focus of most of what I have done and written about.

And I think that those two, those two factors, my experience, a lot of experience in all sorts of pathology, including oral cavity, a good deal of knowledge about the behavior of cancers.

Q. You believe that your expertise extends to the treatment of cancer?

A. I do not treat patients and I certainly would not give opinions on treatment, on specifics of treatment.

Q. Does your expertise in your opinion extend to the probability of survival from cancer with proper treatment?

A. It might. It might, yes.

Q. When you say it might, what do you mean?

A. It would depend on how specific the question was and how it, you know, and what it related to.

Q. Do you believe that in expressing an opinion concerning -- let me ask it this way.

Essentially you would defer to an oncologist or a surgeon in terms of treatment of cancer and his opinion concerning that, would you not?

A. I would defer to an oncologist or a surgeon in terms of treatment, yes.

Q. In other words, as I understand it, a pathologist takes a look at the slide, diagnoses cancer, stages cancer and that information is taken to the clinician in order to form a treatment plan, correct?

A. In part correct. Again, depending on the nature of the practice, it is the pathologist also who provides the clinician with data on survival, on modes of treatment.

Again, it depends on the situation and that's why I say, you know, my expertise in treatment would be -- I might have expertise, I might not. It would depend and at this hospital we work with our clinicians. We give them the data. We make suggestions.

It is not uncommon, in fact I would say it's almost the rule. For example, when a breast cancer is excised in this hospital, that I or one of my colleagues is the person who would recommend to the surgeon that he or she re-excise the lesion, that it does involve the margins, in my opinion, there's enough this or that that you need to go back and do this or that or consider radiation.

So yes, we do provide data that would be pertinent to prognosis, outcome, risk for reoccurrence, whatever, and that is frequently present in our pathology reports. It's not always. It depends on the situation.

Q. Do you believe that the standard of care with

regard to a pathological practice requires you to do such things, to recommend treatment and to participate in the consideration of what's proper for the patient in that manner?

A. The standard of care, and again it depends on the nature of the biopsy or excision, the standard of care requires that if appropriate, that the surgeon or oncologist be given information on whether margins of an excision are negative or involved by a tumor.

Q. All right.

A. Standard of care requires that the lymph nodes have been removed, that the presence or absence of metastatic disease is noted.

But again, it depends on the situation. It depends on the lesion. It depends on the type of procedure that is being done, an excision versus a biopsy and so forth.

Q. Are you familiar with generally accepted standards for staging oral cancer?

A. I am familiar with generally accepted standards for staging any cancer.

Q. With regard to oral cancer, what do you understand the stages or how do you define the stages?

A. Well, the stage of any tumor is dependent on the size of the tumor, the extent to which it invades, presence or absence of lymph node involvement, presence or absence of distant metastasis.

So the staging is based on the tumor, the lymph node status and the metastatic, metastasis status. The staging criteria vary from tumor to tumor. The size of a tumor for -- let me back up a little bit. The staging is based on whether a tumor is non-invasive, invasive, the extent to which it invades. That would be the T stage or tumor stage. Lymph node is just negative, zero or involved one or a distant group of lymph nodes would be two, regional local lymph nodes one and metastasis is either negative, zero or one.

The criteria for staging different cancers vary. The criteria for colon cancer are different for the criteria of breast cancer, oral cancer.

Q. Let's deal with oral cancer.

Are you familiar with the stages of that?

A. Again, I would, you know, we use staging books. I don't think that anyone necessarily has to

recall specifically whether a T1 lesion is two centimeters or one centimeter. We all have a TNM, American College of Cancer next to our microscopes and when we deal with a cancer, if appropriate, if it's been an excision, not just a biopsy, then we stage it.

I will be very honest with you, the size of, a tumor size related to staging an oral cancer is not something I need to remember or I care to remember, but right or wrong, my recollection is two centimeters, less than two centimeters is a stage one. But I see no need to recall those kinds of details.

Q. I understand. I am just trying to understand what it is that you do here and what your level of understanding is.

A. We do cancer staging on every tumor removed in this hospital. We use the standard TNM staging and one of my colleagues is the TNM police and he surveys our reports every year, every month, sorry, to --

Q. Make sure it's right?

A. Make sure we're doing it correctly.

Q. Do you report the staging of tumors to any central authority for collecting data on oral

cancer?

A. Our staging is part of our pathology report. So if a tumor has been excised, the TNM stage is part of that report. A copy of the report goes to the tumor registry downstairs and the data is then collected and collated by the tumor registry downstairs, correct.

Q. And what is the tumor registry, what are we talking about?

A. The tumor registry is two meticulous ladies who work in the medical records department who keep records on all tumors, keep track of them in their part of the medical records department essentially.

Q. Why do you have someone who does that, Doctor, two ladies who keep information on size and staging of tumors?

A. We keep records on all tumors for accreditation, for accreditation as a cancer center we need to do that. Records are kept of all cancers and the data are used for studies, for ongoing studies and they are used as part of treatment. It is part of the completeness of the chart is a complete TNM stage.

Q. And when we talk about TNM, we're talking about

the staging process which is published by the American Joint Committee on Cancer, correct?

A. Yes.

Q. In other words, the joint committee has put out standards, constant standards concerning tumors?

A. Clinicians, pathologists. There is a clinical stage. There is a pathology stage. Pathologic stage is often different from the clinical because often we are the people that see the lymph nodes or see a biopsy.

Q. But essentially that reporting requirement or staging requirement is done so you have a uniform language so that there's an understanding concerning tumors and some predictability of the disease, would you agree?

A. Yes.

Q. Was there any TNM consideration that went into your opinion in this case?

A. Well, again, I'm not sure specifically whether you're referring to my examination of the original biopsy slides from Marymount or how I would stage it based on what I now know about the whole case. And the staging would be dependent on time.

So do I have an opinion, I think my opinion

is that you could not give a T stage for the original biopsy from Marymount.

Q. Why is that, Doctor?

A. I would need to know that that was an excisional biopsy. I would also need to know that the tumor had been completely excised. If it was an excisional biopsy, that's a small biopsy. The fragments are four or five millimeters, somewhere less than a centimeter.

Q. The depth you're talking about?

A. Well, yes, the depth.

Q. The depth was --

A. The depth based on what I see, on what I've seen is very difficult to evaluate from those, from those biopsies.

Q. But it would appear to be four millimeters?

A. Oh, the size of that lesion on the biopsy slide is small. But the nature of the biopsy is such that I cannot guarantee that there isn't residual lesion left behind. I think my opinion though is expressed in the letter here.

Q. Let's back up and think about the size of the biopsy.

A. Okay.

Q. Have you read the deposition of Dr. Brown?

A. No.
Q. You've never had that?
A. No.
Q. Mr. Jackson didn't provide that to you at any point in time?
A. No.
Q. Has he told you what Dr. Brown's testimony was concerning the nature of the biopsy and what it was he intended to do?
A. The information I have about what Dr. Brown did really is from Dr. Shumrick's deposition where it is stated that this was an excisional biopsy.
Q. And in Dr. Shumrick's opinion?
A. Correct.
Q. Let's talk about your opinion.

Have you taken a look -- well, you've certainly seen the Marymount Hospital record and the pathology report?

A. Correct.
Q. You've seen the gross description contained therein?
A. Correct.
Q. You've seen the records of Dr. Brown in which he refers to it as an excisional biopsy?
A. Correct.

Q. But you haven't had the benefit of his testimony to understand what it was he intended to do and how he took this biopsy?

A. You know, my opinion here is not based on the surgical procedure that was done. So that would not be something that I would have reviewed. It may have been in the medical records on an op note but that is really not what I reviewed. I don't feel that it was pertinent to my opinion.

Q. Well, the pathologist is never there when the specimen is taken or very rarely there, would you agree?

A. That's correct.

Q. And what the surgeon tells the pathologist he did is clinically is important in consideration of the case, wouldn't you agree?

A. Boy, in some instances yes. In other instances no. Because as a pathologist, I am reporting on what I see in the slide. The physician, surgeon, gynecologist, it doesn't matter, the person who took that biopsy then interprets my result in association with his clinical findings.

Q. I understand. But we're talking about the size of the lesion now. And we're talking about

whether it's an excisional biopsy or incisional?

A. That is the surgeon's call. If he has excised it, he has excised it and I certainly don't argue that. My report is going to indicate that this is a small fragment of tissue with whatever it is.

If it's a small biopsy, and it's clear that it's a push biopsy and I can tell, then I don't comment on margins because it's not applicable.

If it's a small ellipse of tissue, I will comment on margins. It is then up to the surgeon to say, oh, I know the margins involved. I didn't take it all. That was just a partial biopsy.

So again, there are certain situations where I will call the surgeon and tell him that, you know, it is very close to the margin, the edge, I can't be sure, was this an excision, wasn't it.

Really, that's the surgeon's call. He sees the lesion. He feels the lesion. He touches the lesion, he looks at the lesion, he takes a bit of tissue and he's really the one that knows what he took. I don't want to say I don't care what he took, but it doesn't influence, for the

most part my pathology report is not dependent in every case on what he did.

Q. As I understood your testimony earlier, I believe you testified that you couldn't tell from the size of the lesion because you didn't know if it was an excisional or incisional biopsy, correct?

A. That's correct.

Q. All right. Now, you don't have the benefit of Dr. Brown's testimony and I'll paraphrase it.

Essentially he said he very carefully palpated this lesion and did an excisional biopsy, cutting out everything that he could identify himself as he did the surgical procedure.

That would be good practice, would it not, to do that?

A. Yes. But again, I'm not a surgeon. I don't want to comment and give opinions on whether what he did was surgically correct or not. That would be the norm.

If it's a small lesion that can be excised easily at the time of biopsy, an excisional biopsy is fine. Again it's the surgeon's call whether he does incision or excisional biopsy.

Q. Essentially even with an excisional biopsy you can miss tumor tissue, can you not?
A. Yes.
Q. That's why the pathologist takes a look at the excision and determines whether the margins are free and clear?
MR. JACKSON: Objection. The pathologist looks at what?
Q. Looks at the specimen.
MR. JACKSON: You said excision.
MR. YOUNG: Let me withdraw it and ask it this way.
Q. In your opinion in this case, is the size of the lesion on the tongue in November of 1989 a consideration?
MR. JACKSON: To whom?
A. I don't understand.
Q. In your consideration of the case.
Is the size of the biopsy or the size of the lesion important?
MR. JACKSON: On the tongue or in the biopsy?
A. I honestly don't understand the question.
Q. All right. On November 22, 1989 Allan Boyd went in to Dr. Brown and he had a lesion on the

tongue.

A. Okay.

Q. Dr. Brown testified that he did an excisional biopsy?

A. Okay.

Q. Is the size of the lesion that was present on November 22, 1989 important in your consideration of the issues in this case?

A. I still don't understand the question.

Q. What is it that you don't understand?

A. I really don't understand what you mean is the size of the lesion important in my consideration of this case.

Q. Well, you draw the conclusion that the cancer had metastasized on November 22, 1989, correct?

A. Well, I don't testify to a date on which it metastasized. I think my opinion is that metastasis was present at the time, so that may be a subtle difference, but I would hate anyone to think that I am predicting a specific day on which it metastasized.

Q. As I understand it from Mr. Jackson's questions to other experts, that will deal with the doubling time theory, correct?

A. Correct.

Q. But essentially in your consideration of whether there had been metastasis of this lesion prior to November 22, 1989, is the size of the tumor, does the size of the tumor at that time existing on the tongue play any part in your consideration?

A. I'm still not sure I understand the question. As -- well, scratch that. Small tumors can metastasize. We know that. In looking at the original biopsy, there are two pieces of tissue. The lesion is present at an edge of the tissue. I'm not sure if that is margin or not.

Those small, you know, again, when an excision is done, we make an attempt to ink the margins, if possible. If a piece of tissue is fragmented and we don't know margins, we don't ink it because that creates a false result.

So in the original biopsy I'm not sure whether the margin is involved or not. I don't know what the size of that original lesion was.

And so I'm not sure how to answer your question about whether the size of the tumor is a factor. I don't know what the size of that original lesion was. The only notes I have, what I took is that he had a small white pimple

on the tongue. I don't know whether or not the entire lesion was removed when that biopsy was done.

Q. You've just testified that small lesions can metastasize.

A. Correct.

Q. It is less likely for a small lesion to metastasize than for a large lesion, would you agree?

A. That is correct.

Q. In determining whether in your opinion this lesion had metastasized prior to November 22, 1989, do you believe it's important to understand the size of the lesion on that date?

A. Not really because small lesions can metastasize. And so whether the lesion was four millimeters or 12 would not impact on my opinion.

Q. Would not impact on it?

A. No.

Q. You believe that you can statistically through the doubling theory determine roughly the time of metastasis, and that is more reliable than the size or thickness of squamous cell carcinoma on the tongue?

MR. JACKSON: I object because that is a misstatement of his opinion.

MR. YOUNG: I'm asking,

MR. JACKSON: You're misstating it.

A. If the biopsy had shown -- let me reword that. If a biopsy shows only in situ carcinoma, which implies non-invasive, that would be critical. Whether that was a two centimeter patch of in situ carcinoma or five millimeter patch of in situ carcinoma would be inconsequential.

So the factors that are important for me are not necessarily size alone but the presence or absence of invasion and it is the presence or absence of invasion that is important.

I lost a very close friend with a skin cancer, melanoma that was in the category of 99 percent and better cure and it metastasized.

As a pathologist I've seen small, too many small cancers metastasize that size alone is not critical for me. The TNM staging is merely a guide to possible outcome. It is not a rock solid rule.

Q. I'm not asking you if it is rock solid, and I understand it's simply a guide.

My question is do you believe that the size of the tumor on November 22, 1989 is important to the consideration of whether statistically in probability this tumor had metastasized prior to that date?

MR. JACKSON: I object. He answered that at least twice already. Is there a better answer that you can give to him, Doctor?

A. All I can say is statistics are only statistics and that is not, when I look at the lymph node metastasis and the subsequent course of this patient, the fact that the lesion was three, five, 10, 12, 15 millimeters doesn't influence me one way or the other because I'm still faced with lymph node metastasis that needs to be explained.

Q. Do you have an opinion concerning the size of the lesion, the tongue lesion on November 22, 1989?

A. No.

Q. Would you disagree with Dr. Shumrick or others who say it is a superficial lesion, very small lesion?

A. I have no idea because I don't believe that the

lesion was entirely excised at the time. We know it wasn't because I have a biopsy 10 months later that shows, from that same area that shows recurrent disease.

Q. All right.

A. And that recurrent disease is invasive. I think a critical point here is that in October when this lymph node was discovered and the surgeon went back and looked in the oral cavity, he couldn't see anything.

And the fact he did a biopsy from the area of the previous biopsy and it shows invasive carcinoma, significant invasive carcinoma, not superficially invasive, and that's 10 or so months later, and that lesion still wasn't visible.

So the fact that Dr. Boyd indicates a white pimple doesn't indicate to me how large the tumor was at the time he biopsied it. 10 months later clinically there didn't seem to be evidence of tumor and there may well have been, and in my opinion, probably was a more extensively invasive tumor that just was invisible and we get back to my point that I don't know how large that tumor was when it was

biopsied.

You asked me if the size is important and I tell you I don't know how large it was because there was probably at that time residual tumor.

My opinion is it had already metastasized by the time that biopsy was done.

MR. JACKSON: You said Dr. Boyd, I believe you meant to say Dr. Brown.

THE WITNESS: Thank you.

Q. The tongue tumor that was excised in 1990, in your opinion, is that the same tumor that was present in 1989 on the tongue?

A. It's from the same area and my opinion is that it's the same tumor.

Q. All right. Is it your opinion that that is the primary tumor which metastasized causing Allan Boyd's death?

A. It was my opinion that it is the same tumor. Dr. Shumrick has brought up the possibility of a second tumor. There is a lesion in the region of the trachea and carina which was never evaluated.

Dr. Shumrick has expressed the opinion that based on some of the clinical, clinically unusual facts in this case that the lymph node

metastasis might have come from a different site and that is a possibility.

Q. You've had the opportunity to review Dr. Shumrick's deposition?

A. Yes.

Q. Concerning a lesion in the trachea?

A. Correct.

Q. Did you find any evidence of that yourself in your review of the medical records?

MR. JACKSON: Evidence of what?

Q. Of a lesion in the trachea.

A. No. And I didn't look, you know, in detail through the records because my opinion, the opinion that was asked of me related to the pathology and I focused on the pathology of the oral lesion, the metastasis, factors related to metastatic disease.

Q. When you wrote your report on June 23, 1994, and you've just testified it was your opinion that it was the tongue lesion that was the primary lesion which had metastasized causing this man's death, correct?

A. Correct. At the time of that letter, yes.

Q. You haven't changed that opinion today, have you?

A. I do not know specifically how to address Dr. Shumrick's opinion. There is no, there is a lesion in the trachea and carina based on his deposition and I will base it on that. Might that be a second lesion? It might be. It might be.

Q. You haven't seen the medical records or the CT Scan results or any of those things necessary to have an independent opinion of your own, correct?

A. No. No.

Q. And based on your review of the medical records which were provided to you by Mr. Jackson, and I assume that was the complete Medina chart, was it not?

A. I don't know whether the chart is complete or not.

Q. All of the records that he submitted to you from the Medina Hospital you did review, did you not?

A. Right. Correct. Some areas in more detail than others, as we've indicated already.

Q. You had reviewed those before you rendered the opinion contained in your letter of June 23rd?

A. Correct.

Q. Have you reviewed any medical records which

would alter your opinion contained in this letter?

A. No. My opinion contained in this letter or my opinions contained in this letter relate to the original biopsy and they relate to the metastatic squamous cell carcinoma in the lymph nodes, okay?

Q. I'm sorry, say that again?

A. My opinions in this case relate to the original biopsy.

Q. All right.

A. I will certainly give an opinion on what the subsequent biopsy of the oral lesion in October showed. And that's certainly no secret. That is a squamous cell carcinoma.

And my opinions relate to the presence of metastatic disease in the cervical lymph nodes and how long those metastases have been present, whether they came from another site or not I think is immaterial. My opinion is not going to change in terms of those lymph nodes having contained metastatic disease at the time the original lesion was diagnosed and prior to that.

Q. Well, in June when you wrote this report, you read the medical records and it was your opinion

at that time that the tongue lesion had metastasized, correct?

A Correct

Q Now, you have read no medical records, and you've looked at no other medical trial other than the deposition of Dr. Shumrick which would cause you to question your conclusion, correct?

A Let's back up a little bit because you may be putting words into my mouth though or telling me what I said and when I really did don't say it.

The more critical question in this case is whether excision of the lesion in November or December would have prevented metastasis It can be stated to a reasonable degree of medical probability that metastasis had already occurred at the time of the original biopsy which was misinterpreted, at the time the original biopsy which was misinterpreted was performed

The cervical lymph node metastases were significantly larger than the primary tumor. At the very least they were several centimeters in diameter. And based on that it was my opinion that metastasis was already present at the time the tongue was biopsied and before that

So yes, what you say is correct, my opinion was that it came from the tongue. I do not know how to address Dr. Shumrick's possibility that it came from somewhere else. That is absolutely certainly a possibility. What I would have to --

Q. Let me stop you right there. When you say it's a possibility, is it a possibility based on your review of the medical records or you having reviewed his deposition?

A. It is a possibility on my having reviewed his deposition.

Q. All right. Go ahead.

A. Maybe the best way to phrase it, regardless of where the metastasis has come from, metastatic tumor was already present in those lymph nodes based on what we know about tumor behavior in November of 1989 when that original biopsy was performed.

Q. Let me back up to the last paragraph of your report in which it says "the cervical lymph node metastases were significantly larger than the primary tumor," what relevance does that have?

A. The relevance of that is that this is a slow growing tumor. The squamous carcinoma in the

mouth is a slow, is a slow growing tumor and the fact that the lymph node metastases are larger, as large or larger than the mouth lesion indicate that that metastasis has been present for a long time and that metastasis occurred early.

This is not a huge oral cancer. We see some fairly big oral cancers. This is not a large oral cancer.

Q. That being that shown on November 22, 1989?

A. That's shown in October of 1990 when it was rebiopsied.

Q. All right.

A. And in the space of those 10 months or 11 months, let's call it 11 months, that tumor in the mouth has not grown very much. It is still not visible as a growth. It's a flat lesion that's growing down. It is not a large lesion. And based on what that primary tumor has shown us about its growth rate, it reflects on the metastasis.

The metastasis, metastatic tumor will grow at about the same rate as the primary tumor. There are some, there may be some variations and some differences, but when we see a small

primary tumor with a large metastasis, it does indicate that metastasis occurred early. It does indicate that metastasis occurred early.

The patient's oral cancer is giving us a live, is giving us live evidence as to how fast this tumor is growing. I think it's critical.

Q. But we know that the metastatic tumor and the primary tumor or the tongue tumor grew at two different rates, do we not?

A. Late during the course of the disease. Certainly between, let us say between October and his death, that late during the course of the disease, certainly metastatic tumor begins to coalesce and you end up with a more virulent disease.

But in lymph nodes, in lymph nodes the tumor grows, tumor spreads to a lymph node and the tumor then grows within that lymph node. It's a little bit different than the dissemination of tumor either within soft tissues or within lung or liver.

Q. Does oral cancer metastasize as other cancers? Essentially when you say that the metastasis grows pretty much at the same rate as the primary tumor, is that true of cancer?

MR. JACKSON: Say that again?

MR. YOUNG: He just testified that metastasis grows at pretty much the same rate as the primary tumor.

Q. Correct?

A. Generally, yes.

Q. All right.. And is that true of cancer as opposed to just oral cancer?

A. It is true, again, it is true of most cancers. There are certainly some virulent types of cancer where growth may change. But squamous cell carcinomas are not rapidly growing tumors.

We know that both clinically and from experimental studies and we can base, we can base our knowledge of how the tumor behaves on what the oral cancer in this patient did, and that is it grew slowly.

It's a well differentiated squamous cell carcinoma that is not a rapidly growing tumor. If you look at the sections of those tumors, of the slides, there are some division figures, some idiotic figures, but this is not a rampantly growing cancer and we know that from what we can see in the slides.

Q. Which slides, '89 or '90?

A. '90.
Q. All right.
A. '90.
Q. Go ahead.
A. So we know from clinically what happened in the mouth and from looking at the slides that this is not one of those rapidly growing tumors, and certainly a lymph node that is two and a half centimeters or 2.2 centimeters, again we're dealing with x-ray here, but a lymph node that is in excess of two centimeters in diameter did not pop up overnight,
Q. In a week and a half this mass grew from three centimeters to seven to eight centimeters, correct?
A. We don't know that the mass grew from three to eight. A review of the records would show that there were several enlarged lymph nodes which varied in diameter measuring up to 2.2 centimeters.

There was a larger mass in the supraclavicular area which I think is an unreliable estimate of size because we know that that was inflamed, that there was necrotic tumor. When the first aspiration was done, the

surgeon appeared to get purulent or pus out of that, which was clearly necrotic tumor and with the inflammation, one can certainly get swelling of soft tissues around it and I think that gives an inaccurate size.

So certainly the neck mass was measured at approximately seven to eight centimeters, that was this mass, that was the mass that aspirated that pus. The x-rays, the CAT scans showed several enlarged lymph nodes ranging up to approximately 2.2 centimeters.

Q So in determining the size, and we're talking about the size and how that indicates how it had grown, are you concerned, and I'm looking at your report, about the seven to eight centimeter mass or the 2.2 centimeter node?

A Well, am I concerned?

Q No. I'm asking how you date this tumor, how you date the metastasis of the tumor.

Is it the seven to eight centimeter mass or the 2.2 centimeter node?

A I will date it on the 2.2 centimeter node because unfortunately within that seven to eight centimeter mass we can't tell how much of it is lymph node and how much is inflamed soft tissue.

Q. We do know there was a lot of infection and so forth that was contained within the seven to eight centimeter mass that could cause the puffiness of the neck?
A. Correct.
Q. The more reliable predictor would be the node?
A. In my opinion that's the only measure I have to go on because it was seen on CT Scan and it's a lymph node and it's not inflamed and it wasn't part of this large inflammatory mass, yes.
Q. And when we conclude that, we conclude it from the CT Scan because those nodes weren't actually removed and examined, you agree?
A. Correct.
Q. You have not seen the CT films?
A. No, I have not.
Q. You've seen the report?
A. Correct.
Q. When you received a request from Mr. Jackson or at any point in time up until today, have you done any research in connection with this case?
A. Have I done any research? No.
Q. Have you looked at any articles, any data whatsoever concerning rates of metastasis, survivability and so forth?

A. There was a paper here that Mr. Jackson gave me given to him by Dr. Murphy. It is really not a paper. Tumors of the Head and Neck from Dr. Batsakis and an article of Oral Cancer in Young Adults Less Than 40 Years of Age.

Q, When did you receive that information?

A. Yesterday. No. The day before. This week. It's within the last two days.

Q. Initially?

A. I was out of the hospital yesterday. So it was the day before.

Q. Initially you received the medical records and the slides from Marymount Hospital, correct?

A. Yes.

MR. JACKSON: Let me correct something. The doctor received all the slides we received from you, including the slides from Medina Hospital.

There were two envelopes which were marked by you which I gave you back today which have slides that were put into a brown envelope, delivered to the doctor and he had all those slides.

MR. YOUNG: I appreciate your comments but that differs from his

testimony. His testimony is that the first thing he saw probably back in 1993 were just the slides from Marymount and he's only seen within the last few weeks the slides from --

MR. JACKSON: His memory in that regard was inaccurate because in order for us to get the slides back, we got them back from the doctor. Those were not just within the last few weeks. I am representing to you that the doctor --

MR. YOUNG: It is your representation he had them all before he did the report?

MR. JACKSON: That's right.

A. And I think my testimony was that I had those slides, you and I reviewed them again in the last couple of weeks.

Q. I think that may not be what you said but we will find out when it's transcribed, Doctor.

In any event, as I understand it, *you* were supplied with medical records from Marymount and from Medina, you were supplied with the slides. You've received Dr. Shumrick's deposition?

A. Correct.

Q. Have you received his report and his supplemental report?
A. I received his supplemental report.
Q. Did you receive his initial report?
A. I don't recall and I don't believe so.
Q. You've received Dr. Murphy's report, correct?
A. Yes, I have.
Q. That's an undated thing that looks like this?
A. If that's what you're talking about, I have received it, yes.
Q. When did you receive that?
A. Within the last few days.
Q. Attached to that you had some pages from a text.

Can you identify what that is?

A. It is from Tumors of the Head and Neck by Dr. Batsakis. B-a-t-s-a-k-i-s.
Q. And the edition of that?
A. Second edition.
Q. And the pages which you received?
A. 160 and 164.
Q. And those were pages provided to you by Mr. Jackson recently?
A. Correct.
Q. Any other information that you've received? You

did not receive the initial report of Dr. Shumrick, you did receive the supplemental report?

A. Correct. And a paper on Oral Tongue Cancer in Young Adults.

Q. May I take a look at that? Was this also supplied to you by Mr. Jackson?

A. Yes. That related to the report of Dr. Murphy.

Q. It appears this was faxed to you on August 3rd?

A. It was not faxed to me.

Q. Here we have Oral Tongue Cancer in Young Adults Less Than 40 years of Age, apparently published in Head and Neck, March/April 1994, correct?

A. Correct.

Q. Pages 107 through page 111.

Have you reviewed these articles which were attached to Dr. Murphy's report?

A. Not in detail, no.

Q. Parts of these have been highlighted and underlined.

Did you do that or did someone else do it?

A. Someone else did that.

Q. Has Mr. Jackson at any time brought data from these articles to your attention?

A. No.

Q. Have you done any research on your own on the issues involved in this case?
A. No.
Q. Have you given Mr. Jackson any information which would guide him in understanding the issues in the case?
A. No.
Q. Is there anything that you received that we've not identified?
A. Not to my knowledge, no.
Q. Have you received the report or any information from Dr. Stephen Haine in Mississippi?
A. No, All I know about that is from the deposition -- no. I have not. I have not.
Q. The deposition of Dr. Shumrick addressed his report, but you've not received the report yourself?
A. No.
Q. Have you received any faxed information concerning his testimony on what he saw in these pathology slides?
A. No.
Q. Do you know how he interpreted these slides?
A. Yes, I do.
Q. How do you know that?

A. Mr. Jackson informed me of that just a few minutes before we came in here.
Q. And what did he tell you?
A. He read me Dr. Haine's or Haine, Dr. Haine's report in the deposition of the slides that he had reviewed.
Q. Last night or today he would have received faxed testimony which Dr. Haine offered yesterday, is that what he read to you?
A. Correct.
Q. He did not show you the actual faxed copy of that?
A. No.
Q. Have you received the report or any information concerning Dr. Jacob's participation in this case?
A. No.
Q. Have you received any information concerning Dr. Brett and his opinions in this case?
A. No.
Q. Have we identified everything that you've taken a look at?
A. We have.
Q. All right. Doctor, what's your understanding of the statistical probability of surviving an oral

lesion of the mobile tongue stage one squamous cell carcinoma?

A I don't have specific numbers for you. The probability of surviving stage one, I could not give you a percent. Five year survival on that off the top of my head.

Q Can you give me a range off the top of your head?

A Five year survival, other than saying the risk for, the five year survival is better than for stage two, which is better than for stage three and four. No, I couldn't give you a specific range.

Q When we talk about the probability of survival, five years survival, can we equate that with the probability of cure?

A. In oral cancer?

Q. Yes.

A. There is always the possibility of recurrent disease beyond five years. Certainly by five years there is, again, and I don't know the numbers for head and neck surgeries for oral cancers specifically.

There is always the possibility of late recurrence. Five year survival is generally a

good indicator of survival for oral cancer but exactly what the numbers are, I'm not sure.

Q. When we talk about there is always the possibility of a recurrence even after five years, do you have any idea on the probability of recurrence after five years?

A. No.

Q. Generally in the treatment of cancer, do we perceive five years survival to mean cure?

A. It depends on the cancer.

Q. With oral cancer?

A. I defer that.

Q. I should say squamous cell cancer of the mobile tongue?

A. I would defer that to an oncologist. I just don't know the numbers.

Q. Now, in the treatment of cancer, are you involved in the treatment or the formulation of plans for the treatment of cancer in any manner here at Mt. Sinai?

A. Am I involved in the formulation? Other than reviewing the slides, reviewing the pathology and answering specific questions that a clinician might have about that biopsy, I do not specifically formulate a treatment plan.

Q. I'm trying to understand the level of your involvement here.

Certainly for T1 lesions of the tongue, the probability of five year survival is much greater than T2, T3 is less, T4 is less than that. But in terms of ascribing some probability of survival to that, are you able to do that?

MR. JACKSON: He's told you that how many times now.

A. I think I have indicated that I do not know the specific numbers.

Q. I'm trying to determine the relevance of your conclusion that this lesion had already metastasized on November 22, 1989.

Do you have an opinion concerning Mr. Boyd's probability of survival on November 22, 1989, assuming that the lesion had metastasized? Very poor. Again, with lymph node metastasis, survival rates for squamous cell carcinoma of the oral cavity are, and again, I don't have the specific number, and if I'm off a couple of percentage points, you know, I'll accept that, but the cure rate for squamous cell carcinoma of the oral cavity with lymph node metastasis is

probably around 15 percent, no better than that.

Q. You draw that from your experience or do you draw it from articles that you've had the opportunity to review?

A. I draw that from general knowledge accumulated over the past many years and I believe I did see a figure in one of those, in either the Batsakis article or not.

But again, the survival rate is very poor with metastatic disease, squamous cell carcinoma of the tongue or oral cavity.

Q. With lymph node metastasis, are we talking about a stage three tumor?

A. It depends on where the lymph node metastasis is. Let's assume you are talking about head and neck, about cervical lymph nodes.

Again, I would review the staging specifically in my handbook, but the T stage would be dependent upon the size of the tumor. This is a lymph node positive, I believe that is stage three. I have to review that.

Q. Do you have an opinion concerning the stage of the cancer present in Mr. Boyd on November 22, 1989?

A. He had lymph nodes positive, in my opinion, in

November of 1989.
Q. And when you say lymph nodes positive, are we talking about an occult metastasis?
A. Metastatic disease we're talking.
Q. Non-palpable lymph nodes?
A. I don't know that they were non-palpable or not. I am talking about metastatic disease in lymph nodes. They may have been palpable back then. I have no way of knowing.
Q. Let's assume that Dr. Brown testified that he would check the nodes and that they were not palpable.
A. Then we're talking about, but again, I have no --
Q. You don't have the basis to determine whether they were palpable or not?
A. But regardless of whether they were palpable or not, clinically non-palpable metastatic disease, yes.
Q. Certainly the probability of surviving is less with palpable nodes than it is with occult nodes, would you agree?
MR. JACKSON: What is an occult node? What do you mean by occult node?
MR. YOUNG: We'll leave it to the

doctor.

MR. JACKSON: Why don't you explain what you're asking?

Q. Do you understand, Doctor?

A. If you're talking about a node that is clinically non-palpable, I'm not sure what the difference in survival is percentage wise between non-palpable node with metastatic disease and palpable node with metastatic disease.

Q. Do you know if there is a difference?

A. I do not know.

Q. All right. It's your opinion that at least there was microscopic disease in the nodes, cervical nodes on November 22, 1989?

A. At the very least microscopic disease, yes. It may have been more than microscopic disease. It may have even been grossly visible. I don't know that.

Q. Are you able to determine that from your doubling time theory?

A. From doubling time and from what we know about what happened to the oral cancer over a period of 10 or 11 months.

Q. Do you have an opinion concerning how long it

takes, it would have taken these cervical nodes to go from microscopically inward to actually palpable metastatic nodes?

A Let's rephrase it a little different

How long would it have taken to go from microscopic to two centimeters?

Q. Yes.

A. Or 2.2 centimeters The doubling time of squamous cell carcinoma of the oral cavity is generally in the region of about 200 days

Now, faster growing tumors, 100 days tumors do not double overnight A tumor that appears to double overnight is doing so because it's inflamed because something else is happening.

Doubling times of tumors range between, oh, for the very fast growing tumors 40, 60 days, to 200 days for some of the slower growing tumors.

Studies that have been done both clinical and experimental with squamous cell carcinoma show doubling times in the region of 200 days

Let's assume this was 100 days, let's even assume it was 50 days, you know, it doesn't matter. It takes approximately four doublings

for the size of a tumor in one dimension to double, okay?

So for a one centimeter tumor to become two centimeters when you look at it purely on an x-ray, it requires four tumor cell doublings.

Q. Which requires how long?

A. If you're going with 100 days, it requires 400 days. If you want to go with 50 days, which this isn't because this is not the histology of this tumor, microscopy of the tumor and the clinical behavior of it, because we watched it grow in the mouth does not indicate that.

My opinion is that this is a slow growing tumor, that if we look at what happened in the mouth, this tumor, even if it was a pimple five millimeters, six millimeters back in November, 11 months later it's now a centimeter, maybe a little larger than a centimeter. This tumor has not exploded and the tumor has grown slowly in the oral cavity and that fits with what we know about oral squamous cell carcinoma, they grow slowly.

So if you look at a tumor and lymph node that is two, two and a half centimeters in diameter, it has probably taken, oh, I wouldn't

give you, you know, an exact figure, it takes approximately 30 doublings before a tumor reaches one centimeter.

Q. Would you expect those doublings to occur at a predictably identifiable rate throughout the growth of the tumor?

A. There may be some sort of incidental increase due to some coalescence, but a tumor and lymph node that is two and a half centimeters did not pop up overnight.

That tumor has been there a long time. It has doubled over the course probably of a few years, probably over the course of a few years.

Q. I'm talking about the metastatic tumor.

A. Yes.

Q. Probably there for a few years?

A. Yes.

Q. But we know that it grew very rapidly in October, November, in that period of time, don't we?

MR. JACKSON: You're talking about the tumor --

MR. YOUNG: The metastatic tumor.

MR. JACKSON: You're talking about the seven to eight?

Q I'm talking about the metastatic tumor
A Where?
Q I'm asking you from your examination of the records. I'm talking about the Medina General Hospital records, did you determine that this was a very aggressive cancer in the fall of 1990?
A. Yes It became a very aggressive tumor but what you have to realize is that once this tumor is in lymph nodes, and then it gets out of the lymph nodes into soft tissues, it then disseminates and it starts disseminating from metastatic sites as well.

So there is a point at which the tumor will gallop and become very aggressive It will spread, for example, to lung and then from lung it gets into blood vessels and it can go throughout the body, bone, liver, brain.

But here we're looking at a lymph node, a contained lymph node and within a contained lymph node, the tumor doubles and grows

Might there have been two or three or four separate little deposits within those lymph nodes which then doubled and coalesced, there might have been. Does that affect my opinion?

No. Because the doubling times of these tumors are very slow. You're talking about 11 months, let's say 330 days from November through to October, 300 days, it doesn't matter. That tumor in those 300 days is probably done nothing more than three or four doublings.

Has it had five or six doublings? I don't know. Maybe. Seven or eight? Possibly. But it doesn't affect the opinion because it requires literally tens and tens of doublings to reach a size of two and a half centimeters. To get from half a centimeter to two centimeters is going to require eight doublings approximately, nine, ten, approximately eight doublings for it to quadruple in diameter. That occurs over a period of probably two or three years.

Q. When you talk about the fact that squamous cell carcinoma is very slow growing and the doubling rate is low, I assume that is generally accepted in the medical community?

A. Yes.

Q. And you referred to studies which demonstrate between 100 to 200 days.

What studies are those?

A. I do not have those specific studies here at

hand. These are data that are well-known in the literature. They're data that I have accumulated over the course of several years.

Q. When you say data that you've accumulated, are you talking about data you've accumulated in your head or articles that you actually have in your possession?

A. Data in my head. I read the articles. I do not keep every article that I read.

Q. So you don't have any articles somewhere that would demonstrate this principle to which you are just testifying?

A. Not that I can lay my hands on during this deposition.

Q. What about after the deposition?

A. Oh, there are lots of articles. If they're not in my files, they are in my library.

Q. Do you keep files pertaining to this issue?

A. Pertaining to head and neck cancer? No.

Q. So you don't have any files that would contain articles that support this conclusion?

A. If one had to keep all the medical literature forever, we wouldn't be sitting in this room. We'd have all our stuff here.

Q. I just am trying to understand. Certain

physicians keep certain files of things that they find relevant to their practice, but you don't have any of these isolated with regard to this case?

A. No. I might. And I might be able to lay my hands on them because doubling time is something that has interested me over the years. Can I lay my hands on them now? No. Can I lay my hands on them sometime? Yes, I bet I can. I probably have them in my file.

Q. You have a file somewhere that might have this information?

A. Oh, absolutely.

Q. This is not a recent development concerning doubling time?

A. No.

Q. Or understanding of tumors?

A. No.

Q. This is something that goes back into the eighties and probably back into the research of the fifties, would you agree?

A. Yes.

Q. Doctor, in the treatment of cancer, we're concerned not only with the ability to eliminate the disease, but also to retard the progression

and perhaps extend the person's life, are we not?

A. Yes.

Q. And I think it's your testimony that Allan Boyd had some element of metastasis from this tongue tumor in November of 1989 and that he had therefore something in the area of 15 percent probability of survival at that time, correct?

A. Based on statistics, yes.

Q. And that's assuming there had been a diagnosis of the condition and the proper treatment of the condition at that time, correct?

A. I would have to defer again to an oncologist to see what impact his modalities of treatment would have on metastatic squamous cell carcinoma of the oral cavity.

Q. Do you defer to an oncologist or a surgeon concerning the probability of survival at that point in time with metastatic disease, or is it your intention to express an opinion concerning the probability of survival in November of 1989?

A. I'm not going to express an opinion on whether he would or wouldn't have survived. My opinion is based on statistics and I can certainly statistically, you know, give numbers, 15

percent, 17 percent. That I can do.

But I really think it's the oncologist, I don't know what impact radiation or chemotherapy is going to have in a case of oral squamous cell carcinoma that is metastasized to lymph node, not a whole lot I think. That would be really the opinion of an oncologist.

Q. You have some thoughts concerning it but you would prefer to defer to specialists in the area of cancer?

A. I have data but I would defer to an oncologist.

Q. And that would also include whether his life would have been extended with proper treatment as opposed to giving him the probability of a five year survival, would you agree?

A. Correct.

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(Thereupon, a recess was had.)

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Q. Doctor, looking at your report here, and your prior testimony, you've concluded that on November 22, 1989 this tongue lesion had already metastasized based on the size of the metastatic lesions in October of 1990.

Are you able to give me an opinion to a

reasonable medical probability as to the earliest time when this tongue lesion would have metastasized resulting in those metastatic lesions?

A. Again, to give a specific time, no. But based on the size of that, the lymph nodes in October of 1990, it would be my opinion that that metastatic disease was present certainly in excess of the year or 11 month delay and probably two, three years prior to that.

Q. And in terms of the latest time when it could have metastasized, are you able to draw a cutoff date beyond which in your opinion it would not have metastasized? Is that the two to three years that you're talking about?

A. I don't understand the question.

Q. Well, if the metastatic disease could have been present for two or three years, I'm looking for the range, not longer or less than, if you're able to draw a range when the metastatic disease would have been present?

MR. JACKSON: I think that's what he just gave you.

A. In my opinion, the metastatic disease started, tumor spread to the lymph nodes, probably two,

three years prior to the discovery of the oral lesion.

Q Is it possible for these two centimeter metastatic nodes to develop over the course of less than 10 months?

MR. JACKSON: Objection. You may answer.

A Is it possible for these two, two and a half centimeter lymph nodes with metastatic tumor to have developed over the course of 10 months?

MR. JACKSON: Dealing with a squamous cell carcinoma as we are.

Q These nodes?

A In this particular case, not in my opinion.

Q I'm not asking whether it's probable. I am asking whether it's possible.

In your opinion, that is not possible?

A Based on what we know about the growth of the tumor in the oral cavity, based on what I've seen microscopically of that tumor, well differentiated squamous cell carcinoma, no.

Q I assume that your opinions are primarily based on research which you've read concerning doubling time theories as opposed to being able clinically here working within the hospital to

back date metastasis, is that fair?

MR. JACKSON: Oh, object to that. I think he said it is based upon his literature and also his personal experience with these disease processes.

A. Yes. It's based on my review of literature, my reading and also experience. We see, I won't say every day, but on a daily basis we see cancer cases and we have, you know, there is an accumulated experience in this, oral squamous cell carcinoma are slow growing tumors.

Q. Generally trying to determine the date of metastasis with hindsight is not something that is relevant to the treatment of the condition, is it?

A. I'm not sure I understand --

Q. It is not something you do in your everyday practice, try to determine a date of metastasis?

A. On a daily basis? No. We receive a lymph node with metastatic disease and we report it out as such.

Q. Under any circumstances, do you try to determine date of metastasis other than for legal purposes?

A. I would think there are rare clinical cases

where that does become an issue but on a day-to-day basis in cases of cancer, is it part of our routine to back date and do that, no

Q Do I understand, Doctor, that you were not provided with Dr. Alonso's deposition in this case?

A. No.

Q. You did not receive that?

A. No.

Q. You didn't receive her explanation in any way concerning her attempts to interpret this slide, her attempts to communicate with the surgeon?

A No

Q Has Mr. Jackson informed you concerning that testimony? Do you have any understanding whatsoever?

A. My sole understanding is that at some point that she made a phone call to Dr. Brown.

Q And how do you get that understanding? What information have you reviewed concerning that?

A It was in this deposition of Dr. Shumrick, correct

Q But Mr Jackson didn't give you the deposition of Dr. Alonso, Dr Brown or Dr Parsenko?

A No

Q. You would agree, would you not, that when Dr. Alonso received this tissue specimen, the purpose was to diagnose the condition, and the concern was to rule out cancer?

A. The purpose was to diagnose the condition. You know, I think with any white plaque there is always the underlying need to exclude cancer, the notes there say rule out candida.

Her role is to diagnose the lesion and let's stop at that, regardless of what the lesion is.

Q. Let's take a look at her report.

Do you have a copy of that?

A. Somewhere I do, I believe. Yes.

Q. We have a gross description contained on the report.

Do you have any reason to doubt the gross description of the specimen which is contained there?

A. No.

Q. What conclusions can you draw, if any, from the gross description of this specimen?

A. My conclusion is that she received two small yellow white pieces of tissue, one measuring 0.6 centimeters in greatest dimension, the other 0.7

centimeters in greatest dimension. That is the sole conclusion from the gross description.

Q. Your report that you prepared for Mr. Jackson talks about the superficial nature of the biopsy.

A. Right.

Q. Do you have any criticism of the biopsy or the tissue that was taken from the tongue?

A. Do I have a criticism of what Dr. Brown did?

Q. Correct.

A. In terms of how he took the biopsy?

Q. Yes.

A. No.

Q. I think you testified that the nature of this specimen causes you to question whether it was an excisional biopsy, correct?

A. I don't believe I say that anywhere.

Q. No. From your prior testimony. Certainly it's not in your report.

A. What, I have no question that in Dr. Brown's opinion this was an excisional biopsy. He saw a small white pimple and removed it. That is the definition of an excisional biopsy. He removed what he saw.

My testimony is that I believe that what he

saw wasn't the entire lesion that existed.
Q. Do you disagree with Dr. Alonso's microscopic description of these slides?
A. Where it says microscopic?
Q. Yes.
A. She's described a whole lot of findings. I don't believe in microscopic descriptions. We give them diagnoses. Most surgeons aren't smart enough to read and understand the description, could you give them a diagnosis.
Q. When we say aren't smart enough, you mean they aren't trained as pathologists so you don't try to give them the pathological description?
A. Most surgeons want a diagnosis. I am being sarcastic. There are physicians and there are instances where we give a microscopic description, but there's a specific reason for doing it in those cases.
Q. Do you believe or does this pathology report cause you to believe that Dr. Alonso had difficulty interpreting these slides?
A. I don't know how much difficulty she had. I cannot, I really can't speak for her. I don't know what she means by focal mild atypia. So I don't know whether she had difficulty in this or

not.

Q. In your opinion, is her microscopic description of what she saw accurate?

A. She has described in the microscopic description things that she saw in that biopsy. There is certainly a hyperplastic epithelium. There is inflammation and fibrosis. There is isolated dyskeratoses, parakeratosis and hyperkeratosis, those are all present. The hyperkeratosis gives a verruccus appearance to the lesion.

Q. An occasional base of a ridge appeared atypical and hyperchromatic?

A. Hyperkeratosis gives a verrucous appearance. I don't believe that's true. But that's neither here nor there. Pigment layer is focally thickened, which is meaningless to me. Isolated vacuolated cells, findings suggestive of a viral infection, I don't believe they do suggest a viral infection. No fungi seen, that is appropriate since it was rule out candida. So the fungal stain was done.

So what she has described certainly occurs, is seen within that lesion. Her interpretation of what she saw I don't agree with.

Q. There is more there that she didn't describe,

would you agree?
A. There's not a whole lot more that she didn't describe. But she's described what's there in essence.
Q. And your interpretation of this is superficially invasive, moderately well differentiated squamous cell carcinoma, correct?
A. That's the interpretation. You asked me did she describe what's on there and clearly you don't understand then the difference between describing what's on there and formulating a diagnosis, because the two are very different.
Q. I understand.
A. You asked me if I agreed with what she described. I'm telling you yes.
Q. Is there anything she omitted from that description which leads you to the conclusion that there is squamous cell carcinoma present in these slides?
A. No. Not really. Not really. If I were describing it, I might have used a few different descriptors, but no. She's described what's there pretty well. Her description is fine.
Q. Do you believe that she deviated from accepted standards of care in failing to diagnose a

lesion which was at the very least suspicious for squamous cell carcinoma?

Yes, I think she should have recognized this as being difficult, suspicious for squamous cell carcinoma. I would have had no problem with the diagnosis here of suspicious for well differentiated squamous cell carcinoma. I would have had no problem with her identifying this as a difficult problem and getting another opinion.

What do we mean by difficult? When you say you'd have no problem with her identifying this as difficult?

This is not an easy, that original biopsy was not an easy slide to diagnose.

Okay. But at the very least if she was unable to arrive at a diagnosis, she had to obtain another opinion, would you agree?

I think she should have obtained another opinion, sought another opinion, yes.

And in failing to do that, did she deviate from accepted standards of care in the practice of pathology?

Yes.

Is her diagnosis of the moderate papillary hyperplasia with hyperkeratosis, focal mild

atypia and chronic inflammation a benign diagnosis?

A. Boy, for me her diagnosis is neither. Her diagnosis is descriptive, unfortunately, and we certainly do give descriptive diagnoses and there certainly is a place for that.

I think once, once she uses the word atypia, that needs to be qualified. Her opinion needed to be that the atypia was dysplastic, it sort of concerned her about the possibility of malignancy, or the atypia was a reactive process due to inflammation and so forth.

So I don't think her diagnosis is benign or malignant, it's kind of, it leaves one hanging. It hasn't drawn the conclusion.

Based on this written pathology report, without looking at the slides, would you be able to rule out the presence of carcinoma in this specimen?

I as a pathologist?

Yes.

As a pathologist looking at these slides, I would either have to call her or look at the slides to rule out carcinoma.

What information would you get in the telephone call that would not be contained in this report?

A Again, as a pathologist, I would ask her if she thought it was dysplastic, what was the atypia, did she think it was reactive

Again, as a pathologist, I'm used to not taking anyone's diagnosis for granted and I get the slides and I look at them myself

Q Certainly it is her duty to put everything in the written report, not simply to provide information to the clinician by telephone, would you agree?

A There are times when we do not put everything in a report.

Q What times?

A There are times when there are certain aspects of a case that don't necessarily go into a report We will call the clinician and indicate on the report that the clinician was called

It's not possible always to put everything in a report.

Q When you say you would call her and talk with her and talk about whether there was presence of dysplasia, what relevance would that have?

A. As a pathologist?

Q. Yes.

A. What you're saying is this patient came to this

hospital for a second opinion and this is the pathology report I got as the pathologist.

Q. As a pathologist you look at this pathology report, you testified you would not be able to rule out cancer, and so you would contact the pathologist to gain more information?

A. Honestly I would ask her to send me the slides and I would look at them myself.

Q. You mentioned in talking with her that you would ask about dysplasia.

What relevance would dysplasia have?

MR. JACKSON: He said atypia I believe.

MR. YOUNG: He said dysplasia as well.

A. I used the term dysplasia as well. Let me back up. As a pathologist I would get the slides, and if I wanted to know what this showed with this report, I would ask her to send me the slides.

Q. All right. So you wouldn't settle for this report?

A. As a pathologist, I would not settle for this report.

Q. Now let's talk about as a surgeon. Do you

believe that a surgeon receiving this report is justified in ruling out cancer based upon the written report alone?

MR. MURPHY: Objection.

MR. JACKSON: If you feel comfortable speaking for a surgeon, Doctor, go ahead and answer.

A I would have to answer that based upon it depends on the surgeon. It depends on the relationship that surgeon has with his or her pathologist.

In other words, if I send out a report that says focal atypia to my surgeons, they know it's not cancer. If someone else -- you need to know your pathologist. So I can't really answer that.

Q And you haven't had the opportunity to review the depositions of either the surgeon or the pathologist?

A No.

Q So you don't know the relationship?

A That's correct.

Q You can't comment on that relationship and their ability to communicate?

A No.

Q. I want to get back to dysplasia. You said that dysplasia would be relevant.

How would it be relevant?

A. Well, dysplasia is an abnormal growth of tissue. It's an abnormal proliferation and maturation of an epithelium which in many instances, and again, it's depends on the location and the site, has a pre-cancerous connotation.

Q. And there are occasions when you report dysplasia to the clinician here at Mt. Sinai and it's understood what you're talking about?

A. Absolutely.

Q. In other words, dysplasia is a diagnosis?

A. Absolutely.

Q. This written report does not report dysplasia in any way, does it?

A. No, it does not.

Q. And there is no reference to mild or severe dysplasia in any way?

A. No.

Q. But you would agree that a surgeon should understand the relevance of a report of dysplasia?

A. If the term dysplasia specifically is used,

every surgeon understands the implications of that, I would hope.

Q. And when we say every surgeon understands the implications, what are the implications?

A. The implications are that there is, in the tissue examined there is no cancer but there is an abnormal cell proliferation, which depending on the degree of severity, has a lesser or greater degree of pre-cancerous connotation or association with cancer.

Q. Certainly if you receive a diagnosis of dysplasia, a surgeon would not be able to rule out cancer based upon that diagnosis?

MR. MURPHY: Objection.

Q. Would you agree?

A. No. He might well be able to rule out cancer because if he saw a white plaque, let us say, we will use that as an example, if he saw white plaque and he excised it and the report is dysplasia, that would rule out the presence of cancer and he would then follow the patient based on that.

So the presence, your question was does the presence of dysplasia rule out cancer, it may well depending upon the nature of that biopsy.

In your answer there you just stated that he biopsied or he excised the dysplasia, but certainly he would have to excise all of the dysplasia and the margins would have to be addressed under those circumstances, would they not?

A. It depends. You know, it depends on the clinical situation as well. But yes, finding dysplasia in a small biopsy does not rule out the presence of cancer next to it or elsewhere in the region.

Q. And if you receive a specimen and your diagnosis is dysplasia, would you yourself address the issue of margins?

A. It depends.

Q. On an excisional biopsy?

A. On excised, absolutely.

Q. If it was not excised, what would your recommendation be?

A. If it's merely an incisional biopsy, the recommendation is that appropriate further management should be undertaken, whether that be excising the whole lesion, or if it is too large to excise, watching very carefully, biopsying other areas, that really is the call of the

surgeon.

But my pathology report would indicate there is dysplasia present, this is only a biopsy and it really becomes then the role of the surgeon to determine what further he is going to do.

Q. Are you aware in this case that by telephone Dr. Alonso informed Dr. Brown that there was mild dysplasia as a diagnosis for this condition?

A. I don't know what Dr. Alonso told Dr. Brown specifically. I know there was a phone call.

Q. Have you seen the telephone note on Dr. Brown's records?

A. No.

Q. You've not seen that?

A. And if it was in the records, I did not see it and didn't look for it, no.

Q. But you did have the opportunity to review his records, you just didn't understand the nature of the notation?

A. When I received the records, I reviewed those records specifically as they pertained to what the biopsy showed, what my opinion was on the lymph node and metastatic disease.

I really did not review the records with

regard to quality of care rendered by Dr. Brown, the appropriateness or inappropriateness of his response to this pathology report.

I'm sure it was in the notes that were sent to me, but I saw no need to review those based on what I was asked to look at.

Q. Let me show you what's been marked for identification purposes previously as Dr. Brown Exhibit 4, which is his office chart.

A. Sure.

Q. And in his office chart we have the notations that he made on November 22, 1989 and later we have a date 11/28/89. And the notation there is "path: Hyperkeratosis, mild dysplasia."

Did you have the opportunity to see that notation in reviewing these medical records?

A. No, I did not see that. I did not look for it and did not see it.

Q. Just to further understand your opinion in this case, is it your opinion that as a result of Dr. Alonso's deviation from accepted standard of care in making a diagnosis in this case, Mr. Boyd failed to get treatment for a cancerous condition which was present on November 22, 1989?

A. No. I don't know what, what would have been done locally. Had a diagnosis of carcinoma been made here, and again this is an assumption, I would assume that Dr. Brown or someone else would have re-excised that area.

Q. It's your opinion that a diagnosis which would cause further follow-up should have been made, correct?

A. Yes.

Q. In other words, when we talk about the fact that a diagnosis of at least suspicious for well differentiated squamous cell carcinoma should have been made, that would have been sufficient to alert a clinician to the need for further care?

A. Correct.

Q. All right. That diagnosis was not made and no further care was rendered, correct? You do know that?

A. Yes. Based on no further care was rendered, that is correct.

Q. You have no opinion concerning whether Dr. Brown deviated from accepted standard of care, and you were not supplied the necessary information to be able to evaluate that, would you agree?

A. I am not going to have an opinion and don't have an opinion on how Dr. Brown should have proceeded given Dr. Alonso's report.
Q. All right. And you have no opinion concerning the way in which whatever care would have been administered would have affected the outcome in this case, do you?
A. I wasn't concentrating. Can you repeat that?
Q. In other words, you don't have and you don't intend to express any opinion concerning the effect that proper treatment of this condition would have had on the outcome?
A. My opinion is going to be or is that metastatic disease was already present.
Q. I'm just trying to find the line at which you --
A. Correct. And based on that, the prognosis was extremely poor. I am not going to render an opinion on how either radiation therapy or chemotherapy or other modalities of treatment would have affected that very poor prognosis.
Q. You would agree with me that had the diagnosis been made in November of 1989 as opposed to in October of '90, the probability of successful treatment would have been greater?
MR. JACKSON: Objection.

A. I don't necessarily agree with that. I don't know that the results would have been any different. With metastatic disease already present, I don't know that therapy would have improved his survival.

Q. I am not asking you if you know if it would have. I am asking if it probably would have.

We know statistically treatment at stage three cancer gives a better result than stage four?

A. But we don't know what effect treatment would have had had the presence of metastatic disease been discovered back in November of 1989.

Q. My question is to your knowledge, within your area of expertise, do you understand that the treatment of stage one cancer gives a better result than stage two?

But he was not stage one in November of 1989. That's not my question.

Does stage one result in a better outcome than stage two?

In statistical terms, yes. For every patient, not necessarily so.

I understand. We're talking about statistically.

And stage two gives a better result than stage three?

A. I'm not sure on the specific numbers there, but I would, again I believe there is a slightly better prognosis for stage two.

Q. And stage three results in a better prognosis than stage four, would you agree, if you know?

A. Yes. Slightly and again, I don't know the specific numbers.

Q. Okay. Now, stage four concerns or includes distant metastasis, does it not?

A. It does.

Q. This gentleman was stage four when he presented in 1990?

A. Correct.

Q. And without asking you specifically without the book in front of you, do you have an opinion to a reasonable medical probability as to what his stage was on November 22, 1989?

A. I don't. I don't because I don't, there were no CT scans, there was no further work-up. So no, I don't. He may already have been stage four at that point.

Q. Is there any evidence of that?

A. There isn't evidence of it. There isn't

evidence that it's not because there isn't, the appropriate tests weren't done. So I don't know what stage he was in in November, '89. He may well have been stage four. But I can't say one way or the other. No one can say.

Q. When you say he could well have been, certainly if he was stage four, you would expect him to have palpable lymph nodes in the neck?

A. Not necessarily.

Q. No?

A. No.

Q. As I understand it, you have no recollection of actually looking at the CT Scan report of October 10th, 1990?

MR. JACKSON: That's not what he said. He didn't look at films.

Q. Do you have the recollection of looking at the report of October 10th, 1990?

A. You are asking me if I looked at the films, I said no. I looked at the report because that's where I got the size of 2.2 centimeters.

Q. All right. Doctor, in Dr. Alonso's deposition she testified that based upon a written pathology report alone, without the telephone call, Dr. Brown should have been alerted to the

need to totally eliminate, further eliminate this atypical condition on the tongue or more closely follow the condition.

Do you agree, disagree?

A. You better repeat that, sorry.

Q. She testified that based on this written --

A. Who did?

Q. Dr. Alonso.

A. Okay.

Q. The woman that Mr. Jackson represents. She testified that based on this written pathology report, Dr. Brown should have totally eliminated the condition on the tongue or more closely followed it.

MR. JACKSON: I'm going to ask you --

Q. Do you agree, disagree --

MR. JACKSON: I'll ask you to read that out of the deposition. Show us what she says specifically.

Q. Let's assume that she says that.

Would you agree with that?

MR. JACKSON: Assume that she says what?

MR. YOUNG: What I just said.

MR. JACKSON: Verbatim as you just said it?

MR. YOUNG: Yes.

MR. MURPHY: Note an objection. Hypothetical phone conversation.

Q. Do you understand the question?

A. Yes. Assuming -- you better repeat that?

Q. Yes. She sent this written report off to Dr. Brown.

A. Based purely on this written report?

Q. Yes. It was her opinion that he should have eliminated the condition surgically or most closely followed it.

Would you agree, disagree or have no opinion?

A. I suppose essentially I would disagree. I don't know, and I'll qualify it by saying that I have no idea how Dr. Alonso makes diagnoses. I have no idea what her typical pathology report indicates. I have no idea how frequently she works with Dr. Brown and how well he understands her standard surgical pathology report.

I don't think it's true to say that based just on this he should have done something else, because I don't think that this is a complete

diagnosis.

Q. Based on what you've just said, is it fair to say that you just don't understand their relationship and you don't have the information to agree or disagree?

A. It's probably fair to say that I don't have information on their relationship to agree with what he said or disagree with what you said. That's fair enough.

Q. Is it common in your practice for a pathologist to contact a clinician to alert him to some special need for further care?

A. It's not only common but it's pretty routine.

Q. Doctor, when we talk about progression of a tumor, what do we mean by progression?

A. Progression of a tumor is a very vague term. Different people probably understand different things.

Progression of a tumor generally implies how that tumor grows, spreads, behaves during the course of its disease.

Q. Foulds, F-o-u-l-d-s, did some work concerning tumor progression back in, it was published I think in 1954, wasn't it?

A. I'm very familiar with his work, with some of

his work

Q You are very familiar with some of it?

A Yes

Q And his work dealt in part with progression of tumors?

A Correct.

Q As you've just defined it?

A Correct.

Q One of the principles -- and he published certain selected principles, did he not?

A Oh, I don't recall the specific details of those papers, but I have reviewed them and referenced them in some of my own papers that I've written, book chapters.

Q In something that I read there, and actually referencing Foulds, one of the principles was progression occurs independently in different tumors, also different lesions of the same tumor

MR JACKSON: May I see your reference?

Q. Is that correct?

MR. JACKSON: Wait a minute. You are ascribing it to a specific article Let's see it.

MR. YOUNG: I am just asking him if he is familiar with the principle at this point in time.

MR. JACKSON: With the principle as set forth by Foulds in a specific writing as you have just said.

MR. YOUNG: I don't have the writing. So I can't say.

Q. Are you familiar with that?

A. I am familiar with that and again, it's not quite as easy and as specific as you've just read it. These are specific types of tumors in experimental animals, yes.

Q. All right. In general, would you agree or disagree with regard to cancer progression occurs independently in different tumors and two different tumors of the same type in the same host may develop or progress differently?

A. In general, that does not occur. It may occur with some tumors.

Q. In general it does not?

A. In general a metastatic tumor behaves pretty much the same as a primary tumor.

Q. In general it does,

A. In general.

Q. What do we mean when we talk about unit characters when we talk about tumors?
A. I'm not sure specifically what you're referring to.
Q. I don't know. It was something I didn't understand in reading some of the studies and I just didn't understand unit characters.
A. I would assume he's talking about, but I would have to read the paper, let's preface that, I would have to read the paper, but if I were to guess, he would be talking about specific characteristics, independent characteristics of a tumor.
Q. In one of those principles he says "progression is continuous or discontinuous. It may occur gradually or abruptly."

In general with regard to cancer, do you agree or disagree with that?

MR. JACKSON: Again, if you have a specific reference, I would like you to show us and let the doctor read it in context. You're not going to do that?

A. Repeat that.
Q. Yes. "Progression is continuous or discontinuous. It can occur gradually or

abruptly."

A. I would agree in part with that. Again, it refers to certain specific types of tumors in an experimental situation. There are certain tumors where changes can occur, absolutely.

Q. With regard to squamous cell carcinoma, would you agree that changes can occur, that it can be present in a quiescent state and flare up and progress rapidly at a given point in time?

A. It depends what your definition of flare up is. If your definition of flare up is that it will double in two days, no, absolutely not.

If your definition of flare up is that over a period of time it may grow faster and double at a slightly greater rate than originally, yes. And I think I indicated that early on, that a doubling time generally is around 200 days.

Let's assume that it increased its doubling time to 100 days or 80 days or 60 days or 50 days, that would be a change in tumor behavior, but is that tumor going to double overnight, no.

Q. Have you published any studies or any materials which would bear on the issues in this case?

A. I have written a couple of book chapters on

tumor progression and how tumors can change their appearance over time. But that time is not an overnight time.

Q. What chapters in what books have you written?

A. It's in my CV.

Q. That's a current CV and it's contained there?

A. A few things may have happened over the last year. But it won't materially affect it.

Q. Can you point that out to us?

A. These are lectures. There's an article here that refers to some changing biochemical patterns.

Q. 13 on your CV?

A. Small Cell Carcinoma of the Lung. Another one that refers is 16, Changes in Morphologic and Biochemical Characteristics of Small Cell Carcinoma.

Article 31 involves some of what we're talking.

Q. That is what?

A. Ectopic Hormone Production of Tumors. Some of Foulds' studies are discussed in there. No. 47.

Q. That's what?

A. Time Dependent Changes in Human Tumors.

Q. That's a 1988 study?

1385.

Q2 Were you a resident at that time?

A No. There is an experimental paperback in 1974, article number 63, dealing with a specific type of tumor.

Q Medullary thyroid carcinoma?

A As you can see, this is something I've been interested in over many years. And there may be some book chapters.

Q. You just referred to two book chapters --

A I referred to --

Q. -- that dealt with progression.

A. Those were in journals, medical journals.

Q. No, I meant earlier, you had referred to having written two book chapters dealing with progression. I'm trying to identify --

A They might have been in the papers I was referring to. It's not always easy to -- here you go, number five in the books, medullary thyroid carcinoma, again, a specific type of tumor.

Number nine in the books, here were my two chapters, I wasn't lying, from 1985.

Q Doctor, have you been asked from time to time by members of Jacobson, Maynard to consult on

cases?
A. From time to time, yes.
Q. Are you able to approximate for me the number of occasions on which you would have been asked to consult?
A. Oh, I would think, I really don't keep track of this, maybe a couple of times each year, two or three times a year.
Q. Over what period of time?
A. Well, I've only been in Cleveland 11 years. So it's probably over the last seven, seven, eight years.
Q. 14 or 15 cases, would that be a fair approximation?
A. Yes. Maybe a few more than that, I really don't keep track. Maybe 20. Most of those are would you take a look at some slides. There may be an issue in this case and I look at slides and that's the last **I** hear of that case.

There are some cases such as this where slides are brought, I might want you to look at them again and, you know, give me an opinion. They come back or don't. So I don't keep track of how many. I probably issue a report a couple of times a year.

Q. Okay. You have a fee arrangement with them for consulting in this area?
A. Yes.
Q. What is your arrangement?
A. If I'm asked to look at a case, and it's a biopsy, I will charge what I would charge if that were a diagnostic case for the first time.

If subsequent to that I'm asked to rereview a photograph, write reports, get involved with the case, I charge $200 an hour.

MR. JACKSON: I don't know if you meant to suggest this. Are you suggesting that there is a fee arrangement specifically with Jacobson, Maynard or in general?

MR. YOUNG: I'm not suggesting anything.

MR. JACKSON: Because the way you asked the question, it might be read later to imply that.

MR. YOUNG: I am asking him what his fee arrangement is.

MR. JACKSON: In general.

A. In general I charge for my time involved per case.

Q. And it's a uniform hourly basis whether you go to court or whether it's here on deposition?
A. I charge more for depositions and for court because generally that's in the middle of the day when it's toughest for me.
Q. Have you been asked to consult at any point in time by them on any squamous cell carcinoma cases?
A. I honestly don't recall. I might have. I honestly do not recall the specifics of each individual case.
Q. Can you recall the number of occasions on which you would have testified for this firm, either by way of deposition or in court?
A. I would think in deposition over the last seven or eight years, probably a dozen times.

In court, four, three, four, five. I again don't recall.

Q. And at this point in time do you have any cases pending, other than this case, on which you've been identified as an expert by that firm?
A. I do not know. I keep a file of cases which I update and I don't know if there are any cases in that file which are still pending. I honestly don't know.

None that, I'll qualify that by saying none that I can think of at this point.

Q. In addition to the consulting work that you do with this firm, you do consulting work with other firms?

A. I have looked at some cases for independent attorneys.

Q. What other attorneys have you reviewed cases or information?

A. Oh, I've looked at cases for Mr. Kennedy as a plaintiff's expert. I've looked at cases for Mr. Scanlon on a few occasions down in Akron. There are some others in there. I've consulted with Mr. Devan on a couple of cases, a couple of murder cases where there have been specific questions that I've been asked. I have been asked to review cases by Reminger & Reminger on a couple of occasions, a few occasions. Arter & Hadden on a few occasions.

Q. Other than on one occasion testifying for Mr. Kennedy, have you ever testified on behalf of a plaintiff in a medical malpractice case?

A. Yes.

Q. What other cases?

A. Oh, I can recall certainly with Mr. Scanlon down

in Akron.

Q. In Akron? What was the nature of that case?

A. It was a breast cancer case. There's an attorney whose name eludes me here in Cleveland that I've appeared in court for, a case of a pancreatic tumor. There are others. I just don't keep track of them.

Q. Are you able to approximate for me the number of defense cases you would review versus the number of plaintiffs medical malpractice cases?

A. Oh, I would think plaintiffs' cases is probably in the region of half a dozen.

Q. In which you participated?

A. In which I've given reports. Not necessarily proceeding all the way to deposition or trial. But a written report. In defense, oh, maybe four a year, somewhere around there approximately.

Q. Have you ever given a plaintiff's report in connection with a case which was defended by Jacobson, Maynard?

A. Yes.

Q. What case?

A. Oh, I can't recall but I did, I believe that I did give an opinion in a case that was defended

by Jacobson, Maynard.

Q. You don't recall the case or who was defending it?

A. I do not.

Q. Do you recall the name of plaintiff's counsel?

A. I do not.

Q. Do you recall the issues involved in the case?

A. Oh, no. I do not. I don't recall if that case, if the case went to trial or whether there was some sort of settlement based on my written report. I have no recollection.

Q. Are you a member, I think it's the American Academy of Pathologists, is it not? You're board certified. What is the organization through which you are certified?

A. American Board of Pathology.

Q. There are standards promulgated by the board with regard to rendering of reports and so forth, are there not?

A. No.

Q. No?

A. No. The College of American Pathologists has standards. Board certification is based on an examination.

Q. Yes. The College of American Pathologists, what

standards are promulgated by that organization?
A. The standards are that reports be accurate, timely and complete. I suppose those are the three general categories.
Q. Are there definitions within those requirements or those standards?
A. No.
Q. As to what that means?
A. No. Well, let me back up. Are there specific definitions? No. A pathology report should include a gross description. It should include -- let's back up even before that. Every report should include the name of the physician, the type of procedure that was done, a description of the material involved and a diagnosis.
Q. When you testified earlier that Dr. Alonso deviated from accepted standards of practice and care, what did you understand accepted standards of practice and care to mean?
A. Well, my opinion was, as I stated it then, is that I don't think her diagnosis was complete or accurate. Those two are tied up, you know, those are intimately sort of associated. An accurate diagnosis obviously needs to be

complete. In my opinion, hers wasn't accurate.

Q. Applying the standard of an ordinary, a physician of ordinary skill, care and diligence, you believe that the pathologist of ordinary skill, care and diligence would have done more and reported this case diagnostically differently?

A. I think that this diagnosis should have indicated that this was, A, a difficult case. B, it should have been shown to someone else. Those would be my two criteria, minimal criteria for which I would have accepted that diagnosis. This is a very difficult case or I'm showing it to someone else or have shown it to someone else.

In your opinion, had those standards been met, the existence of this carcinoma would have come to the attention of the clinician, is that correct?

MR. JACKSON: I'll object. I think that's been asked and answered at least once.

I don't know. I don't know. It would have depended on who she showed it to. Let's assume she showed it to someone and the opinion of one

of her colleagues might have been the same.

Really I think that is, you know, the surgeon's call. Had she said suspicious, had she said this is a difficult case, I'm concerned about it, would he have done something else? Possibly, probably, I really don't know how he would have reacted to that. He probably would have, yes.

Q. Would you agree that a pathologist of ordinary skill, care and diligence would have diagnosed the condition in such a way that the clinician would have concluded that he could not rule out cancer in this case?

A. Yes, I think that the appropriate report in this case would have been to indicate that.

MR. YOUNG: Thank you. I have nothing further at this time.

MR. MURPHY: I don't have any questions.

GEOFFREY MENDELSOHN, M.D.

C E R T I F I C A T E

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

I, Linda A. Astuto, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the above-named GEOFFREY MENDELSOHN, M.D., was by me, before the giving of his deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above-set forth was reduced to writing by me by means of stenotypy, and was later transcribed into typewriting under my direction; that this is a true record of the testimony given by the witness, and was subscribed by said witness in my presence; that said deposition was taken at the aforementioned time, date and place, pursuant to notice or stipulations of counsel; that I am not a relative or employee or attorney of any of the parties, or a relative or employee of such attorney or financially interested in this action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this ____ day of _____, A.D. 19 __.

_____

Linda A. Astuto, Notary Public, State of Ohio
1750 Midland Building, Cleveland, Ohio 44115
My commission expires October 24, 1997