

IN THE CIRCUIT COURT OF RUTHERFORD COUNTY
MURFREESBORO, TENNESSEE

NANCY GORMAN and Husband,
GERALD GORMAN,

Plaintiffs,

vs.

ELIZABETH LAROCHE, M.D.,

Defendant.

No. 31218

TRANSCRIPT OF EXCERPTED PROCEEDINGS

February 14, 1995

BEFORE: The Honorable John Turnbull, Judge

RESHA * BLACK
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DOC. 347

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The above-styled cause came on for
hearing on February 14, 1995, in the Circuit Court
of Rutherford County, when the following
proceedings were had, to-wit:

THE COURT: Call your next witness
for the plaintiff, please.

MR. JOHNSTON: Dr. Howard Ozer.

DR HOWARD OZER,
having first been duly sworn, was examined and
testified as follows:

DIRECT EXAMINATION BY MR. JOHNSTON

Q. Doctor, would you state your full
name for the record, please, sir.

A. Howard Ozer.

Q. And you occupation is a medical
doctor?

A. That's correct.

Q. Do you have a specific specialty as a
medical doctor, sir?

A. Yes, my specialty is internal
medicine and my subspecialty is hematology and
oncology.

Q. And just very generally, sir, what is
internal medicine?

A. Internal medicine is multisystem

disease treated by medical rather than surgical
means.

Q. And what is hematology/oncology?

A. Treatment of malignant disease of
both leukemia lymphoma as well as solid tumors such
as breast cancer, colon and lung cancer.

Q. Are you what we might call a medical
oncologist, sir?

A. Yes, I am.

Q. Okay. Are you licensed to practice
your specialties in internal medicine and medical
oncology anywhere, sir?

A. Yes, I am in the State of Georgia.

Q. Were you practicing medical oncology
anywhere in 1990 and 1991, sir?

A. Yes, in '90 and '91 I was the chief
of the Division of Medical Oncology at the
University of North Carolina in Chapel Hill.

Q. Allright. And were you practicing
internal medicine anywhere?

A. Yes, as the specialty of which
oncology is the subspecialty, I was in the same
location.

Q. Okay. What is your current job?

A. Currently I'm chairman and director

1 of the Windship Cancer ~~Center~~ at Emory University
2 in Atlanta.

3 Q. What is the Windship Cancer Center?

4 A. ~~Windship~~ is Emory's cancer center
5 responsible for all clinical care, education and
6 research in cancer at Emory.

7 Q. And Emory, I take it, then, is a
8 university and ~~there's~~ a university-affiliated
9 hospital and it's a teaching hospital, correct?

10 A. That's correct.

11 Q. Where did you receive your medical
12 education, Doctor?

13 A. I was an undergraduate at Yale
14 College and then went and got my M.D. and Ph.D.
15 both at Yale Medical ~~school~~. I subsequently went
16 to Massachusetts General Hospital for my internal
17 medicine training, then to the Dana Farber Cancer
18 Center, which is Harvard's cancer center, for my
19 fellowship training and subsequently obtained a job
20 at Rosswell Park in Buffalo.

21 Q. All right. Have you published any
22 articles regarding any ~~aspect~~ of breast cancer,
23 treatment, care, detection, diagnosis, et cetera?

24 A. I have about 200 peer-reviewed
25 articles, and about five or six of those ~~are~~ in the

1 area of breast cancer.

2 Q. And do any of those specifically
3 mention survivability rates and that sort of
4 thing?

5 A. A couple of ~~them~~ ~~are~~ looking at
6 survivability ~~as~~ it correlates with early detection
7 and issues related to mammography and screening.

8 Q. You've been practicing internal
9 medicine and medical oncology for how long, sir?

0 A. I began -- if you count the
1 fellowship years, I began in 1977.

2 Q. All right. In your almost 20 ~~years~~
3 of practice in internal medicine and medical
4 oncology, have you learned and are you familiar
5 with the recognized standard of acceptable
5 professional practice for ~~primary~~ caregivers in
7 breast cancer matters?

3 A. Yes, I am.

3 Q. And when we talk about primary
3 caregivers, does that include
1 obstetrician/gynecologists?

2 A. Yes, it does.

3 Q. Now, let me -- I'm going to do ~~the~~
4 same thing with you, Dr. ~~O m~~, that I did with
5 Dr. Cohn. I'm using the phrase, recognized

1 standard of acceptable professional practice. Do
2 you understand that ~~phrase as~~ being the same thing
3 as standard of care?

4 A. Yes, I do.

5 Q. All right. I'm going to refer in all
6 of my questions from here on out ~~as~~ standard of
7 care. It's just easier for me to say, probably
8 easier for all of us to understand, too. ~~Based~~ on
9 your education, your training, and your experience
10 in internal medicine and medical oncology, ~~are~~ you
11 generally familiar with the standard of care for
12 primary caregivers, including
13 obstetrician/gynecologists, regarding the care and
14 treatment of breast cancer in Murfreesboro,
15 Tennessee, or in a community similar to
16 Murfreesboro, Tennessee?

17 A. I am.

18 Q. And in addition to that ~~are~~ you
19 generally familiar based on your education, your
2 training, ~~and~~ your experience ~~as~~ an internal
21 medical doctor and in medical oncology with such
22 matters ~~as~~ the staging of breast cancer and
2 survivability rates?

24 A. Yes, I am.

25 Q. Would you ~~tell~~ the Court, please,

1 Dr. Ozer, what materials you have examined in
2 formulating any opinions that you hold in this
3 case?

4 A. I examined Mrs. Goman's medical
5 records from Dr. LaRoche, I examined the surgical
6 record and pathology specimen ~~report~~, the xeroxes
7 of the mammograms ~~as~~ well as depositions from the
8 other experts in the case.

9 Q. Having reviewed those documents and
0 relying on your education, your training and
1 experience ~~as~~ an internist and ~~as~~ a medical
2 oncologist, do you have ~~an~~ opinion rendered with a
3 reasonable degree of medical ~~certainty~~ ~~as~~ to
4 ~~whether~~ or not the issues regarding the standard of
5 care and any breach of the standard of ~~care~~ ~~are~~
6 complicated in this case?

7 A. No, actually I think that this is a
8 very simple ~~issue~~, a failure to do an immediate ~~and~~
9 early workup of a dominant breast mass in a woman
0 who had clearly complained, and then subsequently
1 ~~failing~~ to have the woman ~~return~~ in a rapid fashion
2 in order to see whether it was ~~enlarging~~ or not.

3 Q. Okay. You used a phrase there that I
4 want you to define, a dominant breast mass. What
5 is a dominant breast mass?

1 A. Well, most women have breasts that
2 are lumpy in some degree or another, and that
3 represents a background against which any physician
4 has to work when feeling for a new mass. On the
5 other hand, most women also know their own breasts
6 reasonably well and point out to the physicians
7 more often than not, unfortunately, when they do
8 have a new mass. And it's at that point that if
9 it's distinct, if it's clear, if the person can
10 feel it, then that is the single lesion that is
11 termed dominant.

12 Q. Now, you have begun to answer this
13 question already, but I do want to make sure that
14 I've put this in the proper form and we have
15 appropriately. Relying on your education,
16 training, and your experience in internal medicine
17 and in medical oncology, do you have an opinion
18 rendered with a reasonable degree of medical
19 certainty as to whether or not Dr. LaRoche met the
20 standard of care in her treatment of Nancy Gorman's
21 dominant right breast mass in 1991?

22 A. Yes, I do.

23 Q. What is that opinion?

24 A. She did not, unfortunately.

25 Q. All right. Now, we've already heard

1 testimony as to the various things that she did
2 wrong. Let me just skip ahead and ask you, sir,
3 relying on your education, your training and your
4 experience, both in internal medicine and medical
5 oncology, do you have an opinion rendered with a
6 reasonable degree of medical certainty, sir, as to
7 whether or not anything that Dr. LaRoche did wrong
8 in the care and treatment of Nancy Gorman in 1991
9 resulted in injury to Nancy Gorman?

10 A. Yes, I do.

11 Q. And what is your opinion, sir?

12 A. My opinion is that the failure to
13 diagnose the breast mass beginning on February
14 20th, '91, led to its continued growth, and as best
15 we can tell from the record, from its transition
16 from a Stage I tumor to a Stage II-B tumor,
17 seriously impacting survivability.

18 Q. All right. Now, had this tumor been
19 appropriately and properly and timely diagnosed in
20 February or March of 1991, do you have an opinion
21 rendered with a reasonable degree of medical
22 certainty, sir, as to Nancy Gorman's 10-year
23 survivability at that point?

24 A. Yes, I do.

25 Q. And what is that, sir?

1 A. Well, because the breast mass was not
2 actually biopsied and ultimately operated on, it's
3 impossible to say with 100 percent certainty that
4 she would have been disease free had she been
5 worked up immediately. However, it's clearly more
6 probable than not that she had a Stage I lesion,
7 which is more probable than not associated with no
8 lymph nodes metastases at that point, and that
9 translates to a survivability at 10 years of better
10 than 70 percent and probably in the 80-percent
11 range.

12 Q. All right. Now, we talked about --
13 we've heard some testimony and some discussion
14 about this 10-year survivability, and I know in
15 other cancer matters some people may have heard
16 five-year survivability and all that. Would you
17 explain what you're talking about when you talk
18 about five-year or 10-year survivability?

19 A. Sue. You have to put a time limit
20 on survivability. Obviously most of us are going
21 to survive for the next hour in this courtroom, but
22 not all of us are going to survive for the next 10
23 years. So you have a period of follow-up at which
24 you define survivability. And for breast cancer,
25 it's usually in five-year increments, five, 10 or

1 15 years.

2 Q. All right. At the time that this
3 lump was actually diagnosed in December of 1991,
4 Doctor, based on your education, your training and
5 your experience as a medical oncologist, do you
6 have an opinion rendered with a reasonable degree
7 of medical certainty as to Nancy Gorman's 10-year
8 survivability from that point?

9 A. From December did you say?

10 Q. December of 1991, yes, sir.

11 A. Yeah, I think it's now dropped below
12 50 percent and it's probably in the 40 or
13 45-percent range.

14 Q. By my calculations then that is going
15 from a four in five probability of 10-year survival
16 to a three in five, roughly, probability of dying
17 in that same period of time. Is that a fair
18 interpretation?

19 A. That's a fair interpretation, yes.

20 Q. And that would be 10 years following
21 December 26th, 1991, when the excisional biopsy
22 took place, correct?

23 A. Actually most -- well, in this case
24 that would be the case, but survivability, the
25 duration is always calculated from the time of

1 diagnosis. In this case, because of the delayed
2 diagnosis, it would be December.

3 Q. Allright. Now, **are** you generally
4 familiar with the staging of breast cancer, sir?

5 A. Yes, I am.

6 Q. You understand ~~there~~ **are** a couple of
7 methods or maybe several methods of staging breast
8 cancers?

9 A. Yes.

10 Q. Are you generally familiar With what
11 is called the TNM system?

12 A. Yes, I am.

13 Q. Would you explain to the jury what
14 the TNM system is, please, sir.

15 A. Well, it's a system designed
16 primarily by my surgical colleagues to define every
17 tumor in such a way that you know what the size of
18 the tumor is, whether ~~there~~ **are** lymph nodes
19 involved, and thus the T and the N, and the M is
20 whether or not metastases have **occurred**. So every
21 tumor can be defined both by size or extent, by
22 nodal involvement locally and by metastatic disease
23 in, for example, the lungs or the brain or the
24 liver.

25 Q. All right. Doctor. let me show you

1 this chart up close so you can take a **look** at
2 that

3 A. Okay.

4 Q. Allright. You understand what this
5 chart is, sir'?

6 A. **Yes**, I do.

7 Q. Would you explain to the jury,
8 please, what this is. .

9 A. Well, that's a chart that actually
0 breaks down in a lot more detail the TNM system.

1 And it includes some other footnotes on each of ~~the~~
2 letters. For example, an X means the **primary** tumor
3 cannot be found, and unfortunately we occasionally
4 ~~see~~ patients that have no **primary** tumor. And ~~the~~
5 other subheadings ~~there~~ define ~~whether~~ or not there
6 is involvement of the skin in breast *cancer*,
7 **whether** there **are** regional lymph nodes or distant
8 lymph nodes involved, et cetera. But **fundamentally**
9 it's the TNM staging classification.

0 Q. All right. Now --

1 A. For breast *cancer*, by the way.

2 Q. I'm sorry. Now, the actual chart
3 itself -- I'm sorry, it's kind of small, but it's
4 down here. Using ~~this~~ chart and the definitions
5 included in this chart, *can* you stage Nancy

1 Goman's breast cancer in February of 1991, sir?

2 A. You can do what is called clinical
3 staging, which is unfortunately all that's
4 available given that **we** don't have a mastectomy and
5 a biopsy specimen to go by. But you can do that
6 through a **clinical** stage, and that stage would be
7 Stage I. As you *can see* there is a T-1 lesion, and
8 if you look up on top, it's less than **two**

9 centimeters. It's one-and-a-half centimeters. And
10 there **are** no lymph nodes involved, we **are** assuming
11 clinically, because they cannot be palpated and
12 because it is **more** likely ~~than~~ not that **they are**
13 not there. And with the M, there **are** no
14 metastases, and we know that's actually a fact.

15 Q. And how do we know that?

16 A. We know that because there **are** no
17 metastases present now. Metastases don't go away
18 unless they're at least **treated**.

9 Q. Allright. Now, using this same TNM
10 staging chart, can you stage Nancy Goman's breast
11 cancer in December of 1991 when the excisional
12 biopsy **took** place?

13 A. Yes. Exactly the same thing. If you
14 **look** at the top -- you always use the largest
15 dimension to do the staging. So ~~her~~ biopsy

1 specimen in December of '91 measures 2.9 by 1.8 by
2 1.2. So that is **larger** ~~than~~ two centimeters but
3 less than ~~five~~ centimeters. So it's now a T-2
4 lesion, and she has involvement of her -- of two
5 nodes, so she's got nodal involvement. And
6 that's -- for understanding, that's called ~~an~~ N-1.
7 And ~~then~~ she still does not have metastases. So
8 she's a T-2, N-1, M-0 by TNM classification, or by
9 the one that we all use because it's easier to
0 converse by, she's a Stage 11-B.

1 Q. Okay. Now, you have indicated here
2 that you're relying on both size and nodal
3 involvement and that in your opinion she went from
4 a Stage I in February to a Stage ~~II-B~~ in December.
5 Have I accurately said that?

6 A. Well, she's unequivocally a Stage
7 ~~II-B~~ by pathological staging in December.

8 Q. I'm going to ask you about ~~the~~ other
9 right now. That's what I'm **getting** to. Now, if
0 **I'm** understanding your testimony correctly, Doctor,
1 a Stage I, **right** here, requires a **finding** of no
2 nodal involvement; is that **right**?

3 A. That is **correct**,

4 Q. And granted, we can't know that
5 because nothing **was** done in this case in

Page 1'

1 February --
 2 A. That's right.
 3 Q. -- at the initial clinical
 4 examination. Is it possible that nodal involvement
 5 can be detected simply through that clinical
 6 examination?
 7 A. Yes, it is possible.
 8 Q. Okay. Is there any indication at all
 9 that any such examination like that took place on
 0 February the 20th of 1990?
 1 A. Well, the physician's assistant that
 2 examined Mrs. Gorman on February 20th did not note
 3 that on the exam. My presumption is that if she
 4 did an exam, a breast exam, that she included it,
 5 and, therefore, I would assume that it was
 6 negative.
 7 Q. Let's make sure -- we've had a little
 8 bit of testimony about this but I want to be sure
 9 that we're all understanding exactly what we're
 10 talking about. What are lymph nodes, what do they
 11 do?
 12 A. The lymph nodes are more or less dams
 13 along the lymphatic system, and the lymphatic
 14 system is much like the blood system, it is
 15 involved in recirculating the lymph throughout the

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1 body. And the lymph is a fluid through which white
 2 cells that eat bacteria travel, and if anyone's
 3 ever had a cut, occasionally you'll get a red
 4 streak that will go up a little ways and that's
 5 because of the infection of the lymphatic system.
 6 The lymph nodes are particularly
 7 prominent in major intersections of the body such
 8 as the axilla or in the groin, and there are always
 9 local lymph nodes that drain all the tissues in the
 10 body. In this case the lymph nodes in the breasts
 11 tend to point up towards the armpit, the axilla,
 12 and drain the lymphatic fluid from the breasts.
 13 They are -- unfortunately that's the root that
 14 breast cancer, in particular, cells will travel as
 15 they metastasize.
 16 Q. All right. So because they act as
 17 these drains for the fluid from the breast, they
 18 are also then going to act as drains for the breast
 19 cancer itself?
 20 A. That's correct. They're more or less
 21 dams or filters, if you will, that tend to capture
 22 the metastasizing breast cancer cells.
 23 Q. You have somewhat answered this
 24 question but I'm going to put it in an appropriate
 25 form just to get a direct answer to the question.

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1 Do you have an opinion rendered with a reasonable
 2 degree of medical certainty, Doctor, as to whether
 3 or not Nancy Gorman's lymph nodes were involved in
 4 February of 1991?
 5 A. Yes, I think one can use medical
 6 statistics to say with a more probably than not
 7 confidence that there was no nodal involvement in
 8 February of '91.
 9 Q. All right, Would you explain to the
 0 jury how it is that you arrive at that?
 1 A. Well, there is a direct correlation
 2 between involvement of lymph nodes and size of the
 3 tumor. And as the tumor doubles, the likelihood
 4 that the lymph nodes will be involved also
 5 doubles. Above two centimeters it's more than 50
 6 percent likely that there will be lymph nodes
 7 involved. If any of the women in the jury were to
 8 come to me and see me with a breast mass larger
 9 than two centimeters, I would say that you have a
 10 50 percent chance of nodal involvement. Below two
 11 centimeters, it's less than 50 percent. And so one
 12 can say with more than 51 percent probability that
 13 there was no nodal involvement in Mrs. Gorman in
 14 February of '91.
 15 Q. And that's because the best clinical

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1 evidence that we have is that this tumor was only
 2 one-and-a-half centimeters at that time; is that
 3 correct?
 4 A. That's correct. I might add, by the
 5 way, that's the whole purpose for early detection,
 6 the smaller it is, the earlier you can get it, the
 7 better your chances of cure.
 8 MR. JOHNSTON: At this time, if Your
 9 Honor please, I would ask that the TNM staging
 10 chart be admitted into evidence as Exhibit Number
 11 4.
 12 THE COURT: Without objection it will
 13 be Exhibit Number 4.
 14 (TNM staging chart marked as
 15 Exhibit Number 4 and filed as
 16 a part of this record)
 17 Q. Now, Dr. Ozer you have expressed your
 18 opinion as to Mrs. Gorman's likelihood of 10-year
 19 survivability in this case. In addition to that do
 20 you have an opinion based on your education, your
 21 training and experience as a medical oncologist
 22 rendered with a reasonable degree of medical
 23 certainty as to whether or not there are other
 24 injuries that she has also suffered as a result of
 25 this delayed diagnosis?

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1 A. Other injuries of what type?
 2 Q. Well, do you have an opinion rendered
 3 with a reasonable degree of medical **Certainty** as to
 4 whether or not the delay in diagnosis has increased
 5 her **risk** of recurrence of **breast** cancer?
 6 A. Yes, it has.
 7 Q. Can you explain to the **jury** - well,
 8 let me ask you this. Do you have an opinion
 9 rendered with a reasonable degree of medical
 10 **certainty** as to what her **risk** of recurrence of this
 11 breast cancer would have ~~been~~ had it been detected
 12 in February of 1991?
 13 A. Yes, I do.
 14 Q. And what is that opinion, sir?
 15 A. Well, we're now talking about the
 16 inverse of survivability because, unfortunately,
 17 breast cancer when it relapses is almost always
 18 fatal. So for all intents and purposes, the rest
 19 of the proportion that don't survive **are** the ones
 20 that will relapse. If she has a 70- to 80-percent
 21 survivability in February at 10 years, that means
 22 she has a 20- to 30-percent chance of relapse in
 23 February of '91 during the following 10 years. By
 24 the time December rolls around, however, because
 25 her survivability has dropped to 40 percent, her

1 radiation and additional surgery, although that is
 2 almost **as** bad as a distant recurrence. Distant
 3 **metastases** **are** essentially always fatal,
 4 particularly in a younger woman who would normally
 5 have a long life expectancy. So the likelihood of
 6 death from the breast **cancer** with **metastatics**
 7 diagnosis is extremely **high** and almost **as high** with
 8 **local**.
 9 Q. Again, **since** more likely than not she
 10 is going to have a recurrence, Doctor, what options
 11 does she have in terms of treatment?
 12 A. **At** this point in time?
 13 Q. Assuming the recurrence, when the
 14 recurrence occurs, since we're talking about what
 15 is more likely than not, what happens at that point
 16 in terms of treatment?
 17 A. Well, ~~there are~~ fundamentally two
 18 options immediately available. One would be
 19 treatment with dose-intensive chemotherapy, and the
 20 other option would be **an** autolysis bone marrow
 21 transplant, which is **another** way of giving
 22 dose-intensive chemotherapy of even greater
 23 degree.
 24 Q. Do you have experience in these forms
 25 of treatment, sir?

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1 chances of relapsing **are** about 60 percent.
 2 Q. All right. Now, the figures that you
 3 just gave for the chance of recurrence in February
 4 of 1991, in that 20- to 30-percent range, that
 5 takes into consideration not only situations in
 6 which there is no nodal involvement, but in which
 7 there is nodal involvement, correct?
 8 A. There is a slightly increased risk of
 9 relapse ~~with~~ nodal involvement if your tumor is
 10 less **than** two centimeters. But it's still better
 11 than 50 percent. Probably in the range of 55
 12 percent survivability at 10 years and, therefore, a
 13 **45** percent chance of relapse, **as long as** the tumor
 14 is less **than** two centimeters.
 15 Q. Does the fact that more likely than
 16 not that **Nancy** Gorman **will** suffer a recurrence of
 17 this breast cancer contribute to your opinion on
 18 her **lack** of 10-year survivability, **sir**?
 19 A. Yes, it does.
 20 Q. Doctor, assuming that more likely
 21 than not Nancy will suffer a recurrence of this
 22 breast cancer, what does that mean for her?
 23 A. Well, there are two kinds of
 24 recurrence. A local recurrence would be at least
 25 amenable to some form of treatment, like additional

1 **A.** Yes, I do.
 2 Q. Can you give us a general idea of
 3 what this patient **might** expect receiving this sort
 4 of treatment?
 5 A. Well, it - with simply the
 6 dose-intensive **therapy**, it would be done **as** an
 7 outpatient, but obviously there would be hair loss,
 8 and because the doses **are higher**, it **tends** to kill
 9 the cells that **are** relatively rapidly dividing.
 10 **Those are cells being** produced in the bone marrow,
 11 all the blood element, platelets, white **cells**, red
 12 cells, and the cells that line the GI **tract**, the
 13 gut, and the hair. So the hair falls out, they **can**
 14 get severe diarrhea and what's called mucositis,
 15 requiring antibiotic therapy. They **can** get
 16 **infections**, and because of the destruction of the
 17 bone marrow they can have bleeding problems and
 18 infections **because** of that.
 19 Q. Is it fair to say, Doctor, that this
 20 is debilitating?
 21 A. **Yes**.
 22 Q. Can you tell us **whether** or not going
 23 through just the treatment itself is painful?
 24 A. Well, I **think** it certainly is painful
 25 in the **sense** that patients have to have permanent

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1 venous access devices placed, they have to receive
 2 multiple sticks. If they get mucositis, it's
 3 terribly painful, so yes, it's painful.
 4 Q. And if, in fact, there is a
 5 recurrence, the result, Doctor, is going to be the
 6 same, more probably than not, whether she gets the
 7 treatment or not; is that right?
 8 A. That's correct.
 9 MR. JOHNSTON Thank you, Doctor.
 10 That's all I have.
 11 THE COURT: Cross-examine.
 12 MR. LAWRENCE: Thank you, Your
 13 Honor.
 14 CROSS-EXAMINATION BY MR. LAWRENCE:
 15 Q. Dr. Ozer, good to see you again. Do
 16 you remember me?
 17 A. I do.
 18 Q. We saw each other back in September
 19 of 1994; is that right?
 20 A. That's correct.
 21 Q. And I took your deposition in Atlanta
 22 at that time?
 23 A. Yes.
 24 Q. Have you read your deposition?
 25 A. Yes.

1 Q. But generally speaking, on a yearly
 2 basis, wouldn't you agree with me that most of what
 3 you do is research rather than looking at patients
 4 and treating patients?
 5 A. About 60 percent of my time is either
 6 administrative or research and about 40 percent is
 7 clinical.
 8 Q. And in addition to that, a great deal
 9 of your time is taken up in administrative duties;
 10 is that right?
 11 A. correct.
 12 Q. So in — so that the jury
 13 understands, your capacity at Emory University is
 14 as an administrator of the Windship Cancer Center,
 15 and I believe that you told me, if I read your
 16 deposition correctly and understood you correctly
 17 that day, that generally speaking you see patients
 18 about a half a day a week.
 19 A. That's correct, in the outpatient
 20 department.
 21 Q. Two or three hours a week you see
 22 patients?
 23 A. That's correct.
 24 Q. And you are not a specialist in
 25 breast cancer, are you?

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1 Q. It came out in a transcript form and
 2 you've seen that?
 3 A. Yes.
 4 Q. Do you have it with you right now?
 5 A. No, I don't.
 6 Q. We may be referring to it and so I
 7 have a copy that I can hand you if you want to
 8 refer to it.
 9 A. That's fine.
 10 Q. Have you read your deposition
 11 recently?
 12 A. Probably about a month ago.
 13 Q. Okay. My understanding, Dr. Ozer,
 14 when I took your deposition is that in your
 15 position over at Emory at the present time, you are
 16 not only a medical doctor but you are — you have a
 17 Ph.D.; is that correct?
 18 A. That's correct.
 19 Q. And, in fact, I got the impression as
 20 I was asking you those questions in Atlanta that
 21 most of your work at the Windship Cancer Center is
 22 in research. Am I correct about that?
 23 A. Not this month. This month I'm the
 24 attending on the service for all the tumor
 25 patients.

1 A. No, I am not.
 2 Q. And you don't represent yourself to
 3 the public to be a specialist in breast cancer?
 4 A. No.
 5 Q. In fact, even in your research and in
 6 the other medical endeavors that you participate in
 7 over at Emory, your real concern is leukemia and
 8 lymphoma and immunology. Am I correct about that?
 9 A. That's correct.
 10 Q. And I'm not even sure about what
 11 immunology is, but those are not the questions one
 12 typically deals with as a physician in breast
 13 cancer cases?
 14 A. I'm sorry?
 15 Q. Leukemia is typically not a breast
 16 cancer — is not a disease that is similar to the
 17 same kind of medical treatment and diagnosis as
 18 breast cancer is.
 19 A. They are two different tumors.
 20 Q. Now, I understand that you are an
 21 oncologist; is that correct?
 22 A. Correct.
 23 Q. I also understand that you are not a
 24 board certified —
 25 A. I'm board eligible, not certified.

1 Q. And board eligible means that you
2 never did take the examination to become board
3 certified; is that correct?
4 A. That's correct.
5 Q. And the reason you haven't done that
6 is because you're so busy with your research and
7 your administrative duties that you just haven't
8 had a chance to get around to that; is that
9 correct?
10 A. In my particular age group, many of
11 the senior academic oncologists never bothered to
12 sit for the boards, that's correct.
13 Q. Now, Dr. Ozer, when you do see
14 patients, you're seeing those patients as an
15 oncologist?
16 A. Yes, I am.
17 Q. You're not seeing them as what I and
18 others in this courtroom perhaps would think of as
19 an internist.
20 A. That's correct.
21 Q. You are an internist, but you in your
22 day-to-day work as a physician are not a primary
23 care physician.
24 A. That's correct.
25 Q. And you don't see patients for common

1 Q. So when you get -- when you get a
2 patient as an oncologist in that half a day a week
3 and also in your other clinical work that you had
4 mentioned earlier, you're seeing that patient
5 because that patient's been referred to you by
6 another primary care physician?
7 A. That's correct.
8 Q. Or perhaps a surgeon.
9 A. I'm referred patients by primary
10 care, by OB/GYNs, by surgeons, et cetera.
11 Q. Okay. So the point is, just so the
12 jury understands, you don't typically see a woman
13 patient who comes in for an appointment wondering
14 what's wrong with her. You are seeing a patient
15 who has already been screened by some primary care
16 physician and then a problem is noted and then
17 referred to you
18 A. Well, that's not entirely true,
19 because we have in our clinic a breast health
20 center, which is a screening center for breast
21 cancer, and many of the patients that come to that
22 center come exactly as Mrs. Gorman did, with a
23 primary lump in their breast.
24 Q. I understand, but what you said to me
25 earlier was that the patients that you are seeing

1 colds and the flu and a broken bone or a sprained
2 knee and all the things that internists routinely
3 screen their patients for, like a family doctor.
4 A. I would argue that an internist
5 usually doesn't either. There would be three
6 levels, primary care or family care, internal
7 medicine, and then subspecialties.
8 Q. Okay. But you are not -- you don't
9 treat patients on a day-to-day basis as an
0 internist.
1 A. No, I don't.
2 Q. And not only that, Dr. Ozer, you're
3 not an OB/GYN, are you?
4 A. No, I'm not.
5 Q. And you have never been an
6 obstetrician.
7 A. No.
8 Q. You have never been a gynecologist.
9 A. No.
0 Q. And you don't represent yourself to
1 be.
2 A. No.
3 Q. And you don't treat any patients as
4 an obstetrician and gynecologist.
5 A. No, I don't.

1 are patients who have been referred to you by other
2 physicians.
3 A. Well, I see patients in that center,
4 too.
5 Q. You are being paid for your work here
6 today; is that correct?
7 A. Yes, I am.
8 Q. \$350 an hour, I think; is that
9 correct?
0 A. Yes.
1 Q. And you are here by virtue of being
2 contacted through the use of some kind of agency
3 that enables attorneys to contact physicians to
4 testify in lawsuits; is that correct?
5 A. That's correct.
6 Q. And I wrote that down, I'm really not
7 even sure what it means, but I think you called it
8 TAB.
9 A. Technical Assistance Bureau.
0 Q. And so you get paid a certain fee, I
1 think it's \$350, then TAB gets a fee on top of
2 that; is that correct?
3 A. I presume so.
4 Q. Well, you knew so at the deposition.
5 A. I don't get to see it.

1 Q. I'm not arguing that with you, but I
 2 think you said that TAB gets \$150, you get \$350,
 3 and that's how you came to become involved in this
 4 case; is that correct?
 5 A. Yes, TAB called me.
 6 Q. And, in fact, you get called probably
 7 from that organization to testify in other cases?
 8 A. Well, this was my first call from
 9 them. I've subsequently received another one.
 10 Q. Is that the one that you're going to
 11 be in Tampa on later this week?
 12 A. That's correct.
 13 Q. When are you supposed to be in Tampa?
 14 A. Thursday.
 15 Q. And you're going to be testifying in
 16 that case about a urological problem; is that
 17 right?
 18 A. Correct.
 19 Q. Dealing with the kidney?
 20 A. correct.
 21 Q. Now, you're going to have to excuse
 22 me because I'm going to be shuffling through some
 23 notes. Dr. Ozer, in Writing down notes as you were
 24 giving your direct testimony, I noticed that you
 25 have — even though you're not an OB/GYN, you have

1 given an opinion today that you believe that
 2 Dr. LaRoche, who is a board certified OB/GYN,
 3 violated a standard of care in her practice of
 4 medicine in this case. Is that correct?
 5 A. That's correct.
 6 Q. And as I understood it when I took
 7 your deposition in September, we talked about a lot
 8 of different issues, and one of the issues that we
 9 discussed was that you believed that it would be
 10 appropriate and within the standard of care for an
 11 OB/GYN such as Dr. LaRoche to, upon seeing and
 12 being made aware of a new lump in a woman's breast,
 13 to watch that lump carefully after taking the
 14 mammogram for a certain period of time; is that
 15 correct?
 16 A. It's critical that you define
 17 carefully and certain period of time.
 18 Q. That period of time that I understood
 19 you to say was a maximum of eight weeks.
 20 A. No, you're misinterpreting what I
 21 said. What I said was that it's appropriate to do
 22 a re-exam in about four weeks, and that's routinely
 23 done for women who are still menstruating in order
 24 to allow for cystic disease to decline. In the
 25 case of a woman such as Mrs. Goman who does not

1 have a uterus, four weeks would be fine,
 2 What the data showed are that within
 3 a period of about eight weeks, if you institute
 4 therapy, there is not any difference in
 5 survivability for breast cancer during that
 6 eight-week period of time. So that's often used by
 7 oncologists and surgeons as a window during which
 8 you can do certain things, work up the patient,
 9 have a Christmas vacation, fly to Tahiti or do
 10 whatever and still reassure the patient that as
 11 long as we do something within that period of time,
 12 the data suggests that there's no problem. Beyond
 13 that window no oncologist would want to wait:
 14 Q. Now, you mentioned that she did not
 15 have a uterus, and of course we all know from the
 16 testimony that has preceded you that Mrs. Gorman
 17 had had a hysterectomy.
 18 A. Correct.
 19 Q. By February 20th of 1991.
 20 A. correct.
 21 Q. But she still had her ovaries; is
 22 that correct?
 23 A. That's correct.
 24 Q. And that means to you as a physician
 25 that she is still having hormonal cycles.

1 A. Absolutely.
 2 Q. And, therefore, she still may have
 3 the indications of whatever changes those hormones
 4 cause in a woman's body in a cyclical basis; is
 5 that correct?
 6 A. That's correct.
 7 Q. And maybe under certain circumstances
 8 those hormonal cycles are a little bit more subtle
 9 than the normal obvious menstrual cycle; is that
 10 correct?
 11 A. They can be more subtle and that's
 12 why it's not unreasonable to delay an exam or a
 13 biopsy or a mammogram, a repeat mammogram, for a
 14 few weeks.
 15 Q. To eight weeks. Up to eight weeks is
 16 what I heard you say.
 17 A. You're still misunderstanding what I
 18 said. It would be prudent and within the standard
 19 of care to tell the patient to come back in four
 20 weeks and let's recheck you, but the therapy, if
 21 the tumor turns out to be present, needs to be
 22 instituted within an eight-week window. We know
 23 from the literature that there's no difference in
 24 survivability, but that doesn't imply that you
 25 start the clock at eight weeks. It implies that

Page 3

Page 3

1 you start the clock on February 20th, 1991.
 2 Q. Okay. I realize at the beginning of
 3 this deposition you said this is very simple. But
 4 to me this is not simple. I thought when you gave
 5 your deposition in Atlanta, you told me that you
 6 could not guarantee one way or the other whether or
 7 not a patient's 10-year survivability would be
 8 reduced within a period of three months, not eight
 9 weeks. Am I wrong about that?

10 A. No, you're not correct. What I said
 11 was I can't tell you -- you then asked me -- after
 12 the eight-week period, you asked me would it make a
 13 difference for three months, and I said, you know,
 14 who knows. You're picking numbers out of the air.
 15 Three months is a period of time when I can't tell
 16 you that metastases are going to occur. And so I'm
 17 giving in essence the examiner, in this case Dr.
 18 LaRoche, a break and saying all right, I'll give
 19 you three months, but beyond that you're really
 20 playing with fire and the patient is likely to have
 21 metastatic disease.

22 Q. And I understand what you're saying
 23 about giving Dr. LaRoche a break and we appreciate
 24 that. I don't mean that sarcastically, but what
 25 you're saying is that in your opinion as an

Page 3

1 oncologist, for a period of three months after the
 2 first office visit to Dr. LaRoche's office, you
 3 can't really say one way or the other whether or
 4 not that reduced this patient's chances for 10-year
 5 survivability.

6 A. No. Had she had a biopsy done at
 7 one-and-a-half months and extrication by radical at
 8 three months, her survivability as a Stage I breast
 9 cancer would have probably been the same.

10 Q. And so that three-month period that
 11 we're dealing with started to run at February 20th,
 12 1991; is that correct?

13 A. Right.

14 Q. And it would have ended on May 20,
 15 1991; is that correct?

16 A. Right.

17 Q. So that -- and of course I realize --

18 A. Presumably with an operation.

19 Q. I'm sorry?

20 A. Presumably with an operation. It
 21 doesn't go exam to exam. It needs to be
 22 completed. You need to have removed the tumor at
 23 that point.

24 Q. Yes. I understand that. That's

25 Correct. But -- and I'm taking into consideration

1 that at some point during that three months, that
 2 there was some treatment taken and diagnosis made,
 3 A. Absolutely.

4 Q. And -- but what you're saying is if
 5 that treatment and diagnosis did take place on or
 6 before May the 20th, you would not be able to say
 7 whether or not it reduced this patient's ability to
 8 survive to 10 years.

9 A. I couldn't say.

10 Q. And you understand that in this case
 11 there is an issue as to whether or not this patient
 12 had an appointment to come back and see Dr. LaRoche
 13 on May the 7th, 1991.

14 A. I do.

15 Q. And had she done so, that date would
 16 have been within the three-month period that you're
 17 talking about.

18 A. Well, it would, but my interpretation
 19 from reading the records is that it's like every
 20 other patient that we see. When we see a patient
 21 in an interval appointment, as it's called between
 22 scheduled appointments, the clock gets reset, and
 23 at that point the patient should be worked up for
 24 whatever problem they're presenting with as well as
 25 the fact that most patients assume they then have

Page 4

1 six more months to go if there is no problem,

2 Q. Dr. Ozer, I don't know -- I don't
 3 think I asked you that question but I appreciate
 4 your response. The simple question that I asked
 5 you was not whether or not you thought she had an
 6 appointment on May 7th of 1991, that's a different
 7 issue, and I think that's what you just answered.
 8 What I'm asking you is if she had an appointment on
 9 May 7th of 1991, that that fell within that
 10 three-month period that you were just talking
 11 about.

12 A. It's less than May 20th, that's
 13 correct.

14 Q. And had she been in the office of a
 15 physician on that day, she could have been examined
 16 by that physician; is that correct?

17 A. As she could have been on February
 18 20th, 1991.

19 Q. That's right. But we're talking
 20 about the three-month period right now because
 21 that's what you're testifying about, okay. And if
 22 she had been worked up at that point in time, then
 23 that still comes within that three-month period.

24 A. It does.

25 Q. Now, despite what -- let's set the

Page 4

1 three-month period aside for just a second. You
 2 have testified as an oncologist that you've looked
 3 at this case and you've decided based on certain
 4 authorities that you've read, on your experience
 5 and so forth, that if this patient had come in to
 6 see Dr. LaRoche on February 20th, 1991, and a
 7 diagnosis of cancer had been made on that day, the
 8 first time she came in to see Dr. LaRoche, that
 9 there — that her rate of survivability for 10
 10 years on that day would have been around 80
 11 percent.

12 A. That's correct.

13 Q. Okay. And then today, I think, you
 14 testified that because there was a 10-month delay
 15 and because the tumor stage changed from a I to a
 16 II, that her chance for survivability had dropped
 17 to 40 percent; is that correct?

18 A. correct.

19 Q. And that leaves me very confused,
 20 because when I read your deposition and took your
 21 deposition, I thought that you said that that
 22 decrease in chance of survivability changed from 80
 23 percent to 50 percent. Am I not correct about
 24 that?

25 A. "here's a range but it's 40 to 50

Page 4

1 percent in the Davita textbook which I referred to
 2 in the deposition.

3 Q. I'm going to talk to you about Davita
 4 in just a second. But when I took your
 5 deposition — and we can refer to that if you
 6 like.

7 MR. LAWRENCE: Your Honor, may I?

8 THE COURT: Sure.

9 Q. If you would, turn to Page 70 — I'm
 10 sorry, Page 71, starting at Line 2.

11 A. Uh-huh.

12 Q. And let me just read that to you and
 13 see if I — you tell me if I read it correctly,
 14 "At the time the appropriate measures were taken,
 15 the lump had grown to an advanced Stage II
 16 carcinoma substantially reducing Mrs. Gorman's
 17 chances of 10-year survival to only 50 percent."
 18 Did I read that correctly?

19 A. You did.

20 Q. And was that your testimony at that
 21 time?

22 A. It was, but it also says if you have
 23 positive nodes you only have 50 percent, 40 to 50
 24 percent. It's a range. Line Number 10 and 11.

25 Q. You have positive nodes under any

Page 43

1 circumstances when she was diagnosed in December of
 2 1991; is that correct?

3 A. correct.

4 Q. I mean, that's the only thing we
 5 could have been talking about was that she had
 6 positive nodes in December.

7 A. I'm telling you I said 40 to 50
 8 percent.

9 Q. Okay.

10 A. Line 10. Line 10 and 11.

11 Q. Is there any reason why when I
 12 summarized that testimony at the top of Page 71
 13 that you did not state your opinion in terms of a
 14 range of 40 to 50 percent?

15 A. You asked me the same question three
 16 different times and I answered 40 to 50 percent, 50
 17 percent, 50 percent. It's a range. It's 40 to 50
 18 percent. Could we compromise at 45.

19 Q. In that range at least one of those
 20 figures is 50 percent; is that correct?

21 A. That's correct.

22 Q. And 50 percent in your mind as a
 23 physician is not a probability one way or the
 24 other, is it?

25 A. It has to be 50.1.

Page 44

1 Q. So the answer is correct, it is not a
 2 probability?

3 A. It falls below 50 percent if it's a
 4 range from 40 to 50.

5 Q. But 50 percent is not

6 A. That's correct.

7 Q. Now, you had mentioned the Davita
 8 text.

9 A. Right

10 Q. What is the Davita text?

11 A. It's probably the most
 12 authoritarian — or authoritative version of
 13 medical oncology practice. It's called Principles
 14 and Practice of Oncology.

15 Q. I hold in my hand the Davita text.

16 A. You hold half of it.

17 Q. Do you recognize it?

18 A. You hold half of it

19 Q. That's right. This is Volume 1.

20 A. That's correct.

21 Q. And I believe this is the volume that
 22 contains a substantial chapter on breast cancer; is
 23 that correct?

24 A. That's correct.

25 Q. And that's what you're talking about,

1 the authoritative text on breast cancer?

2 A Right.

3 Q. May I hand this to you, sir?

4 A sure.

5 Q. Now, my understanding when I took
6 your deposition back earlier in 1994 was that in
7 preparing for your deposition and preparing for the
8 testimony that you were going to give today in the
9 courtroom was that you reviewed certain tables and
10 charts in the Davita text to substantiate your
11 opinion; is that correct?

12 A. Yes, I did.

13 Q. And one of those was Table 40-8, am I
14 correct?

15 A. That's correct.

16 Q. It's on Page 175; is that correct?

17 A. Yes, it is.

18 Q. Just so that I understand your
19 testimony about the range of 40 to 50 percent, as I
20 read Table 40-8, Mrs. Gorman came in to
21 Dr. LaRoche's office in February of 1991 with a
22 mass less than two centimeters.

23 A. She did.

24 Q. And, therefore, if you look at that
25 table, she had an 82 percent chance of survival if

1 A. Oh, it does.

2 Q. Okay. Dr. Ozer, so that all of us
3 can see this, we have just blown up this chart, it
4 will make it easier to discuss.

5 A. That's fine.

6 Q. I'm going to put it on the easel
7 here. Is that it, that is that correct chart?

8 A. That would appear to be the correct
9 chart.

10 Q. Make sure you compare them now so --

11 A. It's identical.

12 Q. Okay. Now, so that the jury
13 understands on February 20th, 1991, when she first
14 came in to see Dr. LaRoche, this was her status
15 right here. Am I correct?

16 A. That's correct.

17 Q. Okay. She had a node less than two
18 centimeters in diameter and she had an 82 permt
19 chance of surviving.

20 A. correct

21 Q. Now, the entry when she came back in
22 December, her node was in this column between two
23 and five; is that correct?

24 A. That's correct.

25 Q. Okay. December. Now, if I follow

1 the cancer had not spread to her lymph nodes; is
2 that correct?

3 A. That is correct.

4 Q. Now, looking at the chart, would you
5 tell me which number is the number that reflects
6 her chances of survival in December after the node
7 had grown to a little over two centimeters?

8 A. Well, here they're saying 51,
9 however, this is one study and if you turn the page
10 to 40-9, you can see that the range for

1 survivability or for relapse rate with positive
2 nodes in three separate studies is 60, 50 and 64.
3 So that's the range,

4 Q. Yeah, and I'm going to get to that.
5 That's a different issue, isn't it? We're talking
6 about overall survivability right now and you're
7 talking about disease-free survivability; is that
8 correct?

9 A. Unfortunately overall survival is
10 what's critical. Disease-free survival is a
11 surrogate end point, which if you'd like me to get
12 into I can.

13 Q. I may ask you to get into that but I
14 just want to make sure that you agree with me that
15 Table 40-8 deals with overall survivability.

1 this chart, this line under the size of the node
2 and the size of the tumor mass down, I see a number
3 which indicates the percentage of survivability for
4 a patient who has positive lymph nodes which are
5 proximal only, do you see that?

6 A. That's correct.

7 Q. And you understand in this case
8 because you've read the pathology record that she
9 had two proximal nodes.

10 A. Correct.

11 Q. And just for the jury's education and
12 for mine, also, my understanding is that the
13 proximal nodes are just the first ones in line --

14 A. correct.

15 Q. If the cancer spreads from the breast
16 tissue out toward the armpit, it gets to the
17 proximal nodes first.

18 A. correct,

19 Q. And that's what we're talking about.

20 A. Correct.

21 Q. And if we drew a circle around that
22 figure, then in December, according to Davita, she
23 had a 74 percent chance of survival,

24 A. No, according to the study published
25 by Shottenfeld, not according to Davita Davita

1 has multiple other charts in here, hopefully which
2 you've blown up, that argue against that.

3 Q. Is this chart in the Davita text?

4 A. It is.

5 Q. Did you refer to this chart in your
6 deposition as being —

7 A. I listed it as one of the charts that
8 I reviewed.

9 Q. And you listed it as a chart which
10 substantiated your opinion?

11 A. AD of the charts go together to form
12 my opinion.

13 Q. But this was one of them, wasn't it,
14 Dr. Ozer?

15 A. It was.

6 Q. And you are telling the jury today
7 that the Davita text is an authoritative, in fact,
8 the most authoritative text to breast cancer; is
9 that correct?

10 A. It is. Would you like me to read the
11 sentence that discusses that table?

12 Q. I just want you to answer my
13 question.

14 A. Yes, I am.

15 THE COURT Anytime a witness is

1 study axillary node involvement and survival rate
2 were examined in 385 patients to determine whether
3 the total number of involved nodes or the level of
4 axillary involvement was a better indicator of
5 prognosis. For any given number of involved nodes
6 survival was independent of the level of
7 involvement and the investigators concluded that
8 progress was related more to the total number of
9 nodes than to the level.

10 And then you turn the page and it has
11 Table 40-9, and that provides data on what amount
12 to probably 1,000 patients as opposed to the
13 smaller number of patients in this one study, and
14 that number comes out to be significantly less than
15 74.

6 Q. Okay. But even the total number
7 which were involved in this study was at least 51
8 percent; is that correct?

9 A. Upper range, yes.

10 Q. Now, let's look at that other table.
11 40-9; is that correct?

12 A. Yep.

13 Q. We may not have it. Just a moment.
14 While Mr. Bassham is looking for that, Dr. Ozer,
15 did you also take into consideration 40-7?

1 asked a question, they do have an opportunity to
2 explain their answer if they choose to.

3 THE WITNESS: May I now read the
4 sentence?

5 MR. LAWRENCE: Your Honor, I may not
6 have heard the witness's response to the —

7 THE COURT: You can repeat the
8 question, have him repeat his response. Of course
9 he does have a right to explain his answer if he
0 chooses to.

1 MR. LAWRENCE: I understand, Your
2 Honor.

3 Q. I want to give you all the
4 opportunity in the world to do that. I just want
5 to be absolutely certain that I heard you say the
6 Davita text was the most authoritative text.

7 A. It is.

8 Q. Okay. Now, would you like to explain
9 your answer?

0 A. Yes. If you look at the text, which
1 is located just above this table, it points out
2 that this is a new study that tends to confirm a
3 higher survivability with proximal, local node
4 involvement rather than distal or further out node
5 involvement. It then goes on to say in another

1 A. Yes, I did.

2 Q. Now, if I understand 40-7, that is an
3 even larger array of potential patients.

4 A. Yes, it is.

5 Q. And it really summarizes what, seven
6 different studies?

7 A. Yes, it does,

8 Q. Does that table — does that table
9 give us some indication of 10-year survivability?

0 A. It does.

1 Q. Is that a table that you could
2 utilize to substantiate your opinion in this case?

3 A. Yes, I could.

4 Q. Let me just ask you, obviously
5 looking at that table, in each of those seven
6 studies, if the lymph nodes were negative in
7 February, if they were negative in February, all of
8 the survival rates are above what, 65 percent; is
9 that correct?

0 A. 65 percent is the lowest, that's
1 correct.

2 Q. And the highest is 80 percent?

3 A. Yes.

4 Q. Meaning that even if the nodes were
5 negative, even if it hadn't spread, 20 per mt of

1 those patients **are** going to die in 10 years.
 2 **A.** correct.
 3 **Q.** Now, if we **look** over in the third
 4 column, would you *agree with* me that those numbers
 5 **are** the percentages that **we** would look at in this
 6 case to **determine** any reduction in 10-year
 7 survivability?
 8 **A.** They would be, yes.
 9 **Q.** And the reason is because she had two
 10 positive nodes in December of 1991, correct?
 11 **A.** Correct.
 12 **Q.** And in one of those, the very first
 13 study, Valadusa, and I may be pronouncing that
 14 wrong, the chance of survivability is 50 percent;
 15 is that correct?
 16 **A.** That's correct.
 17 **Q.** Which is the number that you had used
 18 in the deposition.
 19 **A.** That's correct.
 20 **Q.** The second study, Hagenson, indicates
 21 that the chance of survivability with positive
 22 nodes is 63 percent; is that correct?
 23 **A.** That's right.
 24 **Q.** The next one is Fisher, and the
 25 Fisher study is only 38 percent.

1 **A.** Fisher's study by the way is the one
 2 that has 10,000 patients in it.
 3 **Q.** And of Fisher's 10,000 patients, he
 4 only felt from his results that the chance of
 5 survival, even if it had not spread, and we're
 6 talking about this tumor back in February of 1991,
 7 was only 65 percent.
 8 **A.** Correct.
 9 **Q.** Meaning that 35 percent of those
 10 patients out of a hundred, or a 35 percent chance
 11 of dying within 10 years.
 12 **A.** **Still** more than 50 percent, that's
 13 correct.
 14 **Q.** And then the final study, Ferguson,
 15 indicates a 52 percent chance.
 16 **A.** That's **right**.
 17 **Q.** So of the four studies that have any
 18 kind of data on nodes that **are** positive, three out
 19 of those four indicate that the chance of **survival**
 20 only drops to 50 percent or above; is that
 21 correct?
 22 **A.** That's the interpretation from the
 23 table, that's right.
 24 **Q.** The table that's in the Davita text.
 25 **A.** Right. Continuereading.

1 **Q.** Continue reading?
 2 **A.** Uh-huh.
 3 **Q.** If you have some comment that you
 4 want to explain, please do.
 5 **A.** Sure. The —if you **look** at the text
 6 of the chapter, it goes on to describe the Fisher
 7 study, which is the **most** contemporary, largest
 8 trial published, and more weight given in the
 9 Davita **text** is placed on that study than on the
 10 smaller studies done in Europe.
 11 **Q.** Is Dr. Fisher the physician who has
 12 been in the news lately about some significant
 13 controversy?
 14 **A.** He is.
 15 **Q.** In fact, I believe he lost his job
 16 with the National Cancer Institute; is that
 17 correct?
 18 **A.** He **did**, but the data were carefully
 19 reviewed by the National Cancer Institute because
 20 of **their** significance and were allowed to stand.
 21 **Q.** He still lost his job, didn't he?
 22 **A.** Oh, he did.
 23 **Q.** For falsifying data?
 24 **A.** Wrong.
 25 **Q.** That was the allegation?

1 **A.** Wrong. Dr. Fisher did not falsify
 2 data.
 3 **Q.** Dr. Fason did so.
 4 **A.** A doctor who was participating in
 5 among the 50 or so in his trials falsified data and
 6 Dr. Fisher was criticized by the NCI for not
 7 catching it early enough.
 8 **Q.** Dr. Ozer, since February of 1990
 9 Mrs. Gorman has survived for four years..
 10 Mrs. Goman does not have cancer. She has not had
 11 a recurrence or relapse. Is that your
 12 understanding as we sit here today?
 13 **A.** It is.
 14 **Q.** Do you h o w of any statistics which
 15 would **indicate** that if a patient like Mrs. Gorman
 16 has a good **result** and survives for the **first** two to
 17 three years, that **she** has survived the most
 18 critical period of that 10-year survivability time
 19 span?
 20 **A.** Survivability increases with each
 21 year after diagnosis.
 22 **Q.** And so **are** you able to state an
 23 opinion today of what you believe her chance of
 24 survivability is having survived four years **since**
 25 the **first** office visit and approximately three

1 years since surgery?

2 **A.** Most of us in the field hesitate to

3 make statements within a five-year time frame

4 because of the fact that breast cancer,

5 unfortunately, often relapses late. I had a woman

6 relapse a few months ago at 28 years. So the

7 answer to your question is no, unfortunately, I'm

8 not. I would still *stick* with the 10-year

9 figures. If you said is it better than the

10 diagnosis, probably by a few percent, but I

11 couldn't go any further than that.

12 **Q.** You had a patient who relapsed after

13 28 years?

14 **A.** Correct.

15 **Q.** Now, I was listening carefully, I

16 hope, to your testimony about how you concluded

17 that the lymph nodes were involved -- were not

18 involved in February of 1991. And that is your

19 position; is that correct?

20 **A.** It's my position that more likely

21 than not they were not involved. I can't know for

22 sure.

23 **Q.** Again, I'm confused because that does

24 not appear and I did not understand that when I

25 read your deposition and took your deposition back

1 in September. I could have mom that you said to

2 me that you couldn't say one way or the other

3 whether or not those lymph nodes were involved in

4 February of 1991. Am I correct about that?

5 **A.** I'll state it again. I cannot say

6 one way or another. I'm not God. I have no idea

7 what the truth is of *this* matter. What I can say

8 is I can give you a probability. The probability

9 is based on statistics with other patients, and if

10 you look at the large numbers of patients, they are

11 less than 50 percent likely to have lymph nodes

12 involvement with Stage I tumors and more than 50

13 percent likely to have them with Stage II tumors.

14 **Q.** So basically what you're doing today

15 is telling this jury that you think it's more

16 likely than not that her lymph nodes were not

17 involved in February of 1991 because of some

18 general statistical analysis.

19 **A.** That's correct.

20 **Q.** And when I asked you about that, I

21 believe that you did not know where those

22 statistics were located; is that right?

23 **A.** Oh, they're in Davita. They're in a

24 number of other places,

25 **Q.** You also testified, didn't you,

1 Dr. Ozer, that breast cancer is an unusual tumor

2 that can progress very rapidly or it can remain

3 dormant for a number of years?

4 **A.** That's correct.

5 **Q.** And you agree with that proposition?

6 **A.** Absolutely.

7 **Q.** And that makes those general

8 statistics like that more difficult to apply on a

9 case-by-case basis, doesn't it?

10 **A.** It is hard to know in any individual

11 case whether they're applicable or not.

12 **Q.** And that's why you would say and why

13 you told me in Atlanta that you just couldn't say

14 one way or the other?

15 **A.** I cannot say.

16 **Q.** Whether or not the cancer had spread

17 to her nodes in February.

18 **A.** It's a probability guess.

19 **Q.** But it's a guess.

20 **A.** It is a guess.

21 **Q.** That's very important. You're

22 speculating on that, aren't you?

23 **A.** I am.

24 **Q.** I'm sorry to be shuffling through the

25 notes again but I just happened to read one of my

1 notes here that you told me in that deposition that

2 the size of the tumor does not prove that the nodes

3 are involved. Did you make that statement?

4 **A.** You can have a very large tumor and

5 when you do an operation find no lymph node

6 involvement. That goes back to what you just said,

7 that statistics don't always apply to the

8 individual case.

9 **Q.** Right. Unusual growth rates is one

10 of the things that you said could challenge those

11 general statistics, correct?

12 **A.** That's correct.

13 **Q.** Another one could be if the person

14 had a very aggressive tumor.

15 **A.** All of those are true, and if I may

16 explain, the statistics that are derived are

17 derived based on survivability. Mrs. Gorman could

18 be hit by a car as we leave the courtroom and she

19 would then be counted as a death in these

20 statistics. So it is impossible to predict for an

21 individual what is actually happening, but you can

22 give a probability and attach a probability to

23 whether there is nodal involvement or not.

24 **Q.** Well, I don't want to belabor this

25 point because I'm hearing you say two different

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1 things. You clearly told me a **few** minutes ago that
 2 it **was** speculative, and the reason you told me it
 3 was speculative, and let me clarify this with you,
 4 is because you were using a general statistic that
 5 you **are** attempting to apply to a specific
 6 situation, and you have advised me that it's very
 7 difficult to apply general statistics to a specific
 8 situation. Tumors grow at different rates, this
 9 could be **an** aggressive tumor. **And**, in fact, I
 10 believe, Dr. Ozer, you told me that in your opinion
 11 this was a rapidly growing tumor that Mrs. Gorman
 12 has; is that correct?

13 A. Moderately rapid.

14 Q. And in addition that you thought she
 15 had a predisposition to breast cancer.

16 A. Certainly the age would indicate
 17 that.

18 Q. And what you mean by that is that
 19 because she was under 40 years old, that when
 20 breast cancer **hits** a woman who is under 40 years
 21 old, it is an aggressive kind of disease; is that
 22 correct?

23 A. I can get into that with you if you
 24 like. There **are** two reasons why people die from
 25 breast cancer more frequently if it occurs before

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1 40. One of which is simply age related. They have
 2 longer — they're alive longer and therefore at
 3 longer **risk** for death. The other is that there do
 4 appear to be **certain** breast cancers that appear
 5 before the age of 40 which **are** most aggressive.

6 But to go **back** to the question that
 7 you started with, statistics give you
 8 probabilities, and the probability — if I flip a
 9 coin 100 times, the probability that it will be
 10 heads on the hundred and first time if it's heads
 11 100 times in a row, what's the probability? It's
 12 still 50 percent. And that's an individual case.
 13 And so the probability with Mrs. Gorman as an
 14 individual case of having involvement is still more
 15 than 50 percent **given** that she's a Stage I breast
 16 cancer. Not having node involvement is **still** less
 17 than 50 percent given that she is a Stage I breast
 18 cancer.

19 Q. And the statistic that you utilized
 20 **was** taking a one-and-a-half **centimeter** tumor into
 21 consideration, which is what we're dealing with.

22 A. Right.

23 Q. That you felt that there was less
 24 than a 50 percent chance.

25 A. Correct.

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1 Q. So it could be 49 percent; is that
 2 correct?

3 A. Could be 49.

4 Q. I mean, you're not excluding that.

5 A. No, I'm not.

6 Q. And so what you're saying is that
 7 using **these** vague statistics that we're trying to
 8 **work** with here, that there was a 49-percent chance
 9 that Mrs. Gorman's lymph nodes were positive on
 10 that **date**.

11 A. That is a **number** less than 50, that's
 12 correct.

13 Q. A 49-percent chance in February of
 14 1991 that the **cancer** had already spread to the
 15 lymph nodes.

16 A. I would have to go back and look up
 17 the individual studies, but it's less than 50
 18 percent.

19 MR. LAWRENCE: Your Honor, I still
 20 have quite a bit more and I'm happy to do whatever
 21 the Court would like.

22 THE COURT: I think it's a good time
 23 to break. The jury has been sitting here for about
 24 an hour and 20, 25 minutes, and I'm **sure** that they
 25 need a break and it's time for lunch. So ladies

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1 and gentlemen of the jury, we're going to **take** a
 2 break for lunch. We're going to meet back promptly
 3 at 1:00 **o'clock**. Remember the instructions that I
 4 have previously given. Do not discuss this
 5 witness's testimony or any witness's testimony with
 6 each other or with anyone **else** or allow anyone else
 7 to discuss this case with you. Don't discuss what
 8 the lawyers have done or haven't done or **anything**
 9 that's happened in the case with each other.

10 Don't — if you go home or if you eat with some
 11 **other friend**, don't allow them to discuss this case
 12 with you or any party in this **case** or anything
 13 about this case. If anybody were to **attempt** to do
 14 that after you informed them that **you're** on the
 15 jury, advise the bailiff **when** you come in, do not
 16 advise your fellow jurors. That is, report **any**
 17 violations,

18 . So don't form or express any opinion
 19 about this case, don't allow yourself to **make** up
 20 your mind **until** you've heard all the proof. And be
 21 **back** promptly at 1:00 o'clock. **All rise** for the
 22 jury.

23 (Jury dismissed from courtroom.)

24 (Luncheon recess.)

25 THE COURT: Are you all ready to

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1 proceed?

2 MR. JOHNSTON: Yes, Your Honor.

3 MR. LAWRENCE: Yes, Your Honor.

4 THE COURT: All **right**. Bring the
5 jury in.

6 (Jury summoned to courtroom.)

7 THE COURT: Be seated. witness may
8 retake the stand. Allright. You may continue
9 your cross-examination.

0 MR. LAWRENCE: Thank you, Your
1 Honor.

2 CONTINUED CROSS-EXAMINATION BY MR. LAWRENCE:

3 Q. Dr. Ozer, if Mrs. Gorman's breast
4 cancer in February of '91 had not spread to the
5 lymph nodes, she was still going to need surgery;
6 is that correct?

7 A. That's Correct.

8 Q. And she was also still going to need
9 chemotherapy for that breast; is that correct?

0 A. ~~She~~ would need probably a lumpectomy
1 and CMF would be the recommended chemotherapy.

2 Q. Right. Okay. And so what you're
3 saying to us today is that even if her cancer had
4 not spread to the lymph nodes back in February when
5 she first came in, she was still going to need a

1 Q. A lumpectomy is certainly not **as**

2 significant **surgery** **as** modified radical mastectomy
3 in most patients; is that correct?

4 A. That is correct.

5 Q. Okay. And the reason I qualified it
6 that way, obviously **as** I understand it **as** a
7 layperson, a mastectomy involves removal of all of
8 the breast **tissue**; is that correct?

9 A. That is correct.

0 Q. Whereas a lumpectomy is **an** attempt to
1 **make** a smaller incision, go in and just remove the
2 affected part. In this case it would be the
3 one-and-a-half centimeter tumor?

4 A. Modified radical mastectomy dso
5 includes dissection of axillary nodes.

6 Q. But in this case if she had selected
7 lumpectomy in February '91, you would have
8 recommended that she have the nodes removed also,
9 or at least biopsied?

0 A. Oh, yes.

1 Q. That would have resulted in the loss
2 of some of her lymph nodes.

3 A. Yes.

4 Q. So under either circumstance, whether
5 the diagnosis was made in February or whether it

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1 lumpectomy, which is a form of *surgery*, and
2 chemotherapy?

3 A. Yes.

4 Q. And if she had the lumpectomy,
5 wouldn't you also have to include radiation?

6 A. That's correct.

7 Q. So if she had a lumpectomy as opposed
8 to a modified radical mastectomy in February of
9 1991, she was going to need surgery **plus** radiation
0 plus chemotherapy?

1 A. Yes.

2 Q. Or she could have achieved the same
3 result **with** a modified radical mastectomy and
4 chemotherapy?

5 A. Yes.

6 Q. And, in **fact**, that's what she had in
7 December of 1991; is that correct, sir?

8 A. That's Correct

9 Q. And to the extent that this patient
0 in this lawsuit may claim that **because** there was
1 not **an** earlier diagnosis, that **she** may have lost
2 the chance or the option to **choose** between a
3 mastectomy and a lumpectomy, I would like to ask
4 you some questions about that.

5 A. **sure**.

1 was made in December, those things were going to
2 happen?

3 A. Yes.

4 Q. And if she had selected lumpectomy,
5 there **are** some additional risks with lumpectomy
6 that she would not have otherwise had with
7 mastectomy; is that correct?

8 A. That's correct.

9 Q. And one of those risks is that she
0 would need the radiation.

1 A. Right.

2 Q. And with the modified radical
3 mastectomy she had in December 1991 she didn't have
4 to have radiation.

5 A. Right.

6 Q. And radiation carries **with** it some
7 fairly significant side effects of its own?

8 A. It carries **with** it some local side
9 effects.

0 Q. **Local** side effects means that it can
1 result **in** permanent change **in** the appearance of the
2 breast; is that correct?

3 A. That's correct.

4 Q. And **in** addition, lumpectomy carries
5 the **risk** that in a small-breasted woman, for

1 example, the lump itself may be of such a *size* in
 2 comparison to available breast **tissue** that what
 3 you're left with is a deformity or a distortion of
 4 the breast tissue; is that correct, sir?
 5 A. Correct.
 6 Q. You've never examined this patient,
 7 have you?
 8 A. No, I have not.
 9 Q. Would you concede that she was a
 10 small-breasted woman? Do you h o w that?
 11 A. I have no knowledge of that and I
 12 couldn't even see her because the chart's in the
 13 way.
 14 Q. Okay. Well, I ask that question
 15 respectfully because — and that's redly not where
 16 I was going with that. I was wondering whether or
 17 not from the records you had read you had noticed
 18 that there was any indication that that was the
 19 case.
 20 A. I don't recall an indication that her
 21 breasts were large or small.
 22 Q. In addition to all of the above,
 23 lumpectomy can be a **risky** procedure because it
 24 might not get it all, as they say; is that
 25 correct?

1 A. The data now suggests that done
 2 properly lumpectomy is **as** safe **as** a radical **as** long
 3 as you include the radiation.
 4 Q. So what you're saying there is that
 5 there is a **risk** that you go in there with the
 6 surgery involved with a lumpectomy, you remove the
 7 tumor, but there may be left behind cancerous
 8 cells?
 9 A. There may be with a radical as well,
 10 or modified radical.
 11 Q. Okay. But there's a **better** chance,
 12 and I think the way you described it to me in
 13 **Atlanta was** that the modified radical mastectomy
 14 was more efficient at removal of all of the
 15 potential cancer cells in the breast.
 16 A. Yes, but if you add together the
 17 radiation and lumpectomy, it's equal to a modified
 18 radical in terms of safety, **as** best they can tell
 19 at this point.
 20 Q. And that's why you have to throw —
 21 in addition to chemotherapy you have to **stack** on
 22 top of that the radiation.
 23 A. Correct.
 24 Q. And which makes it an even more
 25 difficult road in terms of **recovery**; is that

1 correct, sir?
 2 A. It's not an easy choice.
 3 Q. Under any circumstances.
 4 A. Correct.
 5 Q. And that's because cancer is a
 6 devastating *disease*, isn't it?
 7 A. **Yes**.
 8 Q. In fact, even though studies have
 9 shown that lumpectomy and mastectomy **are**
 10 approximately *the* same in terms of — or maybe
 11 exactly the same in terms of **the** end result, the
 12 only **reason** to attempt a lumpectomy is for cosmetic
 13 **reasons**, to attempt to save breast tissue?
 14 A. That is **correct**.
 15 Q. In this patient's case that point
 16 became moot in 1993, didn't it?
 17 A. It did.
 18 Q. And the reason is because she then
 19 contracted cancer in her left breast?
 20 A. Yes.
 21 Q. Correct?
 22 A. That's **correct**.
 23 Q. And when she contracted cancer in her
 24 left breast, at that point it **was** apparent to
 25 everyone involved with her treatment that she was

1 predisposed to cancer.
 2 A. Clearly she is in a high **risk**
 3 *category* given her age and her bilateral
 4 incidence.
 5 Q. Unrelated in any way to when a
 6 diagnosis was **made**?
 7 A. That's true.
 8 Q. Okay. And for that **reason** she had a
 9 modified radical mastectomy of the left breast at
 10 that time, in March of 1992?
 11 A. That **reflects** a wise decision.
 12 Q. It's a **wise** decision because at that
 13 point you're **dealing with** an aggressive situation
 14 **with the cancer**?
 15 A. correct.
 16 Q. And she had to have another course of
 17 chemotherapy; is that **correct**?
 18 A. **Correct**.
 19 Q. A **six-month** course.
 20 A. **Yes**.
 21 Q. And so **what this patient has been**
 22 through is a tough situation where she contracted
 23 cancer in one breast, she had **six** months of
 24 chemotherapy, then she contracted *cancer* in another
 25 breast, she had another course of chemotherapy, and

1 every one of those treatments involving
2 chemotherapy and surgery in each instance were
3 going to happen regardless of when ~~this~~ diagnosis
4 ~~was~~ made?

5 A. The therapy and the surgery for both
6 lesions were necessary regardless of when the
7 diagnosis was made.

8 Q. Let me just ask you a few points in
9 closing my cross-examination, Dr. Ozer, and ~~this~~ is
10 really by way of clarifying what the situation is
11 with this patient at the present time. Certainly,
12 and I realize I'm slanting the obvious here, under
13 no circumstances can we say — and I don't think
14 there's been any serious — there has not been any
15 claim made that Dr. LaRoche caused this patient to
16 have cancer on her right breast.

17 A. No.

18 Q. The only question is how it ~~was~~
19 handled after it was already ~~there~~; is that
20 correct?

21 A. That's correct.

22 Q. And it's also true that the fact that
23 she contracted cancer in the left breast a year
24 later, or a year and some odd months later, had
25 nothing to do with the cancer in the right breast.

1 risks associated with a lifetime dose of some of
2 the drugs that ~~are~~ used, such as cyclophosphamide,
3 and there is a **risk**, an increased risk of leukemia
4 with additional dosing of cyclophosphamide, and it
5 is possible that there is some problem as a result
6 of multiple therapies.

7 Q. Is it your opinion that the treatment
8 of the breast cancer on the left side was more
9 severe due to any delay in diagnosis?

10 A. No, I don't believe it ~~was~~.

11 Q. In your opinion, Dr. Ozer, does the
12 **fact** that this patient contracted breast cancer on
13 the left side in addition to her primary cancer on
14 ~~the~~ right side further decrease her survivability
15 for 10 years?

16 A. Oh, yes.

17 Q. And the reason is that once she
18 contracted the cancer in the left side, then we
19 have to go back and **look** at tables and Davita and
20 charts and so forth and **look** at percentages and
21 that kind of thing and apply those percentages to
22 that breast as well?

23 A. Those data ~~are~~ not really known with
24 clarity because of low numbers, but yes, obviously
25 the **risk** is great.

1 Am I correct about that as well?

2 A. I can't say that, but I think, **again**,
3 discussing probabilities, the probability is that
4 it is a new primary lesion.

5 Q. Okay, And, in fact, have you read
6 the pathology reports from the second mastectomy?

7 A. Yes.

8 Q. And those pathology reports indicate
9 from the pathology that that's a new primary lesion
0 in the left breast?

1 A. Right.

2 Q. Which means that looking at the
3 allegations in this lawsuit, even if — even if we
4 assumed, which we **certainly are** not, that
5 Dr. LaRoche had caused a delay in diagnosis, then
6 that delay did not cause this lady to **contract**
7 cancer in the left breast, did it?

8 A. No, it did not.

9 Q. Nor did any such alleged delay cause
10 the treatment in the right breast to **be** worse than
11 the treatment of the **right** breast — I may have —
12 did I reverse them? Nor did it ~~cause the~~ treatment
13 of the cancer in the left breast to **be any** worse
14 than the one in the right where it started out?

15 A. That could be debated. There are

1 Q. And whatever that **risk** is, it's in
2 **addition** to what ~~was~~ already present for the right
3 breast?

4 A. Correct.

5 Q. And in your opinion as **an** oncologist,
6 Dr. Ozer, doesn't the fact — setting statistics
7 aside for the moment, doesn't the fact that we're
8 dealing with a woman under 40 who is premenopausal
9 and who has contracted cancer in both breasts has a
0 very serious **aggressive** disease?

1 A. I didn't **hear** a question.

2 Q. We're dealing With a patient who is
3 under 40 years old; is that **correct**?

4 A. That's correct.

5 Q. Who I think you have already stated
6 is predisposed to *cancer*.

7 A. Correct.

8 Q. Who has a rapidly — or maybe you
9 said a moderately rapidly progressing tumor. And
10 she **has** now contracted cancer in **primary** lesions in
11 both of her breasts.

12 A. Correct.

13 Q. And what I'm asking you is, setting
14 aside all of the statistics about survivability
15 aside, what we're dealing with here is a very, very

1 aggressive disease in ~~this~~ patient.

2 **A.** This patient has a **very high** risk for
3 primary breast cancer. We don't know at this point
4 whether ~~she's~~ cured or not. **She** may still be cured
5 and completely disease free and live a normal life
6 span.

7 **Q.** And we certainly hope so. But my
8 question is when a patient has this *degree* of
9 breast cancer, doesn't it make it even more
10 difficult to determine the percentages of
11 survivability based on the allegation that ~~there~~
12 was a 10-month delay in diagnosing the lesion?

13 **A.** Well, I think you have to go back to
14 the basis. The basis is thousands of patients, all
15 of whom ~~are~~ assigned a number based on their time
16 of diagnosis. So even in those studies some of
17 those patients wound up with bilateral breast
18 cancer, and given that we don't have numbers broken
19 out that way, all we can rely on is what the
20 statistics say.

21 **Q.** And one final point. Earlier in your
22 direct testimony you had mentioned the concept of
23 relapse rate, correct?

24 **A.** correct.

25 **Q.** And I don't want to get too — you

1 longer. **A** small ~~percentage~~ **are** cured as a result
2 of ~~the~~ bone marrow transplant, for example.

3 **MR. LAWRENCE:** I think that's all.

4 Thanks.

5 **THE WITNESS:** Thank you.

6 **MR. LAWRENCE:** Oh, I'm sorry, Your
7 Honor, housekeeping measure. I would like to mark
8 this chart as Exhibit 4.—

9 **THE CLERK:** 5.

10 **MR. LAWRENCE:** 5, sorry.

11 (Table 40-8 marked as Exhibit

12 ~~Number~~ 5 and fded as a part
13 of this record.)

14 **BY MR. LAWRENCE:**

15 **Q.** Doctor, this is the other — let me
16 just be *certain*. I forgot to put this one up when
17 we were talking about it. But this is the 40-7
18 table which we discussed

19 **A.** Correct.

20 **Q.** This is the same one that's in the
21 Davitaxtext?

22 **A.** That is correct.

23 **Q.** And one that you had utilized in
24 coming to your conclusions.

25 **A.** Correct.

1 ma& some comment earlier to me today which I took
2 to heart, and that is ~~the~~ most important statistic
3 is overall survivability for 10 years; is that
4 right?

5 **A.** That's correct.

6 **Q.** And we've discussed that. And we've
7 looked at it on these ~~tables~~ from the Davita text;
8 is that right?

9 **A.** Right.

10 **Q.** And so **as** I understand the whole
1 concept of even bringing up relapse **rate**, what
2 you're talking about there is not necessarily
3 10-year survival, but it's whether or not the
4 primary cancer is going to recur during that
5 10-year period.

6 **A.** That's correct.

7 **Q.** Those **are** the statistics you're
8 applying to that situation.

9 **A.** That's correct.

10 **Q.** And when that happens you may have a
11 patient who **relapses** but who **with** proper treatment
12 and perhaps **luck**, but **certainly** with proper
13 treatment and the treatment that's available, those
14 folks may live much longer ~~than~~ 10 years.

15 **A.** Generally **they** live a few years

1 **MR. LAWRENCE:** Mark that **as** Exhibit
2 6.

3 **THE COURT:** Without objection let it
4 be introduced as Exhibits 5 and 6.

5 (Table 40-7 marked **as** Exhibit
6 Number 6 and fded as a part
7 of this record.)

8 **MR. LAWRENCE:** Thank you, Your
9 Honor.

10 **MR. JOHNSTON:** Excuse me. Just for
11 my clarification, Exhibit Number 5 is 40-8 and
12 Exhibit Number 6 is 40-7?

13 **THE CLERK:** Yes.

14 **REDIRECT EXAMINATION BY MR. JOHNSTON:**

15 **Q.** Dr. Ozer, I want to follow up on just
1 a few things that Mr. Lawrence brought up with you
2 earlier, mostly this morning. You pointed out, I
3 think **correctly** **when** he asked you about the Davita
4 book that **this** volume in front of you is half **the**
5 Davita book, right?

6 **A.** That's **correct**. I have a whole one
7 in my briefcase.

8 **Q.** **Right.** And that book, the Davita
9 book that we've been making **reference** to here
10 today, literally **contains** hundreds if not thousands

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1 of **studies** on all **aspects** of cancer treatment,
2 detection, diagnosis, et cetera, survivability, all
3 of those various things; is that right?

4 **A.** That's right.

5 **Q.** And what is the reason for compiling
6 all of those studies into a two-volume work like
7 that?

8 **A.** In order to provide the most
9 authoritative documentation in a particular **area**.

10 **Q.** **Allright.** And would it be fair to
11 say that pulling out one single study and saying
12 this is the **definitive** study, would that be fair or
13 reasonable?

14 **A.** Not at all. There's actually a
15 definition for that. It's called a type one
16 statistical error.

17 **Q.** What is a **type** one statistical error,
18 sir?

19 **A.** It means that you draw a conclusion
20 from insufficient data.

21 **Q.** Okay. Now, when I asked you earlier
22 if you had any opinions rendered with a reasonable
23 degree of medical **certainty** regarding Mrs. Gorman's
24 chances of survival both in February and in
25 December of 1991, and then when I **asked** you later

1 earlier about node involvement, specifically
2 whether or not you could **tell** for certain whether
3 there was node involvement in February, and I think
4 we've all admitted here, I mean, there's no way to
5 know. You can't possibly know because we can't
6 look into the body at that point.

7 **A.** **Right.**

8 **Q.** Let me pull out this exhibit that we
9 talked about earlier in your testimony, Exhibit
10 Number **4**, which is the **TNM** chart. Let me **ask** you
11 to make an assumption about something, Dr. Ozer.
12 If the two nodes that we know were involved in
13 December of 1991 were in fact involved in February,
14 where would Mrs. Gorman have fallen on the staging
15 chart according to this stage, sir?

16 **A.** She'd fall where the asterisk is, if
17 everyone can see that.

18 **Q.** That's a Stage II-A?

19 **A.** T-1, N-1, M-0.

20 **Q.** Okay. And there's a **Little asterisk**
21 **here**, and I know you can't read it from that far.
22 Let me just bring it up to you and if you'll read
23 that to us, please, sir.

24 **A.** The prognosis of patients with T-1,
25 N-1, M-0 is similar to that of patients with N-0.

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1 about whether you had **an** opinion rendered with a
2 reasonable degree of medical **certainty** **as** to **her**
3 chances of recurrence of breast cancer in February
4 and in December of '91, and you told me yes, were
5 you relying not only on 40-8 and 40-7, but **all** of
6 the studies that you were aware of and in addition
7 to those studies your general practice over 20
8 years in oncology?

9 **A.** I was.

10 **Q.** **All** right. And simply because we've
11 been shown a study in Table 40-8, or any other
12 table, does that change your opinion at all?

13 **A.** No, it does not.

14 **Q.** **Real** quickly, on **the** material that
15 you recall reading about the left breast cancer,
16 that was detected, diagnosed and removed at Stage I
17 level, wasn't it?

18 **A.** Yes, it was.

19 **Q.** And then: was no node involvement
20 there.

21 **A.** That's correct.

22 **Q.** And that's **pretty** good, isn't it?

23 **A.** Obviously that's much **better**. It's
24 in the 80-percent category of survival.

25 **Q.** Okay. There was also some discussion

1 **Q.** And what does that mean, sir?

2 **A.** That means that at that level the
3 involvement of the nodes don't make as much of a
4 difference as **the** size of the **primary** lesion.

5 **Q.** Okay. So if you assume then that,
6 again, that the nodes were involved in February,
7 even with that, did Mrs. Gorman more likely than
8 not have the chance for survival - 10-year
9 survival?

10 **A.** Even **with** nodal involvement, a Stage
11 I breast cancer is still **better** than 50 percent
12 10-year survival.

13 **Q.** **All** right. **One** more thing I want to
14 **talk** to you **about**. There was some discussion about
15 some testimony that you gave earlier about this
16 three-month window that we **were** talking about, and
17 I think, if I'm understanding it correctly, and you
18 **correct** me if I'm wrong, that that three-month
19 window that you laid out is basically from
20 presentation to treatment?

21 **A.** **Correct.**

22 **Q.** And that's the absolute outside.

23 **A.** **Correct.**

24 **Q.** You really don't want to push that
25 envelope very far, do you?

1 A. That's correct.
 2 Q. But that's the outside. In your
 3 review of the records, do you recall when it was
 4 that Mrs. Goman called Dr. LaRoche in December of
 5 1991?
 6 A. Which date in December?
 7 Q. Yes.
 8 A. I'm afraid I don't know that date off
 9 the top of my head.
 10 Q. If you'll take a quick look, I think
 11 you'll find on the last page there, sir, that it
 12 was December the 17th of 1991.
 13 A. Yes, it says 12/17/91, phone call,
 14 notes increased size of nodule of right breast.
 15 Q. And you've seen the records relating
 16 to the biopsy on December the 26th and the modified
 17 radical mastectomy that was done on January 17th,
 18 have you not?
 19 A. Yes, I have.
 20 Q. And would you agree that the time
 21 period that was utilized there from the time that
 22 she called in to the time that that modified
 23 radical mastectomy took place was reasonable and
 24 appropriate?
 25 A. That was perfectly appropriate.

1 Q. Now, if you superimpose that, sir, on
 2 May the 7th, and you assume that May the 7th was
 3 the time that Mrs. Goman would have called in,
 4 what then would have been the date of the modified
 5 radical mastectomy?
 6 A. It would have been Within two weeks.
 7 Q. Well, I'm —
 8 A. I'm sorry, four weeks.
 9 Q. From December 17th to January 17th,
 0 onemonth.
 1 A. Four weeks.
 2 Q. So that puts you into June, does it
 3 not?
 4 A. Yes, it does.
 5 Q. And that's at least two weeks beyond
 6 your three-month window, is it not?
 7 A. Yes, it is.
 8 MR. JOHNSTON: Thank you
 9 THECOURT: Anything further?
 0 MR. LAWRENCE: I do, Your Honor.
 1 RE-CROSS-EXAMINATION BY MR. LAWRENCE:
 2 Q. Dr. O m ,on that same point, if a
 3 physician wanted to have a breast tumor removed,
 4 that physician could have it removed the same day
 5 by sending that patient to the OR: is that correct?

1 A. At Emory that would be possible,
 2 yes.
 3 Q. And you certainly would not Contest
 4 the fact that that probably would happen at
 5 Vanderbilt University Medical Center in Nashville?
 6 A. It would probably happen in
 7 Murfreesboro, too.
 8 Q. So that if there was any risk of a
 9 one-month delay, the physicians certainly could
 10 take care of that problem; isn't that correct?
 11 A. Yes.
 12 Q. Now, you may have me on that type one
 13 statistical error. I'm not much with statistics
 14 anyway, and I don't know what a type one
 15 statistical error is, but I must say that I need to
 16 ask you some questions about what you said about
 17 the type one statistical error.
 18 A. Certainly.
 19 Q. Dr. Davita and the other editors of
 20 those very large textbooks compile those textbooks
 21 attempting, I take it, to utilize data that is the
 22 most useful and the most up to date and the most
 23 practical for the guidance of other physicians; is
 24 that correct?
 25 A. That's correct.

1 Q. And it is inconceivable that
 2 Dr. Davita and Dr. Hellman and the other editors of
 3 that text would place a table or a chart in the
 4 Davita text that was useless.
 5 A. That's correct.
 6 Q. And so Mr. Johnston's comment that
 7 there are hundreds and thousands of data
 8 compilations in those two volumes of that textbook
 9 is true, but every one of them means something;
 10 isn't that correct?
 11 A. That's correct.
 12 Q. And, in fact, that's probably why
 13 when I took your deposition in Atlanta, you zeroed
 14 in on the two that I asked you about today; isn't
 15 that correct?
 16 A. That's correct.
 17 Q. Let's zero in on them again. Table
 18 40-8, right?
 19 A. Right.
 20 Q. There's something special about this
 21 table in terms of determining 10-year survivability
 22 rate in a cancer patient because this table is the
 23 only one in the Davita text that locates the level
 24 of node involvement in 10-year survivability
 25 analysis; is that correct?

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1 A. The table is in ~~there~~ because it is
2 the ~~best~~ published study that correlates level of
3 node involvement with 10-year survivability, and
4 that is the only reason that it's in there. It is
5 cited, that study, along with four or five others
6 in there that actually show numbers that ~~are~~ much
7 lower than what's indicated ~~there~~.

8 Q. Okay. And when you look -- there
9 aren't any ~~other~~ charts that show what Mrs. Gorman
10 had. ~~She~~ had positive lymph nodes in December and
11 they were in the proximal level, correct?

12 A. Correct.

13 Q. And when you **look** at this level, she
14 still had a 74 percent chance of survival,
15 according to this data that's in the Davita text;
16 is that c o r n ?

17 A. In that one study from 1976 ~~she~~ would
18 fit into that category were she a patient in that
19 study.

20 Q. Well, this is a chart. Whether or
21 not she was in the study or not, the profile of her
22 cancer is included within the statistics, correct?

23 A. That's correct, but if I may explain,
24 you criticized me before for drawing a specific
25 from statistical probabilities.

1 A. That's correct.

2 Q. And one of them goes as **high as 63**
3 percent

4 A. And one goes as low as 38.

5 Q. One goes as low as 38. What happens
6 if you add them all up and divide by four?

7 A. You wind up with an average of 52.

8 Q. Which is a probability, correct?

9 A. Correct.

10 Q. A probability that she was going to
11 live; is that right? She **was** going to have -- she
12 **was** not going to have a reduced --

13 A. It's a 52-percent survival at 10
14 **years** for those four studies.

15 Q. She was probably going to survive
16 over that 10-year period.

17 A. For those four studies, it's a
18 52-percent survival. It has nothing to do with
19 her. The studies show that the probability of a
20 patient surviving is 52 percent for those four.

21 Q. For all of the thousands of patients
22 included in these studies.

23 A. correct.

24 Q. And this is kind of a general
25 statistic. These are statistics that physicians

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1 Q. We're even. You criticized ~~me~~ for a
2 **type** one statistical error. Now, let's zero in on
3 40 -- Table **40-7**. Is that the correct chart?

4 A. That is the correct chart.

5 Q. And I understood when you were
6 answering questions from Mr. Johnston about all
7 those hundreds and thousands of ~~tables~~, that you
8 said it would be inappropriate just to pull out one
9 from all of that group and draw some conclusions
10 from it. Because that was a **type** one statistical
11 error, correct?

12 A. correct

13 Q. And so here is a table, if I
14 understand this correctly, and I think we've
15 already talked about this, that is not a single
16 study, correct?

17 G That's correct.

18 Q. This is a compilation of **seven**
19 significant **studies**, am I right?

20 A. You are right.

21 Q. And out of those seven **studies**, in
22 **terms** of patients who have a couple of positive
23 lymph nodes when they have cancer, **three** out of the
24 four show that the chance of survival is at least
25 50 percent. Is that correct?

1 use to make evaluations; isn't that right?

2 A. That's correct.

3 Q. Just like the statistics that you use
4 to **determine** whether or not you could tell from
5 just a single -- the one-and-a-half centimeter
6 diameter of a tumor whether or not the lymph nodes
7 were involved.

8 A. That's correct.

9 Q. Even though that may not be this .
10 specific patient.

11 A. **Those** are all probabilities, that's
12 right.

13 MR. **LAWRENCE**: Thank you, Dr. Ozer.

14 THE COURT: Re-redirect?

15 MR. **JOHNSTON**: I promise this will be
16 short.

17 FURTHER REDIRECT EXAMINATION BY MR. JOHNSTON

18 Q. Doctor, out of ~~these~~ studies that **are**
19 listed there, there are some that indicate that
20 they broke it down by node -- the number of nodes
21 positive, **and** others that did not. Let me ask you
22 if you -- do you know which of ~~these~~ studies
23 included the most number of patients?

24 A. Yes, I do.

25 Q. Which one is that?

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1 A. Well, Fisher is clearly the largest.

2 Q. By **far**, isn't it?

3 A. Yes. If I may, maybe I can help the
4 jury understand. The **type** one statistical error is
5 when you draw a conclusion based on insufficient
6 information, and the problem with any study **has** to
7 do with what — how large the number of patients
8 included in the study is, and also whether it's
9 valid in **terms** of reality. And if you notice, the
10 **numbers** under one to three positive nodes tend to
11 be **higher** when the numbers under the negative nodes
12 **are higher**. And that means that Dr. Valadusa chose
13 a patient population that did very well, that had a
14 80-percent survival with negative nodes and
15 therefore did better with one to three nodes.

16 Dr. Fisher chose a population because
17 of demographics mostly that did not do so well and
18 those patients also didn't do so well. So that
19 when I answered the question **with** ranges, those
20 ranges **are** because if you're doing the study in
21 **Spain** or you're doing the study in Scotland or
22 you're doing the study **here** in **America**, there **are**
23 **differences** in the types of patients and how
24 they're selected. **And** that explains the
25 differences in some of the numbers.

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1 MR. JOHNSTON: okay. *Thank* you.

2 MR. LAWRENCE: No questions, Your
3 Honor.

4 THE COURT: All right. Approach just
5 a minute before this witness leaves.

6 (Bench **conference** held outside *the*
7 hearing of the jury.)

8 THE COURT: He used a word in
9 **reference** to one of the questions that may be
10 **confusing** to the jury and I'd like you to ask him a
11 question or **two** with reference to what he meant by
12 the word speculation. If you **all are** afraid to, I
13 **will**.

14 MR. LAWRENCE: Does that mean that
15 Your Honor's going to whether or not we will?

16 THE COURT: One of you do it or I
17 will.

18 MR. LAWRENCE: If Mr. Johnston does
19 that do I get a re-recross?

20 THE COURT: Sure. And if I do
21 neither one of you can follow up,

22 (End of bench conference.)

23 THE COURT: Doctor, your first
24 cross-examination before lunch, you had stated that
25 it **was** more likely **than** not that lymph nodes were

1 not involved as of February of '91.

2 THE WITNESS: That's correct.

3 THE COURT: And ~~then~~ in answer to
4 questions you said that you could not positively
5 say that **because** nobody got in ~~there~~ and operated
6 and biopsied those nodes.

7 THE WITNESS: That's also correct,

8 THE COURT: And ~~then~~ you used a word
9 that judges and lawyers kind of take — and because
10 it's used in **instruction**, it's important that I
11 know **that** you mean the same by **this** word **as** the
12 judge or a lawyer or maybe a **juror**, would mean. You
13 used the word speculation. What do you mean by the
14 term speculation?

15 A. I apologize for **using** that word, Your
16 Honor. It obviously *can* be taken in a number of
17 **different** contexts. The use of the word
18 speculation is the *same* — I use it in the same
19 **context as** I would a statistical probability. I
20 would speculate that her lymph nodes **were** not
21 involved in February of '91 based on the
22 probability that patients with **small** tumors less
23 than two centimeters will have no nodes involved.
24 So by speculation I mean statistical probability.
25 THE COURT: But less than 100

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1 permt.

2 THE WITNESS: Oh, it's less than 100
3 percent, yes.

4 THE COURT: You **may** follow up.

5 MR. JOHNSTON: I have no questions.

6 MR. LAWRENCE: Your Honor, may I?

7 THE COURT: You may.

8 MR. LAWRENCE: Dr. Ozer, did you not
9 also use the word guess?

10 THE WITNESS: Yes, I did.

11 MR. LAWRENCE: Thank you.

12 MR. JOHNSTON I have nothing
13 further.

14 THE COURT: All **right**, you may step
15 down.

16 * * * * *

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1 STATE OF TENNESSEE)

2 COUNTY OF DAVIDSON)

3 I, Cindi C. Resha, Notary Public in

4 and for the ~~State~~ of ~~Tennessee~~ at *Large*,

5 DO HEREBY CERTIFY that the foregoing

6 proceedings was taken at the time and place set

7 forth in the caption *thereof*; that *the* witnesses

8 *therein* were duly sworn on oath to testify the

9 *truth*; that the proceedings were reported by me in

0 shorthand; and that the foregoing pages constitute

1 a *true* and ~~correct~~ transcription of said

2 proceedings to the best of my ability.

3 I FURTHER CERTIFY that I am not a

4 relative or employee or ~~attorney~~ or ~~counsel~~ of any

5 of the parties hereto; nor a relative or employee

6 of such attorney or ~~counsel~~, nor do I have any

7 interest in the outcome or events of *this action*.

8 IN WITNESS ~~WHEREOF~~, I have hereunto

9 affixed my official signature and ~~seal~~ of *office*

0 this 16th day of February, 1995, at Nashville,

1 Davidson County, Tennessee.

2 ~~Cindi C. Resha~~ _____
3 Notary at Large

4 ~~State of Tennessee~~

5 My Commission Expires: April 14, 1998

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