IN THE CIRCUIT COURT OF RUTHERFORD COUNTY
MURFREESBORO, TENNESSEE

NANCY GORMAN and Husband, GERALD GORMAN,

Plaintiffs,

vs. No. 31218

ELIZABETH LAROCHE, M.D.,

Defendant.

TRANSCRIPT OF EXCERPTED PROCEEDINGS

Doc. 347

February 14, 1995

BEFORE: The Honorable John Turnbull, Judge

RESHA * BLACK
COURT REPORTERS
Suite 315 - Washington Square Building
222 Second Avenue, North
Nashville, Tennessee 37201
(615) 242-8822



APPEARANCES:

For the Plaintiffs: Mr. Douglas S. Johnston, Jr.
Attorney at Law
217 Second Avenue, North
Nashville, Tennessee 37201

For the Defendant: Mr. Thomas Lawrence
Mr. Michael K. Bassham
Attorneys at Law
5th Floor
200 Fourth Avenue, North
Nashville, Tennessee 37219

INDEX

Witness: DR. HOWARD OZER



EXHIBITS





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. Andwereyoupracticing 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

Page 5

of the Windship Cancer Center at Emory University in Atlanta.

Q. What is the Windship Cancer Center?

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

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

A. That's correct.

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

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

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

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

Page 6

area of breast cancer.

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

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

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

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

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

A. Yes, I am.

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

A. Yes, it does.

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

Page 7

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

A. Yes, I do.

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

A. I am.

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

A. Yes, I am.

Q. Would you tell the Court, please,

Page 8

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

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

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

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

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

Page 9

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

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

A. Yes, I do.

Q. What is that opinion?

A. She did not, unfortunately.

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

Page 10

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

A. Yes, I do.

Q. And what is your opinion, sir?

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

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

A. Yes, I do.

Q. And what is that, sir?

Page 11

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

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

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

Page 12

15 years.

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

A. From December did you say?

Q. December of 1991, yes, sir.

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

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

A That's a fair interpretation, yes.

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

A Actually most — well, in this case that would be the case, but survivability, the duration is always calculated from the time of

Page 13

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

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

A. Yes, I am.

Q. You understand there are a couple of methods or maybe several methods of staging breast cancers?

A. Yes.

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

A. Yes, I am.

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

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

Q. All right. Doctor. let me show vou

Page 14

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

A. Okay.

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

A. Yes, I do.

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

A. Well, that's a chart that actually breaks down in a lot more detail the TNM system. And it includes some other footnotes on each of the letters. For example, an X means the primary tumor cannot be found, and unfortunately we occasionally see patients that have no primary tumor. And the other subheadings there define whether or not there is involvement of the skin in breast *cancer,* whether there are regional lymph nodes or distant lymph nodes involved, et cetera. But fundamentally it's the TNM staging classification.

Q. All right. Now –

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

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

Page 15

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

A. You can do what is called clinical staging, which is unfortunately all that's available given that we don't have a mastectomy and a biopsy specimen to go by. But you can do that through a clinical stage, and that stage would be Stage I. As you *can see* there is a T-1 lesion, and if you look up on top, it's less than two centimeters. It's one-and-a-half centimeters. And there *are* no lymph nodes involved, we are assuming clinically, because they cannot be palpated and because it is more likely than not that they are not there. And with the M, there are no metastases, and we know that's actually a fact.

Q. And how do we know that?

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

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

A. Yes. Exactly the same thing. If you look at the top – you always use the largest dimension to do the staging. So her biopsy

Page 16

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

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

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

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

A. That is correct,

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

Page 1'

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

Page 19

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

Page 1!

body. And the lymph is a fluid through which white cells that eat bacteria travel, and if anyone's ever had a cut, occasionally you'll get a red *streak* that will go up a little ways and that's because of the infection of the lymphatic system.
The lymph nodes *are* particularly prominent in major intersections of the body such as the axilla or in the *groin,* and there are always local lymph nodes that drain all the tissues in the body. In this case the lymph nodes in the breasts tend to point up towards the armpit, the axilla, and drain the lymphatic fluid from the breasts. They *are* – unfortunately that's the root that breast cancer, in particular, cells will travel as they metastasize.
Q. All right. Sobecausetheyactas these drains for the fluid from the breast, *they are* also then going to *act* as drains for the breast cancer itself?
A. That's correct. They're more or less dams or filters, if you will, that tend to capture the metastasizing breast cancer cells.
Q. You have somewhat answered this question but I'm going to put it in an appropriate form just to get a direct answer to the question.

Page 2(

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

Page 21

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

Page 22

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

Page 23

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

Page 24

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

Page 25

venous access devices placed, they have to receive multiple sticks. If they get mucositis, it's terribly painful, so yes, it's painful.

Q. And if, in fact, there is a recurrence, the result, Doctor, is going to be the same, more probably than not, whether she gets the treatment or not; is that right?

A. That's correct.

MR. JOHNSTON Thank you, Doctor. That's all I have.

THE COURT: Cross-examine.

MR. LAWRENCE: Thank you, Your Honor.

CROSS-EXAMINATION BY MR. LAWRENCE:

Q. Dr. Ozer, good to see you again. Do youremembermе?

A. I do.

Q. We saw each other back in September of 1994; is that right?

A. That's correct.

Q. And I took your deposition in Atlanta at that time?

A. Yes.

Q. Have you read your deposition?

A. Yes.

Page 26

Q. It came out in a transcript form and you've seen that?

A. Yes.

Q. Do you have it with you right now?

A. No, I don't.

Q. We may be referring to it and so I have a copy that I can hand you if you want to refer to it.

A. That's fme.

Q. Have you read your deposition recently?

A. Probably about a month ago.

Q. Okay. My understanding, Dr. Ozer, when I took your deposition is that in your position over at Emory at the present time, you are not only a medical doctor but you are — you have a Ph.D.; is that correct?

A. That's correct.

Q. And, in fact, I got the impression as I was asking you those questions in Atlanta that most of your work at the Windship Cancer Center is in research. Am I correct about that?

A. Not this month. This month I'm the attending on the service for all the tumor patients.

Page 27

Q. But generally speaking, on a yearly basis, wouldn't you agree with me that most of what you do is research rather than looking at patients and treating patients?

A. About 60 percent of my time is either administrative or research and about 40 percent is clinical.

Q. And in addition to that, a great deal of your time is taken up in administrative duties; is that right?

A. correct.

Q. Soin—sothatthejury understands, your capacity at Emory University is as an administrator of the Windship Cancer Center, and I believe that you told me, if I read your deposition correctly and understood you correctly that day, that generally speaking you see patients about a half a day a week.

A. That's correct, in the outpatient department.

Q. Two or three hours a week you see patients?

A. That's correct.

Q. And you are not a specialist in breast cancer, are you?

Page 28

A. No, Iamnot.

Q. And you don't represent yourself to the public to be a specialist in breast cancer?

A No.

Q. In fact, even in your research and in the other medical endeavors that you participate in over at Emory, your real concern is leukemia and lymphoma and immunology. Am I correct about that?

A. That's correct.

Q. And I'm not even sure about what immunology is, but those are not the questions one typically deals with as a physician in breast cancer cases?

A. I'm sorry?

Q. Leukemia is typically not a breast cancer — is not a disease that is similar to the same kind of medical treatment and diagnosis as breast cancer is.

A. They are two different tumors.

Q. Now, I understand that you are an oncologist; is that correct?

A. Correct.

Q. I also understand that you *are* not a board certified —

A. I'm board eligible, not certified.

Page 29

Q. And board eligible means that you never did take the examination to become board certified; is that correct?
A. That's correct.
Q. And the reason you haven't done that is because you're so busy with your research and your administrative duties that you just haven't had a chance to get around to that; is that correct?
A. In my particular age group, many of the senior academic oncologists never bothered to sit for the boards, that's correct.
Q. Now, Dr. Ozer, when you do see patients, you're seeing those patients as an oncologist?
A. Yes, I am.
Q. You're not seeing them as what I and others in this courtroom perhaps would think of as an internist.
A. That's correct.
Q. You are an internist, but you in your day-to-day work as a physician are not a primary care physician.
A. That's correct.
Q. And you don't see patients for common

Page 30

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

Page 31

Q. So when you get – when you get a patient as an oncologist in that half a day a week and also in your other clinical work that you had mentioned earlier, you're seeing that patient because that patient's been referred to you by another primary care physician?
A. That's correct.
Q. Or perhaps a surgeon.
A. I'm referred patients by primary care, by OB/GYNs, by surgeons, et cetera.
Q. okay. So the point is, just so the jury understands, you don't typically see a woman patient who comes in for an appointment wondering what's wrong with her. You are seeing a patient who has already been screened by some primary care physician and then a problem is noted and then referred to you
A. Well, that's not entirely true, because we have in our clinic a breast health center, which is a screening center for breast cancer, and many of the patients that come to that center come exactly as Mrs. Gorman did, with a primary lump in their breast.
Q. I understand, but what you said to me earlier was that the patients that you are seeing

Page 32

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

Page 3

Q. I'm not arguing that with you, but I think you said that TAB gets $150, you get $350, and that's how you came to become involved in this case; is that correct?
A. Yes, TAB called me.
Q. And, in fact, you get called probably from that organization to testify in other cases?
A. Well, this was my first call from them. I've subsequently received another one.
Q. Is that the one that you're going to be in Tampa on later this week?
A. That's correct.
Q. When are you supposed to be in Tampa?
A. Thursday.
Q. And you're going to be testifying in that case about a urological problem; is that right?
A. Correct.
Q. Dealing with the kidney?
A. correct.
Q. Now, you're going to have to excuse me because I'm going to be shuffling through some notes. Dr. Ozer, in Writing down notes as you were giving your direct testimony, I noticed that you have – even though you're not an OB/GYN, you have

Page 35

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

Page 36

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

Page 34

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

Page 3

you start the clock on February 20th, 1991.
Q. Okay. I realize at the beginning of this deposition you said this is very simple. But to me this is not simple. I thought when you gave your deposition in Atlanta, you told me that you could not guarantee one way or the other whether or not a patient's IO-year survivability would be reduced within a period of three months, not eight weeks. Am I wrong about that?
A. No, you're not correct. What I said was I can't tell you -- you then asked me - after the eight-week period, you asked me would it make a difference for three months, and I said, you know, who knows. You're picking numbers out of the air. Three months is a period of time when I can't tell you that metastases are going to occur. And so I'm giving in essence the examiner, in this case Dr. LaRoche, a break and saying all right, I'll give you three months, but beyond that you're really playing with fire and the patient is likely to have metastatics disease.
Q. And I understand what you're saying about giving Dr. LaRoche a break and we appreciate that. I don't mean that sarcastically, but what you're saying is that in your opinion as an

Page 3

oncologist, for a period of three months after the first office visit to Dr. LaRoche's office, you can't really say one way or the other whether or not that reduced this patient's chances for IO-year survivability.
A. No. Had she had a biopsy done at one-and-a-half months and extrication by radical at three months, her survivability as a Stage I breast cancer would have probably been the same.
Q. And so that three-month period that we're dealing with started to run at February 20th, 1991; is that correct?
A. Right.
Q. And it would have ended on May 20, 1991; is that correct?
A. Right.
Q. So that - and of course I realize -
A. Presumably with an operation.
Q. I'm sorry?
A. Presumably with an operation. It doesn't go exam to exam. It needs to be completed. You need to have removed the tumor at thatpoint.
Q. Yes. I understand that. That's Correct. But - and I'm taking into consideration

Page 3

that at some point during that three months, that there was some treatment taken and diagnosis made,
A. Absolutely.
Q. And - but what you're saying is if that treatment and diagnosis did take place on or before May the 20th, you would not be able to say whether or not it reduced this patient's ability to survive to 10 years.
A. I couldn't say.
Q. And you understand that in this case there is an issue as to whether or not this patient had an appointment to come back and see Dr. LaRoche on May the 7th, 1991.
A. I do.
Q. And had she done so, that date would have been within the three-month period that you're talking about.
A. Well, it would, but my interpretation from reading the records is that it's like every other patient that we see. When we see a patient in an interval appointment., as it's called between scheduled appointments, the clock gets reset, and at that point the patient should be worked up for whatever problem they're presenting with as well as the fact that most patients assume they then have

Page 4

six more months to go if there is no problem,
Q. Dr. Ozer, I don't know - I don't think I asked you that question but I appreciate your response. The simple question that I asked you was not whether or not you thought she had an appointment on May 7th of 1991, that's a different issue, and I think that's what you just answered. What I'm asking you is if she had an appointment on May 7th of 1991, that that fell within that three-month period that you were just talking about.
A. It's less than May 20th, that's correct.
Q. And had she been in the office of a physician on that day, she could have been examined by that physician; is that correct?
A. As she could have been on February 20th, 1991.
Q. That's right. But we're talking about the three-month period right now because that's what you're testifying about, okay. And if she had been worked up at that point in time, then that still comes within that three-month period.
A. It does.
Q. Now, despite what - let's set the

Page 4

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

A. That's correct.

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

A. correct.

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

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

Page 43

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

A. correct.

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

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

Q. Okay.

A. Line 10. Line 10 and 11.

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

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

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

A. That's correct.

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

A. It has to be 50.1.

Page 4

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

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

MR. LAWRENCE: *Your* Honor, may I?

**THECOURT:** *Sure.*

Q. If you would, turn to Page 70 – I'm *sorry,* Page 71, starting at Line 2.

A. Uh-huh.

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

A. You did.

Q. And was that your testimony at that time?

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

Q. You have positive nodes *under* any

Page 44

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

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

Q. But 50 percent is not

A. That's correct.

Q. Now, you had mentioned the Davita text.

A. Right

Q. What is the Davita text?

A. It's probably the most authoritarian – or authoritative version of medical oncology practice. It's called Principles and Practice of Oncology.

Q. I hold in my hand the Davita text.

A. You hold half of it.

Q. Do you recognize it?

A. You hold half of it

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

A. That's correct.

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

A. That's correct.

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

Page 45

the authoritative text on breast cancer?
A Right.
Q. May I hand this to you, sir?
A sure.
Q. Now, my understanding when I took your deposition back earlier in 1994 was that in preparing for your deposition and preparing for the testimony that you were going to give today in the courtroom was that you reviewed certain tables and charts in the Davita text to substantiate your opinion; is that correct?
A. Yes, I did
Q. And one of those was Table 40-8, am I correct?
A. That's correct.
Q. It's on Page 175; is that correct?
A. *Yes,* it is.
Q. Just so that I understand your testimony about the range of 40 to 50 percent, as I read Table 40-8, Mrs. Goman came in to Dr. LaRoche's office in February of 1991 with a mass less than two centimeters.
A. She did.
Q. And, therefore, if you look at that table, she had an 82 percent chance of survival if

Page 46

the cancer had not spread to her lymph nodes; is thatcorrect?
A. That is correct.
Q. Now, looking at the chart, would you tell me which number is the number that reflects her chances of survival in December after the node had grown to a little over two centimeters?
A. Well, here they're saying 51, however, this is one study and if you turn the page to 40-9, you can see that the range for survivability or for relapse rate with positive nodes in three separate studies is 60, 50 and 64. So that's the range,
Q. Yeah, and I'm going to get to that. That's a different issue, isn't it? We're talking about overall survivability right now and you're talking about disease-free survivability; is that correct?
A. Unfortunately overall survival is what's critical. Disease-free survival is a surrogate end point, which if you'd like me to get into I can.
Q. I may ask you to get into that but I just want to make sure that you *agree* with me that Table 40-8 deals with overall survivability.

Page 47

A. Oh, it does.
Q. Okay. Dr. Ozer, so that all of us can see this, we have just blown up this chart, it will make it easier to discuss.
A. That's fine.
Q. I'm going to put it on the easel here. Is that it, that is that correct chart?
A. That would appear to be the correct chart.
Q. Make sure you compare them now so –
A. It's identical.
Q. Okay. Now, so that the jury understands on February 20th, 1991, when she first came in to see Dr. LaRoche, this was her status right here. Am I correct?
A. That's correct.
Q. Okay. She had a node less than two centimeters in diameter and she had an 82 permt chance of surviving.
A. correct
Q. Now, the entry when she came back in December, her node was in this column between *two* and five; is that correct?
A. That's correct.
Q. Okay. December. Now, if I follow

Page 48

this chart, this line under the size of the node and the size of the tumor mass down, I see a number which indicates the percentage of survivability for a patient who has positive lymph nodes which are proximal only, do you see that?
A. That's correct.
Q. And you understand in this case because you've read the pathology record that she had two proximal nodes.
A. Correct.
Q. And just for the jury's education and for mine, also, my understanding is that the proximal nodes *are* just the first ones in line –
A. correct.
Q. If the *cancer* spreads from the breast tissue out toward the armpit, it gets to the proximal nodes first.
A. .correct,
Q. And that's what we're talking about.
A. Correct.
Q. And if we *drew* a circle around that figure, then in December, according to Davita, she had a 74 percent chance of survival,
A. No, according to the study published by Shottenfeld, not according to Davita Davita

Page 4

has multiple other charts in here, hopefully which you've blown up, that argue against that.
Q. Is this chart in the Davita text?
A. It is.
Q. Did you refer to this chart in your deposition as being –
A. I listed it as one of the charts that I reviewed.
Q. And you listed it as a chart which substantiated your opinion?
A. AD of the charts go together to form myopinion.
Q. But this was one of them, wasn't it, Dr. Ozer?
A. It was.
Q. And you are telling the jury today that the Davita *text* is an authoritative, in fact, the most authoritative text to breast cancer; is thatcorrect?
A. It is. Would you like me to read the *sentence* that discusses that table?
Q. I just want you to answer my question.
A. Yes, I am.
THE COURT Anytime a witness is

Page 5

asked a question, they do have an opportunity to explain their answer if they choose to.
THE WITNESS: May I now read the sentence?
MR. LAWRENCE: Your Honor, I may not have heard the witness's response to the –
THE COURT: You *can* repeat the question, have him repeat his response. Of course he does have a right to explain his answer if he chooses to.
MR. LAWRENCE: I understand, Your Honor.
Q. I want to give you all the opportunity in the world to do that. I just want to be absolutely certain that I heard you say the Davita text was the most authoritative text.
A. It is.
Q. Okay. Now, would you like to explain your answer?
A. Yes. If you look at the text, which is located just above this table, it points out that this is a new study that tends to confirm a higher survivability with proximal, local node involvement rather than distal or further out node involvement. It then goes on to say in another

Page 51

study *axillary* node involvement and survival rate were examined in 385 patients to determine whether the total number of involved nodes or the level of *axillary* involvement was a better indicator of prognosis. For any given number of involved nodes survival was independent of the level of involvement and the investigators concluded that progress was related more to the total number of nodes than to the level.
And then you turn the page and it has Table 40-9, and that provides data on what amount to probably 1,000 patients as opposed to the smaller number of patients in this one study, and that number comes out to be significantly less than 74.
Q. Okay. Buteventhetotalnumber which were involved in this study was at least 51 percent; is that correct?
A. Upper range, yes.
Q. Now, let's look at that other table. 40-9; is that correct?
A. Yep.
Q. We may not have it. Just a moment. While Mr. Bassham is looking for that, Dr. Ozer, did you also take into consideration 40-7?

Page 52

A. Yes, I did.
Q. Now, if I understand 40-7, that is an even larger array of potential patients.
A. Yes, it is.
Q. And it really summarizes what, seven different studies?
A. Yes, it does,
Q. Does that table – does that table give us some indication of 10-year survivability?
A. It does.
Q. Is that a table that you could utilize to substantiate your opinion in this case?
A. Yes, I could.
Q. Let me just ask you, obviously looking at that table, in each of those seven studies, if the lymph nodes were negative in February, if they were negative in February, all of the survival rates are above what, 65 percent; is thatcorrect?
A. 65 percent is the lowest, that's correct.
Q. And the highest is 80 percent?
A. Yes.
Q. Meaning that even if the nodes were negative, even if it hadn't spread, 20 permt of

Page 53

those patients are going to die in 10 years.
A. correct.
Q. Now, if we look over in the third column, would you agree with me that those numbers are the percentages that we would look at in this case to determine any reduction in 10-year survivability?
A. They would be, yes.
Q. And the reason is because she had two positive nodes in December of 1991, correct?
A Correct.
Q. And in one of those, the very first study, Valadusa, and I may be pronouncing that wrong, the chance of survivability is 50 percent; is that correct?
A. "hat's correct.
Q. Which is the number that you had used in the deposition.
A. That's correct.
Q. The second study, Hagenson, indicates that the chance of survivability with positive nodes is 63 percent; is that correct?
A. That's right.
Q. The next one is Fisher, and the Fisher study is only 38 percent.

Page 54

A Fisher's study by the way is the one that has 10,000 patients in it.
Q. And of Fisher's 10,000 patients, he only felt from his results that the chance of survival, even if it had not spread, and we're talking about this tumor back in February of 1991, was only 65 percent.
A Correct.
Q. Meaning that 35 percent of those patients out of a hundred, or a 35 percent chance of dying within 10 years.
A. Still more than 50 percent, that's correct.
Q. And then the final study, Ferguson, indicates a 52 percent chance.
A. "hat's right.
Q. So of the four studies that have any kind of data on nodes that are positive, three out of those four indicate that the chance of survival only drops to 50 percent or above; is that correct?
A. That's the interpretation from the table, that's right.
Q. The table that's in the Davita text.
A. Right. Continuereading.

Page 55

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

Page 56

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

Page 57

years since surgery?
A. Most of us in the field hesitate to make statements within a five-year time frame because of the fact that breast cancer, unfortunately, often relapses late. I had a woman relapse a few months ago at 28 years. So the answer to your question is no, unfortunately, I'm not. I would still stick with the 10-year figures. If you said is it better than the diagnosis, probably by a few percent, but I couldn't go any further than that.
Q. You had a patient who relapsed after 28 years?
A. Correct.
Q. Now, I was listening carefully, I hope, to your testimony about how you concluded that the lymph nodes were involved – were not involved in February of 1991. And that is your position; is that correct?
A. It's my position that more likely than not they were not involved. I can't know for sure.
Q. Again, I'm confused because that does not appear and I did not understand that when I read your deposition and took your deposition back

Page 58

in September. I could have mom that you said to me that you couldn't say one way or the other whether or not those lymph nodes were involved in February of 1991. Am I correct about that?
A. I'll state it again. I cannot say one way or another. I'm not God. I have no idea what the truth is of *this* matter. What I can say is I can give you a probability. The probability is based on statistics with other patients, and if you look at the large numbers of patients, they are less than 50 percent likely to have lymph nodes involvement with Stage I tumors and more than 50 percent Likely to have them with Stage II tumors.
Q. So basically what you're doing today is telling this jury that you think it's more likely than not that her lymph nodes were not involved in February of 1991 because of some general statistical analysis.
A. That's correct.
Q. And when I asked you about that, I believe that you did not know where those statistics were located; is that right?
A. Oh, they're in Davita. They're in a number of other places,
Q. You also testified, didn't you,

Page 59

Dr. Ozer, that breast cancer is an unusual tumor that can progress very rapidly or it *can* remain dormant for a number of years?
A. That's correct.
Q. And you agree with that proposition?
A. Absolutely.
Q. And that makes those general statistics like that more difficult to apply on a case-by-case basis, doesn't it?
A. It is hard to know in any individual *case* whether they're applicable or not.
Q. And that's why you would say and why you told me in Atlanta that you just couldn't say one way or the other?
A. I cannot say.
Q. Whether or not the cancer had spread to her nodes in February.
A. It's a probability guess.
Q. But it's a guess.
A. It is a guess.
Q. That's very important. You're speculating on that, aren't you?
A. I am.
Q. I'm sorry to be shuffling through the notes again but I just happened to read one of my

Page 60

notes here that you told me in that deposition that the size of the tumor does not prove that the nodes are involved. Did you make that statement?
A. You can have a very large tumor and when you do an operation find no lymph node involvement. That goes back to what you just said, that statistics don't always apply to the individual case.
Q. Right. Unusual growth rates is one of *the* things that you said could challenge those general statistics, correct?
A. That's correct.
Q. Another one could be if the person had a very aggressive tumor.
A. *All* of those are true, and if I may explain, the statistics that are derived are derived based on survivability. Mrs. Goman could be hit by a *car* as we leave the courtroom and she would then be counted as a death in these statistics. So it is impossible to predict for an individual what is actually happening, but you can give a probability and attach a probability to whether there is nodal involvement or not.
Q. Well, I don't want to belabor this point because I'm hearing you say two different

Page 61

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

A. Moderately rapid.

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

A. Certainly the age would indicate that.

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

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

Page 62

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

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

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

A. Right.

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

A. Correct.

Page 63

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

A. Could be 49.

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

A No, I'm not.

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

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

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

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

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

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

Page 64

and gentlemen of the jury, we're going to take a break for lunch, We're going to meet back promptly at 1:00 o'clock. Remember the instructions that I have previously given. Do not discuss this witness's testimony or any witness's testimony with each other or with anyone else or allow anyone else to discuss this *case* with you Don't discuss what the lawyers have done or haven't done or anything that's happened in the *case* with each other. Don't – if you go home or if you eat with some other friend, don't allow them to discuss this case with you or any party in this case or anything about this *case.* If anybody were to attempt to do that after you informed them that you're on the jury, advise the bailiff when you come in, do not advise your fellow jurors. That is, report any violations,

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

(Jury dismissed from courtroom.)

(Luncheon recess.)

THE COURT: Are you all ready to

Page 65

proceed?
MR. JOHNSTON: Yes, Your Honor.
MR. LAWRENCE: Yes, Your Honor.
THE COURT: All right. Bring the jury in.
(Jury summoned to courtroom.)
THE COURT: Be seated. witness may retake the stand. Allright. Youmaycontinue your cross-examination.
MR. LAWRENCE: Thank you, Your Honor.
CONTINUED CROSS-EXAMINATION BY MR. LAWRENCE:
Q. Dr. Ozer, if Mrs. Gorman's breast cancer in February of '91 had not spread to the lymph nodes, she was still going to need surgery; is that correct?
A. That's Correct.
Q. And she was also still going to need chemotherapy for that breast; is that correct?
A. She would need probably a lumpectomy and CMF would be the recommended chemotherapy.
Q. Right. Okay. And so what you're saying to us today is that even if her cancer had not spread to the lymph nodes back in February when she first came in, she was still going to need a

Page 66

lumpectomy, which is a form of *surgery*, and chemotherapy?
A. Yes.
Q. And if she had the lumpectomy, wouldn't you also have to include radiation?
A. That's correct.
Q. So if she had a lumpectomy as opposed to a modified radical mastectomy in February of 1991, she was going to need surgery plus radiation plus chemotherapy?
A. Yes.
Q. Or she could have achieved the same result with a modified radical mastectomy and chemotherapy?
A. Yes.
Q. And, in fact, that's what she had in December of 1991; is that correct, sir?
A. That's Correct
Q. And to the extent that this patient in this lawsuit may claim that because there was not an earlier diagnosis, that she may have lost the chance or the option to choose between a mastectomy and a lumpectomy, I would like to ask you some questions about that.
A. sure.

Page 67

Q. A lumpectomy is certainly not as significant *surgery* as modified radical mastectomy in most patients; is that correct?
A. That is correct.
Q. Okay. And the reason I qualified it that way, obviously as I understand it as a layperson, a mastectomy involves removal of all of the breast tissue; is that correct?
A. Thatiscorrect.
Q. Whereas a lumpectomy is an attempt to make a smaller incision, go in and just remove the affected part. In this case it would be the one-and-a-half centimeter tumor?
A. Modified radical mastectomy dso includes dissection of axillary nodes.
Q. But in this case if she had selected lumpectomy in February '91, you would have recommended that she have the nodes removed also, or at least biopsied?
A. Oh, yes.
Q. That would have resulted in the loss of some of her lymph nodes.
A. Yes.
Q. So under either circumstance, whether the diagnosis was made in February or whether it

Page 68

was made in December, those things were going to happen?
A. Yes.
Q. And if she had selected lumpectomy, there are some additional risks with lumpectomy that she would not have otherwise had with mastectomy; is that correct?
A. That's correct.
Q. And one of those risks is that she would need the radiation.
A. Right.
Q. And with the modified radical mastectomy she had in December 1991 she didn't have to have radiation.
A. Right.
Q. And radiation carries with it some fairly significant side effects of its own?
A. . It carries with it some local side effects.
Q. Local side effects means that it *can* result in permanent change in the appearance of the breast; is that correct?
A. That's correct.
Q. And in addition, lumpectomy carries the risk that in a small-breasted woman, for

Page 69

example, the lump itself may be of such a *size* in comparison to available breast tissue that what you're left with is a deformity or a distortion of the breast tissue; is that correct, sir?

A. Correct.

Q. You've never examined this patient, have you?

A. No, I have not.

Q. Would you concede that she was a small-breasted woman? Do you h o w that?

A. I have no knowledge of that and I couldn't even see her because the chart's in the way.

Q. Okay. Well, I ask that question respectfully because – and that's redly not where I was going with that. I was wondering whether or not from the records you had read you had noticed that there was any indication that that was the case.

A. I don't recall an indication that her breasts were large or small.

Q. In addition to all of the above, lumpectomy can be a risky procedure because it might not get it all, as they say; is that correct?

Page 70

A. The data now suggests that done properly lumpectomy is as safe as a radical as long as you include the radiation.

Q. So what you're saying there is that there is a risk that you go in there with the surgery involved with a lumpectomy, you remove the tumor, but there may be left behind cancerous cells?

A. There may be with a radical as well, or modified radical.

Q. Okay. But there's a better chance, and I think the way you described it to me in Atlanta was that the modified radical mastectomy was more efficient at removal of all of the potential cancer cells in the breast.

A. Yes, but if you add together the radiation and lumpectomy, it's equal to a modified radical in terms of safety, as best they *can* tell at this point.

Q. And that's why you have to throw – in addition to chemotherapy you have to stack on top of that the radiation.

A. Correct.

Q. And which makes it an even more difficult road in terms of recovery; is that

Page 71

correct, sir?

A. It's not an easy choice.

Q. Under any circumstances.

A. Correct.

Q. And that's because cancer is a devastating *disease,* isn't it?

A. Yes.

Q. In fact, even though studies have shown that lumpectomy and mastectomy are approximately the same in terms of – or maybe exactly the same in terms of the end result, the only reason to attempt a lumpectomy is for cosmetic reasons, to attempt to save breast tissue?

A. That is correct.

Q. In this patient's case that point became moot in 1993, didn't it?

A. It did.

Q. And the reason is because she then contracted cancer in her left breast?

A. Yes.

Q. Correct?

A. That's correct.

Q. And when she contracted cancer in her left breast, at that point it was apparent to everyone involved with her treatment that she was

Page 72

predisposed to cancer.

A. Clearly she is in a high risk *category* given her age and her bilateral incidence.

Q. Unrelated in any way to when a diagnosis was made?

A. That's true.

Q. Okay. And for that reason she had a modified radical mastectomy of the left breast at that time, in March of 1992?

A. That reflects a wise decision.

Q. It's a wise decision because at that point you're dealing with an aggressive situation with the *cancer?*

A. correct.

Q. And she had to have another course of chemotherapy; is that *correct?*

A . Correct.

Q. A six-month course.

A. Yes.

Q. And so what this patient has been through is a tough situation where she contracted *cancer* in one breast, she had *six* months of chemotherapy, then she contracted *cancer* in another breast, she had another course of chemotherapy, and

Page 73

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

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

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

A. No.

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

A. That's correct.

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

Page 74

Am I correct about that as well?

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

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

A. Yes.

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

A. Right.

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

A. No, it did not.

Q. Nor did any such alleged delay cause the treatment in the right breast to be worse than the treatment of the right breast – I may have – did I reverse them? Nor did it cause the treatment of the cancer in the left breast to be any worse than the one in the right where it started out?

A. That could be debated. There are

Page 75

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

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

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

Q. In your opinion, Dr. Ozer, does the fact that this patient contracted breast cancer on the left side in addition to her primary cancer on the right side further decrease her survivability for IO years?

A. Oh, yes.

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

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

Page 76

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

A. Correct.

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

A. I didn't hear a question.

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

A. That's correct.

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

A. Correct.

Q. Who has a rapidly – or maybe you said a moderately rapidly progressing tumor. And she has now contracted cancer in primary lesions in both of her breasts.

A. Correct.

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

Page 77

aggressive disease in this patient.
A. This patient has a very high risk for primary breast cancer. We don't know at this point whether she's cured or not. She may still be cured and completely disease free and live a normal life span.
Q. And we certainly hope so. But my question is when a patient has this *degree* of breast cancer, doesn't it make it even more difficult to determine the percentages of survivability based on the allegation that there was a 10-month delay in diagnosing the lesion?
A. Well, I think you have to go back to the basis. The basis is thousands of patients, all of whom *are* assigned a number based on their time of diagnosis. So even in those studies some of those patients wound up with bilateral breast cancer, and given that we don't have numbers broken out that way, all we can rely on is what the statistics say.
Q. And one final point. Earlier in your direct testimony you had mentioned the concept of relapse rate, correct?
A. correct.
Q. And I don't want to get too – YOU

Page 78

ma& some comment earlier to me today which I took to heart, and that is the most important statistic is overall survivability for 10 years; is that right?
A. That's correct.
Q. And we've discussed that. And we've looked at it on these tables from the Davita text; isthatright?
A. Right.
Q. And so as I understand the whole concept of even bringing up relapse rate, what you're talking about there is not necessarily IO-year survival, but it's whether or not the primary cancer is going to recur during that 10-year period.
A. That's correct.
Q. Those *are* the statistics you're applying to that situation.
A. That's correct.
Q. And when that happens you may have a patient who relapses but who with proper treatment and perhaps luck, but *certainly* with proper treatment and the treatment that's available, those folks may live much longer than 10 years.
A. Generally they live a few years

Page 79

longer. A small percentage *axe* cured as a result of the bone marrow transplant, for example.
MR. LAWRENCE: I think that's all. Thanks.
THE WITNESS: Thank you.
MR. LAWRENCE: Oh, I'm sorry, Your Honor, housekeeping measure. I would like to mark this chart as Exhibit 4 –
THE CLERK: 5.
MR. LAWRENCE: 5, sorry.
(Table 40-8 marked as Exhibit Number 5 and fded as a part of this record.)
BY MR. LAWRENCE:
Q. Doctor, this is the other – let me just be *certain.* I forgot to put this one up when we were talking about it. But this is the 40-7 table which we discussed
A. Correct.
Q. This is the same one that's in the Davitatext?
A. That is correct.
Q. And one that you had utilized in coming to your conclusions.
A. Correct.

Page 80

MR. **LAWRENCE:** Mark that as Exhibit 6.
THE COURT: Without objection let it be introduced as Exhibits 5 and *6.*
(Table 40-7 marked as Exhibit Number 6 and fded as a part of this record.)
MR. **LAWRENCE:** Thank you, Your Honor.
MR. JOHNSTON: Excuse me. Just for my clarification, Exhibit Number 5 is 40-8 and Exhibit Number 6 is 40-7?
THE CLERK: *Yes.*
**REDIRECT** EXAMINATION BY MR. JOHNSTON:
Q. Dr. Ozer, I want to follow up on just a few things that Mr. Lawrence brought up with you earlier, mostly this morning. You pointed out, I think correctly when he asked you about the Davita book that this volume in front of you is half the Davita book, right?
A. That's correct. I have a whole one inmybriefcase.
Q. Right. And that book, the Davita book that we've been making reference to here today, literally contains hundreds if not thousands

Page 8

of studies on all aspects of cancer treatment, detection, diagnosis, et cetera, survivability, all of those various things; is that right?
A. That's right.
Q. And what is the reason for compiling all of those studies into a two-volume work like that?
A. In order to provide the most authoritative documentation in a particular area.
Q. Allright. Andwoulditbefairto say that pulling out one single study and saying this is the definitive study, would that be fair or reasonable?
A. Not at all. There's actually a definition for that. It's called a type one statistical error.
Q. What is a type one statistical error, sir?
A. It means that you draw a conclusion from insufficient data.
Q. Okay. Now, when I asked you earlier if you had any opinions rendered with a reasonable degree of medical certainty regarding Mrs. Gorman's chances of survival both in February and in December of 1991, and then when I asked you later

Page 82

about whether you had an opinion rendered with a reasonable degree of medical certainty as to her chances of recurrence of breast cancer in February and in December of '91, and you told me yes, were you relying not only on 40-8 and 40-7, but all of the studies that you were aware of and in addition to those studies your general practice over 20 years in oncology?
A. I was.
Q. All right. And simply because we've been shown a study in Table 40-8, or any other table, does that change your opinion at all?
A. No, it does not.
Q. Real quickly, on the material that you recall reading about the left breast cancer, that was detected, diagnosed and removed at Stage I level, wasn't it?
A. Yes, it was.
Q. And then: was no node involvement there.
A. That's correct.
Q. And that's pretty good, isn't it?
A. Obviously that's much better. It's in the 80-percent category of survival.
Q. Okay. There was also some discussion

Page 83

earlier about node involvement, specifically whether or not you could tell for certain whether there was node involvement in February, and I think we've all admitted here, I mean, there's no way to know. You can't possibly know because we can't look into the body at that point.
A. Right.
Q. Let me pull out this exhibit that we talked about earlier in your testimony, Exhibit Number 4, which is the TNM chart. Let me ask you to make an assumption about something, Dr. Ozer. If the two nodes that we know were involved in December of 1991 were in fact involved in February, where would Mrs. Gorman have fallen on the staging chart according to this stage, sir?
A. She'd fall where the asterisk is, if everyone can see that.
Q. That's a Stage II-A?
A. T-1, N-1, M-0.
Q. Okay. And there's a Little asterisk here, and I know you can't read it from that far. Let me just bring it up to you and if you'll read that to us, please, sir.
A. The prognosis of patients with T-1, N-1, M-0 is similar to that of patients with N-0.

Page 84

Q. And what does that mean, sir?
A. That means that at that level the involvement of the nodes don't make as much of a difference as *the* size of the primary lesion.
Q. Okay. So if you assume then that, again, that the nodes were involved in February, even with that, did Mrs. Gorman more likely than not have the chance for survival – IO-year survival?
A. Even with nodal involvement, a Stage I breast cancer is still better than 50 percent 10-year survival.
Q. All right. One more thing I want to talk to you about. There was some discussion about some testimony that you gave earlier about this three-month window that we *were* talking about, and I think, if I'm understanding it correctly, and you correct me if I'm wrong, that that three-month window that you laid out is basically from presentation to treatment?
A. Correct.
Q. And that's the absolute outside.
A. Correct.
Q. You really don't want to push that envelope very far, do you?

Page 85

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

Page 86

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

Page 87

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

Page 88

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

Page 89

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

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

A. Correct.

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

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

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

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

Page 90

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

A. That is the correct chart.

Q. And I understood when you were answering questions from Mr. Johnston about all those hundreds and thousands of tables, that you said it would be inappropriatejust to pull out one from all of that group and draw some conclusions from it. Because that was a type one statistical error, correct?

A. correct

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

G That's correct.

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

A. Youareright.

Q. And out of those seven studies, in terms of patients who have a couple of positive lymph nodes when they have cancer, three out of the four show that the chance of survival is at least 50 percent. Isthatcorrect?

Page 91

A. That's correct.

Q. And one of them goes as high as 63 percent

A. And one goes as low as 38.

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

A. You wind up with an average of 52.

Q. Which is a probability, correct?

A. Correct.

Q. A probability that she was going to live; is that right? She was going to have – she was not going to have a reduced –

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

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

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

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

A. correct.

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

Page 92

use to make evaluations; isn't that right?

A. That's correct.

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

A. That's correct.

Q. Even though that may not be this specificpatient.

A. Those are all probabilities, that's right.

MR. LAWRENCE: Thank you, Dr. Ozer.

THECOURT: Re-redirect?

MR. JOHNSTON: I promise this will be short.

FURTHER REDIRECT EXAMINATION BY MR. JOHNSTON

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

A. Yes, I do.

Q. Which one is that?

Page 93

A. Well, Fisher is clearly the largest.
Q. By far, isn't it?
A. Yes. If I may, maybe I can help the jury understand. The type one statistical error is when you draw a conclusion based on insufficient information, and the problem with any study has to do with what - how large the number of patients included in the study is, and also whether it's valid in terms of reality. And if you notice, the numbers under one to three positive nodes tend to be higher when the numbers under the negative nodes are higher. And that means that Dr. Valadusa chose a patient population that did very well, that had a 80-percent survival with negative nodes and therefore did better with one to three nodes.

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

Page 94

MR. JOHNSTON: okay. *Thank* you.
MR. LAWRENCE: No questions, Your Honor.
THE COURT: All right. Approach just a minute before this witness leaves.
(Bench conference held outside *the* hearing of the jury.)
THE COURT: He used a word in reference to one of the questions that may be confusing to the jury and I'd like you to ask him a question or two with reference to what he meant by the word speculation. If you all are afraid to, I will.
MR. LAWRENCE: Does that mean that Your Honor's going to whether or not we will?
THE COURT: One of you do it or I will.
MR. LAWRENCE: If Mr. Johnston does that do I get a re-recross?
THE COURT: Sure. And if I do neither one of you can follow up,
(End of bench conference.)
THE COURT: Doctor, your first cross-examination before lunch, you had stated that it was more likely than not that lymph nodes were

Page 95

not involved as of February of '91.
THE WITNESS: That's correct.
THE COURT: And then in answer to questions you said that you could not positively say that because nobody got in there and operated and biopsied those nodes.
THE WITNESS: That's also correct,
THE COURT: And then you used a word that judges and lawyers kind of take - and because it's used in instruction, it's important that I know that you mean the same by this word as the judge or a lawyer or maybe a juror, would mean. You used the word speculation. What do you mean by the term speculation?
A. I apologize for using that word, Your Honor. It obviously *can* be taken in a number of different contexts. The use of the word speculation is the *same* - I use it in the same context as I would a statistical probability. I would speculate that her lymph nodes were not involved in February of '91 based on the probability that patients with small tumors less than two centimeters will have no nodes involved. So by speculation I mean statistical probability.
THE COURT: But less than 100

Page 96

permt.
THE WITNESS: Oh, it's less than 100 percent, yes.
THE COURT: You may follow up.
MR. JOHNSTON: I have no questions.
MR. LAWRENCE: Your Honor, may I?
THE COURT: You may.
MR. LAWRENCE: Dr. Ozer, did you not also use the word guess?
THE WITNESS: Yes, I did.
MR. LAWRENCE: Thank you.
MR. JOHNSTON I have nothing further.
THE COURT: All right, you may step down.
* * * * * * * * *.

STATE OF TENNESSEE )
COUNTY OF DAVIDSON )

I, Cindi C. Resha, Notary Public in and for the State of Tennessee at Large,

DO HEREBY CERTIFY that the foregoing proceedings was taken at the time and place set forth in the caption thereof; that the witnesses therein were duly sworn on oath to testify the truth; that the proceedings were reported by me in shorthand; and that the foregoing pages constitute a true and correct transcription of said proceedings to the best of my ability.

I FURTHER CERTIFY that I am not a relative or employee or attorney or counsel of any of the parties hereto; nor a relative or employee of such attorney or counsel, nor do I have any interest in the outcome or events of this action.

IN WITNESS WHEREOF, I have hereunto affixed my official signature and seal of office this 16th day of February, 1995, at Nashville, Davidson County, Tennessee.

Cindi C. Resha
Notary at Large
State of Tennessee

My Commission Expires: April 14, 1998