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SUPERIOR COURT OF THE STATE OF CALIFORNIA  
FOR THE COUNTY OF LOS ANGELES

RICHARD BOEKEN, )  
 )  
 Plaintiff, )  
 )  
 -vs- ) NO. BC226593  
 )  
 PHILIP MRRIS, INCORPORATED, a )  
 corporation; INTERNATIONAL HOUSE )  
 OF PANCAKES, INCORPORATED, a )  
 corporation; DOES 1-100, )  
 inclusive, )  
 )  
 Defendants. )  
 )

DEPOSITION OF THOMPSON ADAMS, M D.,  
taken on behalf of the Plaintiff, at  
11755 Wilshire Boulevard, Suite 1170,  
Los Angeles, California, commencing at  
10:00 A.M, on Thursday, March 15, 2001,  
before FRANCES M GARRITY, CSR NO. 8934 in  
and for the State of California.

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APPEARANCES

For the Plaintiff:  
LAW OFFICES OF MICHAEL J. PIUZE  
By: Michael J. Piuze, Esq.  
117dd Wilshire Boulevard  
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Los Angeles, California 90049  
323-655-5353

For the Defendants:  
ARNOLD & PORTER  
By: Angel Tang, Esq.  
777 South Figueroa Street  
Suite 4400  
Los Angeles, California 90017  
213-243-4101

Also present:  
Chris Johnson

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LOS ANGELES, CALIFORNIA; THURSDAY, MARCH 15, 2001  
10:00 A.M

THOMPSON ADAMS, M.D.,  
called as a witness on behalf of Plaintiff, having been  
first duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. PIUZE:

Q Tell me your name.

A Thompson Adams.

Q Do you have a C.V.?

A Yes.

Q Can I have it?

A Yes, you may.

MR. PIUZE: We'll mark this Exhibit 1.

(Plaintiff's Exhibit 1 was marked for  
identification by the Certified Shorthand  
Reporter and is attached hereto.)

BY MR. PIUZE:

Q Up to date?

A Yes.

Q When were you hired?

A I was contacted in October or --

MS. TANG: Objection. Vague and ambiguous.

1 MR. PIUZE: You think so?  
2 MS. TANG: Yes.  
3 MR. PIUZE: I don't.  
4 Q October?  
5 A October or November of last year.  
6 Q By whom?  
7 A By Chris Johnson.  
8 Q Who is Chris Johnson?  
9 (Witness indicating.)  
10 BY MR. PIUZE:  
11 Q It's like a court drama.  
12 Is that the guy who did it (indicating)?  
13 A Yeah.  
14 Q The man in the room with us?  
15 A Yes.  
16 Q How did you get in contact with Chris Johnson?  
17 A He visited me with a representative from  
18 Bonne, Bridges.  
19 Q Let me guess. Mitzie?  
20 A Yes.  
  
21 Q How do you know Mitzie?  
22 A I don't know Mitzie.  
23 Q How did Mitzie contact you?  
24 A I don't know. I did medical/legal work for  
25 Bonne, Bridges, but other than that I don't have any

6

1 idea.  
2 Q I'm scheduled to be in trial with Bonne,  
3 Bridges starting tomorrow on a medical/legal case. Lucky  
4 me.  
5 George Peterson, do you know him?  
6 A I don't know if I worked with him. The name  
7 sounds familiar.  
8 Q I think he's the fifth guy.  
9 Anyways, how many times do you think you've  
10 done medical/legal work for Bonne, Bridges over the  
11 years?  
12 A Probably about eight.  
13 Q With Mitzie?  
14 A None.  
15 Q I don't know her last name. It's  
16 disrespectful, I guess. What is her last name?  
17 A I believe, and my memory isn't as good, but I  
18 think it's Dobson.  
19 Q Dobson?  
20 A Um-hmm  
21 Q Who have you worked with?  
22 A Tom Scully, Rick Ryan, when he was there. A  
23 fellow by the name of Marshall, I believe.  
24 Q Okay. So how did Mitzie -- excuse me. How did  
25 Ms. Dobson initiate the conversation?

1           A     Well, she just basically asked if I would be  
2 willing to talk to people from Shook, Hardy & Bacon.  
3           Q     Did you know who Shook, Hardy & Bacon were?  
4           A     They told me they were lawyers in a tobacco  
5 company.  
6           Q     Did she tell you which tobacco company?  
7           A     No.  
8           Q     Did she tell you the purpose of the review?  
9           A     Well, there wasn't a specific review. It was  
10 just an introduction meeting.  
11          Q     The purpose of the meeting, did she tell you  
12 that?  
13          A     She didn't specify a specific purpose of the  
14 meeting.  
15          Q     Could you guess?  
16          A     No.  
17          Q     It had to do with tobacco and cancer?  
18          A     Frankly, you know, I wouldn't have been able to  
19 anticipate, but when you realize they represent a tobacco  
20 company, yeah. I mean, there was -- it would be  
21 relationship between tobacco and cancer, yes.  
22          Q     You're an oncologist and treat cancer, and they  
23 defend tobacco companies?  
24          A     I'm an oncologist that's willing to render  
25 medical opinions about clinical situations.

1 Q Well, I wasn't wrong when I said you're an  
2 oncologist that treats cancer?  
3 A No. That's true, correct.  
4 Q That's what you do most of your professional  
5 time?  
6 A Yes.  
7 Q What percentage of the time is for treatment of  
8 cancer, and then to rendering professional opinions?  
9 A About 5 percent.  
10 Q The medical/legal work in the past, are we  
11 talking med-mal cases?  
12 A Yes.  
13 Q Also for the defendant?  
14 A No. 25 percent for plaintiff.  
15 Q Who has retained you for plaintiffs?  
16 A There was Schumer, Schumer & Drane in  
17 Santa Barbara would send cases, and if they thought there  
18 was cause of action. There's a fellow in Northern  
19 California near Sacramento, California. I had one case  
20 with him. A situation that was unfortunate. I mean, the  
21 clinical situation was unfortunate.  
22 And let me think. I don't know how to get to  
23 the 25 percent with the names that I mentioned, but  
24 that's about what I remember it being. I can't think of  
25 anyone else particularly right now that I've worked with

1 as a plaintiff.  
2 Q How many medical/legal cases have you done?  
3 A I guess not more than about 35, 30, something  
4 like that.  
5 Q Okay. All right. So when was your meeting  
6 with Chris and Ms. Dobson?  
7 A That was in, I think, August or so.  
8 Q Where?  
9 A In my office.  
10 Q You mean, you let them on the same block with  
11 me?  
12 A I didn't know you were here then.  
13 Q What did they have to tell you?  
14 A They asked me questions about my opinions about  
15 lung cancer, and they asked me opinions about what I do,  
16 in terms of my practice. Very general questions.  
17 Q Well, you never heard of Richard Boeken at that  
18 point?  
19 A No.  
20 Q What were your opinions about lung cancer?  
21 It's a pretty big question, it sounds like.  
22 A Well, your question is also broad. I mean,  
23 there are several different kinds of -- pathological  
24 kinds of lung cancer.  
25 Q Let me stop you. It is broad because it's

1 their question.

2 In other words, they asked you what you thought  
3 about lung cancer. What did you tell them?

4 A First of all, I don't recollect the specific --  
5 what I was trying to convey to you in my answer was, it  
6 was a general discussion. Beyond that, I mean, I don't  
7 remember the specifics. I don't -- we didn't get into  
8 specifics.

9 Q Well, what was the general discussion?

10 A I think the general discussion centered around  
11 what kind of patients I saw in my practice; a little bit  
12 about what I thought about lung cancer and how it was  
13 treated.

14 I don't remember them specifically asking me  
15 questions at that time about what I thought the cause of  
16 lung cancer was at that time. I just don't remember.  
17 But I think they -- as near as I can tell, it was really,  
18 I think -- well, I had no idea of exactly what the long  
19 distance thought was that they were -- that they were  
20 going to utilize me for. But since I know Bonne, Bridges  
21 and respect them, and since they suggested that I  
22 consider meeting with them, I thought, "All right. I  
23 will meet with them "

24 Q You gave me three questions that were posed to  
25 you that day.

1                   Can you give me the short answers to each?  
2           A     The questions being?  
3           Q     The three questions you told the court  
4     reporter, which she can reread to you to refresh your  
5     recollection, if you'd like.  
6           A     Yeah, please.  
7                   (Whereupon, the record was read as follows:  
8                   "A I think the general discussion centered  
9                   around what kind of patients I saw in my practice;  
10                  a little bit about what I thought about lung cancer,  
11                  and how it was treated.")  
12          THE WITNESS: Well, my patient practice consists of  
13     75 percent medical oncologist and 25 percent hematology.  
14     In the medical oncology range, I deal with all treatment  
15     and diagnosis and staging of almost all cancers, all  
16     solid tumors.  
17                   And with regard to hematology, that constitutes  
18     hematologic malignancy and other disorders of the blood,  
19     such as coagulation, hemostasis, thrombotic problems,  
20     disorders of red and white cell function. So that's  
21     basically what my practice consists of.  
22     BY MR. PIUZE:  
23           Q     Okay. Question Number 2.  
24           A     Number 2, having to do with lung cancer,  
25     basically types of patients that I see, I see about, in

1 my own practice, about maybe 25 lung cancers a year that  
2 are new.

3 And I see, in presentations, probably an  
4 additional 50 or 75 patients, or 25 to 50 additional  
5 patients that have lung cancer that are discussed in the  
6 meetings that are held both at the City of Hope through  
7 teleconferences equipment, and at John Wayne, where there  
8 is a weekly conference in oncology.

9 Q So those people would not be your patients?  
10 A Those would not be mine.  
11 Q What is your role in the conference?  
12 A Well, I participate in rendering opinions as to  
13 diagnosis, treatment.  
14 Q And other doctors similarly would be  
15 participating when your patient's turn came up to be  
16 discussed?  
17 A Yes.  
18 Q Okay. Thanks.  
19 Is that your end of the answer to Question 2?  
20 A I think so.  
21 Q Okay. Question 3.  
22 A I only remember two questions that were read  
23 back.  
24 Could I maybe have her reask the question?  
25 Q Sure.

1                   (Whereupon, the record was read as follows:  
2                   "A I think the general discussion centered  
3                   around what kind of patients I saw in my practice;  
4                   a little bit about what I thought about lung cancer,  
5                   and how it was treated.")  
6                   THE WITNESS: The answer to the way in which lung  
7                   cancer is treated is a really broad question, because it  
8                   depends on self-type.  
9                   BY MR. PIUZE:  
10                  Q    Let me interpret that. I thought when the  
11                  court reporter was nice enough to read back for the  
12                  second time your answer, or what you had said was, "what  
13                  I thought about lung cancer." So only you know what you  
14                  meant by that. But I'm reminding you of what your words  
15                  were, "what I thought about lung cancer."  
16                  A    Well, when I say, "what I thought about lung  
17                  cancer," I was talking about what my knowledge about lung  
18                  cancer was, based on my clinical experience.  
19                  Q    Okay. So we're on the same wavelength.  
20                  What did you tell them?  
21                  A    I said that it's a disease that more often than  
22                  not is legal, exception being early staged disease. Even  
23                  then, depending on what the pathological staging is, it  
24                  can be fatal. I don't know if at that time I talked  
25                  about anything about survival, depending on stage. The

1 management of the disease is basically dependent on the  
2 cell type, whether it's a small cell or nonsmall cell in  
3 nature. And it's also dependent on staging. So that  
4 pretty much is what I can remember saying, in answer to  
5 your question.

6 Q How often is lung cancer fatal?

7 A Well, more often than no.

8 Q Well, all right. Thank you. 51? 65?

9 A We have to define the stage. Because stage 3-B  
10 cancer probably is more around 7 percent five-year  
11 survival.

12 Q All stages, all lung cancers. Can you do that,  
13 or is it impossible?

14 A As I indicated, it's less than 50 percent if  
15 you put it altogether, because more often than not you  
16 have advanced stage of the disease.

17 Q All right. Can you do better than more than  
18 50 percent fatal? Can you? That's a big number. It  
19 covers a lot of territory.

20 A I mean, I would say probably maybe mortality  
21 rate is in the range of around 60 percent for all  
22 cancers. 60 to 35. 50 to 60 percent.

23 Q Do you know who the John Wayne Cancer Institute  
24 was named after?

25 A Yes.

1 Q Who?  
2 A John Wayne.  
3 Q Why?  
4 A He died of lung cancer.  
5 Q He had a pulmœctomy, didn't he?  
6 A Yes.  
7 Q After his original diagnosis he lived a pretty  
8 good long time, didn't he?  
9 A Yes. As a matter of fact, he actually died of  
10 gastric cancer.  
11 MR. PIUZE: We are now off the record.  
12 (Discussion held off the record.)  
13 BY MR. PIUZE:  
14 Q John Wayne did not die of lung cancer?  
15 A It was gastric cancer, I believe.  
16 Q And --  
17 A But he did have lung cancer. I believe he had  
18 a lungectomy.  
19 Q He survived for 15 years after he had that lung  
20 removed, didn't he?  
21 A Yes.  
22 Q Okay. So you had this meeting.  
23 How long did it last?  
24 A About an hour.  
25 Q And now what was your next involvement with

1 Mr. Boeken's case?  
2 A I think the next involvement was in November  
3 when I was asked to review records on Mr. Boeken.  
4 Q By?  
5 A By Chris Johnson.  
6 Q Did you ever write a Declaration in regards to  
7 Mr. Boeken?  
8 A Yes.  
9 Q When was that?  
10 A It was in November.  
11 Q And in the Declaration you thought he had no  
12 more than six months to live?  
13 A Yes.  
14 Q How long ago was that?  
15 A That was in November.  
16 Q How many months ago?  
17 A It's about five, four -- well, it's not quite  
18 April, so we've got December, January, February, March.  
19 About four months.  
20 Q Do you still think he's going to make it passed  
21 the next couple of months?  
22 A I think he will live two months, although he  
23 has brain metastasis now, which he didn't have at that  
24 time.  
25 Q When you rendered the opinion you were unaware

1 with regard to the brain metastasis?  
2 A That's right.  
3 Q What is your best estimate now?  
4 A Well, I think it's probably unlikely he would  
5 live more than six months. Looking at the -- it depends  
6 on how he responds to the radiation that he had.  
7 But I would say if -- it would appear that his  
8 survival will be dictated, right now, by the clinical  
9 features of his brain metastasis. So if he responds  
10 well, he could live between six months and a year.  
11 But if he doesn't do well, then it will be a  
12 little more closer to six months.  
13 Q So the upside is maybe a year, max?  
14 A That would be my best estimate, at this point,  
15 based on what I see in the VNA.  
16 Q If you had known of the brain metastasis at the  
17 time that you wrote the Declaration, you would have  
18 written the Declaration differently?  
19 A Yeah, absolutely.  
20 Q What would you have said?  
21 A I wouldn't have said six months. I would have  
22 considered the trial go forward in the normal fashion.  
23 Q Well, the records came to you in November. And  
24 before the records came to you in November, you heard  
25 from -- tell me again whom Chris?

1           A    Yes.  
2           Q    What did Chris say at that time?  
3           A    Just that he was sending these records and  
4 wanted me to review them. He mentioned there was a  
5 question about what I thought the life expectancy was of  
6 the patient.  
7           Q    And that's when the Declaration came up, at  
8 this time?  
9           A    Yes.  
10          Q    You were charging 250 bucks an hour?  
11          A    Yes.  
12          Q    I'd like to inform you I had a deposition  
13 within the last eight months of a truck driver expert and  
14 he was charging me 260 bucks per hour for his opinion.  
15 You may wanted to think about raising your rates a little  
16 bit.  
17          A    That's encouraging to hear, but I set the rates  
18 at what I thought they were worth.  
19          Q    You've been dealing with HMOs, have you?  
20          A    Not a lot. I've had some dealings with HMOs,  
21 both from an administrative point of view and provider  
22 point of view. But that's not the reason I charge what I  
23 charge.  
24          Q    How long did you spend reviewing the records?  
25          A    The records? I think probably --

1 MS. TANG: I'm sorry, in reference to the initial  
2 meeting for the Section 36 Declaration?  
3 MR. PIUZE: He said on the record it was November.  
4 THE WITNESS: I think I spent about two, two and a  
5 half hours reviewing them  
6 BY MR. PIUZE:  
7 Q Do you know Dr. Sarna?  
8 A Yes.  
9 Q How?  
10 A He and I trained together at UCLA a long time  
11 ago.  
12 Q Do you see him socially?  
13 A No.  
14 Q Professionally?  
15 A No.  
16 Q Are you aware his deposition was taken  
17 yesterday?  
18 A No.  
19 Q Do you have any idea what his current thoughts  
20 are regarding Mr. Boeken's condition?  
21 A Well, I don't have any firsthand knowledge, but  
22 I would imagine that our notes would be similar.  
23 Q I guess we'll find out. The only one in the  
24 room here who knows are these people (indicating),  
25 because they were present at Dr. Sarna's deposition

20

1 yesterday?  
2 MS. TANG: I was the only one present there.  
3 MR. PIUZE: I thought cigarette lawyers traveled in  
4 packs.  
5 MS. TANG: I was the only person there.  
6 MR. PIUZE: I thought that up last time when I was  
7 here.  
8 MS. TANG: I think you've used that line a lot of  
9 times.  
10 MR. PIUZE: No. It's my first case. I'm a virgin.  
11 You're my first.  
12 Q So Dr. Sarna's treatment was appropriate  
13 obviously?  
14 A Yes.  
15 Q Do you have any comments about stuff you think  
16 you would have done different, that he should have done  
17 different?  
18 A No.  
19 Q Was the surgery appropriate in your view?  
20 A Yes.  
21 Q Do you have any comments about the way the  
22 surgery could have or should have been done differently?  
23 A No.  
24 Q Has the radiation been appropriate in your  
25 view?

1           A     Yes.  
2           Q     Do you have any comments about the way that  
3 could have been done or should have been done  
4 differently?  
5           A     No.  
6           Q     Okay. Mr. Boeken has been getting quality  
7 care, then?  
8           A     Yes.  
9           Q     And despite quality care, nature will have its  
10 way with him?  
11          A     Yes.  
12          Q     What side effects, if any, as far as mental  
13 acuity do the treatments that he has been receiving have  
14 on a person?  
15          A     Well, chemotherapy has been shown to have some  
16 cognitive dysfunctional-type problems, in terms of  
17 memory, some specific kinds of intellectual skills could  
18 be diminished by chemotherapy.  
19          Q     Such as?  
20          A     I don't remember exactly which ones, whether  
21 it's counting. As I said, I believe some of them have to  
22 do with memory. It may be with some mathematical  
23 calculations. They're very subtle.  
24                 To my knowledge they only recently, within the  
25 last couple of years, have been described. Particularly

1 in women taking breast cancer treatment.

2 Q How do steroids play into the treatment?

3 A Okay. Well, steroids are used to, in this  
4 case, I suspect to decrease a chemical in the brain which  
5 occurs from the brain metastasis. Then there is a  
6 radiation therapy to the brain, which usually doesn't  
7 cause acute changes in mental function, but beyond 12  
8 months, and certainly by two years of brain radiation can  
9 cause significant changes in mental function.

10 The steroids can cause some individuals to  
11 behave in a manic way, so they can affect behavior  
12 somewhat. But that would be my answer to your question.

13 Q Let's have your definition of manic as you used  
14 it here, please.

15 A Manic means they're a little agitated. They  
16 have a little bit of a fright of ideas, trouble sleeping,  
17 that kind of symptomatology.

18 Q If I were to say that sometimes Mr. Boeken  
19 seems a little thick, that his mental acuity seems a  
20 little thick, without any further explanation, that sound  
21 right to you, wrong to you, or neither?

22 A It would be hard for me to evaluate that  
23 without having seen him before the treatment. Some  
24 people are that way. But I understand he was a  
25 stockbroker. That's what the information I had --

1 Q That's not really true.  
2 A It's not true?  
3 Q No.  
4 A Regardless, I think that the answer is that one  
5 should be able -- and I'm sure Dr. Sarna would be able to  
6 do this -- document some specific changes that he  
7 observed with treatment, based on the changes and the  
8 functions that we talked about.  
9 Q Would you do that?  
10 A Would I do it in an individual?  
11 Q Yeah, in the normal course of --  
12 A I would make observations. I don't always  
13 record all of them. If they're not going to have  
14 clinical ramifications, I might not. But if asked  
15 retrospectively, and if I could remember, I would comment  
16 on them if I saw them.  
17 Q Okay. For whatever it's worth, I'll disclose  
18 to you that I think Mr. Boeken might be more accurately  
19 called a security salesperson. And I could also disclose  
20 to you that according to a psychiatrist or psychologist  
21 having seen him in regard to the litigation and treatment  
22 of litigation, it seems that he's of above-average  
23 intelligence, if that's what you were trying to factor in  
24 there.  
25 A I will factor that in. With whatever good or

1 bad, that would be a factor.  
2 Q What if I said something like he seems to have  
3 tunnel vision sometimes, like just staring straight ahead  
4 of him, as opposed to seeing more of the world around  
5 him  
6 Would that sound right, wrong or neither to  
7 you?  
8 A In terms of what? In terms of treatment? In  
9 terms of --  
10 In other words, in terms of disease, I can't  
11 answer --  
12 Q In terms of life.  
13 A Well, are you describing somebody what is  
14 clinically depressed.  
15 Q Might be. I don't know. I'm not --  
16 A See the steroids do that. They cause just the  
17 reverse of what you're describing. I mean, again, I'm  
18 not actually sure what you're describing. I heard the  
19 words, but I don't really know what the clinical feeling  
20 for it is.  
21 In other words, is he having problems relating  
22 to people, does he have a negative view of the world? Is  
23 that what you mean by this? Or are you saying that he  
24 has visual acuity to the side, like a peripheral nervous  
25 system? I don't think you mean that.

1 Q No, I don't.

2 Go ahead. Continue.

3 A What you're describing, if it is not organic,  
4 would be more along the signs of someone who is  
5 depressed.

6 Q If I said -- you know, and I apologize for the  
7 general-type terms, but my total days in medication  
8 school are zero.

9 That he seems to be focusing his energy or  
10 attention on survival to the exclusion of -- everything  
11 else is peripheral to survival, more peripheral. Does  
12 that sound like something you see in cancer patients that  
13 you're treating?

14 A It's one of the things I see, yes.

15 A cancer patient's reaction to their disease is  
16 quite varied. Often it depends on what they really  
17 believe their outlook to be, and what their understanding  
18 of the disease is.

19 Many cancer patients don't really understand  
20 how difficult their disease is. They want to believe  
21 that it's better than and it is. They adjust  
22 psychologically with less obvious depression. But if  
23 they feel they understand that they have a fatal disease,  
24 then they may be focusing all their attention on what the  
25 significance of that is to them in their lives.

1 Q What are the most recent records that you  
2 reviewed? What dates?  
3 A I've seen records -- let's see.  
4 I've seen records, I believe, the beginning of  
5 this year. I'd have to actually go through -- I just --  
6 I don't remember the exact last set of records, whether  
7 it was from very late last year or early this year.  
8 Q Let's put it this way to try to move on. The  
9 latest records you've seen are at least a couple of  
10 months old. Does that sound right?  
11 A Yeah. They involve the brain metastasis.  
12 Q Good enough.  
13 Did you see any reference in the records that  
14 you've reviewed to Mr. Boeken's mental acuity, mental  
15 status, including depression?  
16 A I have not -- I'm not aware of that  
17 information. I just am not aware of it. It may be in  
18 the record, but I'm not aware of it.  
19 Q You've already explained that you believe all  
20 the treatment is appropriate and constituted good quality  
21 care. Let's look at that from the other side.  
22 Has Mr. Boeken done everything he could to stay  
23 alive, as you can --  
24 MS. TANG: Objection. Calls for speculation.  
25 THE WITNESS: From the time he was diagnosed?

27

1 BY MR. PIUZE:  
2 Q Yes.  
3 A Yes.  
4 Q Diagnosed with what? Are you talking about  
5 lung cancer?  
6 A Yes.  
7 Q What else have you read besides medical  
8 records, if anything?  
9 A I've reviewed, I've not read any depositions or  
10 any other specifics with regard to the case, but I did  
11 read an extensive amount of literature with regard to  
12 lung cancer.  
13 And I've also read the basic literature from  
14 the surgeon general, and I've basically reviewed -- the  
15 bulk of the information that I specifically read was in  
16 this area.  
17 And, in addition, I specifically reviewed two  
18 books -- three books having to do with lung cancer, that  
19 are fairly current.  
20 Q What are the books?  
21 A I made copies for you.  
22 Basically one is Second Edition of Lung Cancer  
23 by these authors.  
24 MR. PIUZE: Let's have that marked as  
25 Exhibit Number 2.

1                   (Plaintiff's Exhibit 2 was marked for  
2                   identification by the Certified Shorthand  
3                   Reporter and is attached hereto.)  
4                   BY MR. PIUZE:  
5                   Q     Lead author Harvey Pass, P-a-s-s.  
6                   A     And this is a second reference (indicating).  
7                   MR. PIUZE: This is Exhibit 3. Lung Cancer, Second  
8                   Edition, lead author is Roth, and the other is Exhibit 4.  
9                   (Plaintiff's Exhibits 3 and 4 were marked for  
10                  identification by the Certified Shorthand  
11                  Reporter and are attached hereto.)  
12                  THE WITNESS: And this is a third book (indicating).  
13                  MR. PIUZE: Exhibit 4. Tumors and Tumor-like  
14                  Lesions of the Lung. Lead author Carter.  
15                  Q     When did Chris tell you you should read these  
16                  things?  
17                  A     He didn't tell me. I'm the one that decided to  
18                  read them  
19                  Q     Were you given a reading list and asked to  
20                  choose from what was on the list?  
21                  A     I had no reading list. My approach to this was  
22                  to try and learn as much as I could about it, beyond what  
23                  I do in my clinical practice, and specifically try to  
24                  understand relationship as to causes of lung cancer,  
25                  various types of lung cancer, areas that I might not --

1 you see, in the clinical practice we basically are  
2 concerned with small cell and nonsmall cell tumors.  
3 Q Let's stop you right there. Remember where you  
4 were. I apologize for interrupting. We can have the  
5 court reporter read it back.  
6 Why?  
7 A Why?  
8 Q Yeah.  
9 A Because I wanted to understand what is  
10 presently available as to the information on causes of  
11 lung cancer, the changes in lung cancer that have  
12 occurred over time. Since tobacco is clearly a cause of  
13 lung cancer, I wanted to understand what was available as  
14 to the smoking habits and, uh, this is not something that  
15 I reviewed in my routine practice.  
16 Q That was an appropriate answer to a bad  
17 question.  
18 Why in the real world of treating lung cancer  
19 are you concerned only with the small cell versus  
20 nonsmall cell category?  
21 A Well, that's because small cell lung cancer is  
22 treated and behaves clinically different than the  
23 nonsmall cell lung cancers.  
24 Q In your clinical practice you never run into a  
25 question of what caused this cancer, true?

1           A    Yeah.  It basically -- you do run into the  
2 question.  Patients do want to know, but in a practical  
3 way the management and significance to the patient that  
4 you're seeing is -- doesn't involve having to know the  
5 cause.  What you have to do is know the management and  
6 the behavior.  So in a practical sense, clinical treating  
7 oncologists are less likely to be involved with  
8 understanding the causes.

9           Now, that isn't -- I don't want it to be an  
10 oversimplification because we do educate the community  
11 and other physicians if we know causes that exist.  And  
12 so in that sense it's part of a clinical oncologist's --  
13 it's his role to try to understand as much as he can  
14 about the disease, but the practical situation is that  
15 lung cancer, which is unfortunately very common, is a  
16 disease where we don't worry as much about the etiology  
17 in the individual type of patient, but are more concerned  
18 with what the cell type is and what the stage is.

19          Q    "We" being treating oncologists?

20          A    Yes.

21          Q    Now, what percentage of your practice now  
22 involves lung cancer?

23          A    Well, it is still the most common tumor,  
24 although my individual practice probably has more breast  
25 cancer than lung cancer in it.

1                   But of the 75 percent of medical oncology, I  
2 suspect probably 20 percent is due to lung cancer.  
3           Q     20 percent of the 75 percent?  
4           A     Yes.  
5           Q     How many lung cancer patients do you have right  
6 now?  
7           A     Probably about 20.  
8           Q     Lung cancer patients?  
9           A     Yes.  
10          Q     Is the 20 percent of your oncology practice,  
11 which you've told me equals lung cancer patients, is that  
12 a figure that is accurate going back 10 years?  
13          A     Yes.  
14          Q     20 years?  
15          A     Well, I don't remember the exacts, but, in  
16 other words, lung cancer is one of the more frequent  
17 tumors. So, you see, I would say it's generally been my  
18 experience, yes.  
19          Q     Does lung cancer, based on your knowledge --  
20 I'm looking for your personal knowledge now as opposed to  
21 what you've reviewed for this case -- does it follow any  
22 kind of socioeconomic trail?  
23          A     In my personal knowledge, I wouldn't be able to  
24 answer that question as saying that I've identified a  
25 specific trail.

1 Q Now, you practice now in the Brentwood area,  
2 correct?  
3 A West L. A.  
4 Q Upper middle class socioeconomics?  
5 A Yes.  
6 Q Have you practiced in different geographic  
7 locations in the past that would yield different  
8 demographics, as far as income?  
9 A No.  
10 Q So all you can compare is yourself to yourself  
11 then, or this area to this area?  
12 A Yes.  
13 Q So let's go beyond what you do in your personal  
14 day-to-day practice. What about what you know from  
15 attending meetings and talking to colleagues? Is lung  
16 cancer following a socioeconomic trend?  
17 A It tends to be related -- well, I'm trying to  
18 figure out if this has ever been really discussed in  
19 meetings. I'm not aware. I'm just not aware that I've  
20 heard that kind of information discussed in meetings,  
21 specifically, the socioeconomic factors in lung cancer.  
22 So I can't really comment on that or say that I've heard  
23 that in my discussions.  
24 Q What's in the box?  
25 A The box has, and I've summarized, I think, the

1 records here, but these are surgeon general reports.  
2 There are articles that have to do with lung cancer  
3 histologic types, clinical behavior, that kind of thing.  
4 And they're summarized here (indicating).

5 Q When you say "they're summarized," you're  
6 talking about the titles or contents?

7 A Titles.

8 Q Have you read all the reports in that box?

9 A I actually have. I mean -- I have read -- I  
10 mean, I certainly don't remember everything and every  
11 individual article, but I have looked at and reviewed  
12 everything that's in that box.

13 Q How long did that take?

14 A It took about, I don't know, 25 hours, 30  
15 hours.

16 Q Is that my copy?

17 A Yes.

18 Q Thank you. I will accept. I'm not going to  
19 have those documents marked because of my love for trees,  
20 but I'd like to have your handwritten title summary  
21 marked as Exhibit Number 5, please.

22 (Plaintiff's Exhibit 5 was marked for  
23 identification by the Certified Shorthand  
24 Reporter and is attached hereto.)

25 THE WITNESS: These were the records that have been

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1 reviewed (indicating).  
2 BY MR. PIUZE:  
3 Q Just leave that aside for a minute.  
4 How many pages is Exhibit Number 5?  
5 A There are four.  
6 Q Thank you. Here's Exhibit 5. Four pages,  
7 handwritten.  
8 This Exhibit 4. "Tumor and Tumor like Lesions  
9 of the Lung, Volume 36 in the Series. Major Problems In  
10 Pathology."  
11 What did you read in that book?  
12 A I was just looking, basically, at what -- what  
13 they described as different types of adenocarcinomas.  
14 Q They who?  
15 A The authors.  
16 Q Are the authors pathologists?  
17 A Yes.  
18 Q How come you're in a pathology book?  
19 A Because I think it's -- in order to understand  
20 what the current pathology link -- in order to understand  
21 clinical pathological correlations we have to be on the  
22 same page as to what the terms mean.  
23 Q You rely on pathologists in your business all  
24 the time, don't you?  
25 A Absolutely.

1 Q Are there occasions when you ever, after  
2 getting a pathology report go look at the slides yourself  
3 to look at the pathologies?  
4 A Yes.  
5 Q What kind of situation?  
6 A Well, in order to double check is probably --  
7 it would be primarily occurring in hematologic problems  
8 where the variations sometimes are a little more  
9 subjective. Or it will be simply a matter of sitting  
10 down and talking with the pathologist and sharing the  
11 clinical findings of the case. There are situations  
12 that -- where that's helpful. It particularly comes up  
13 in types of tumors where there's no nonprimary and you're  
14 trying to figure out where the origin of the tumor was.  
15 Q Let's come out of hematology now and go for the  
16 remaining 75 percent of your practice.  
17 Are there occasions when after receiving a  
18 pathology report you decide that you want to take a look  
19 at the specimen yourself under a microscope?  
20 A Well, I mentioned where you don't know where  
21 the primary tumor is. That's certainly one thing where I  
22 always go down and look at the slides with the  
23 pathologist.  
24 Q Is that the extent of it?  
25 A Well, there may be others. I just -- where I

1 routinely do it, I would say that would be the one thing  
2 that I can think of where I routinely do it.  
3 When I was in practice originally, back in the  
4 beginning, I did it more often because there was less  
5 strength in pathology at the time. But pathology has  
6 gotten so strong, with markers, and there's a less  
7 subjective aspect of pathology now, and there's less of a  
8 need to review routine cases, in my opinion.  
9 Q Why don't you give me a year that separates,  
10 again, when you used to do it more frequently and your  
11 current status in regard to how often you review path  
12 slides?  
13 A Well, in the '70s I think I routinely reviewed  
14 most, but not all the path slides.  
15 And through the '80s, I just did less and less.  
16 And presently the area where -- and I should say that I'm  
17 answering your question as you asked it, mainly looking  
18 at pathology with the slides. But you just remember that  
19 in the conferences that are attended, the pathology is  
20 presented, so you see the pathology presented by the  
21 pathologist. And in that sense I'm constantly exposed to  
22 pathological material, but breast cancer is an area where  
23 I would tend to review the slides more, more than I do  
24 with most other types of tumors.  
25 Q All right. That's nice. Thank you. I think

1 you got off the track a little, though. It's not a  
2 criticism, but let me put you back on.  
3 Can you just sort of give a timeline when you  
4 stopped reviewing path slides very frequently and the  
5 present where you do it infrequently? And you got into  
6 in the '80s, and then decreased a little bit?  
7 A Well, I think the '80s and '90s were  
8 approximately the same. I don't -- so the answer is that  
9 I just right now -- I'm not reviewing the slides as much  
10 as I was earlier, but one of the reasons may be because  
11 there is better presentation of pathological material at  
12 conferences, and in some cases -- in fact, frequently in  
13 difficult clinical problems, they are both in tumor  
14 conference where the slides on the individual patient are  
15 showed.  
16 Q Most of your patients who you treat, they don't  
17 get presented at the conference, do they?  
18 A Well, I mean, it means that City of Hope do,  
19 but City of Hope conference doesn't involve looking at  
20 pathology slides. But the patients get presented.  
21 Q Let's leave that out. We're not talking about  
22 the City of Hope, anymore. Your patients, do you ever  
23 treat patients that aren't involved with the City of  
24 Hope?  
25 A Understand that the hospital that I use is

1 St. John's, and the conferences we're talking about  
2 are -- in other words, it is City of Hope. Patients in  
3 west Los Angeles use St. John's Hospital. They don't go  
4 somewhere else. So they may come to see me at the west  
5 Los Angeles office, but they still are St. John's  
6 patients, as much as they're City of Hope patients. And  
7 they get presented at the St. John's tumor conference.  
8 Q Are you there?  
9 A Yes.  
10 Q You said primarily?  
11 A Well, there is a weekly breast cancer and every  
12 two-week tumor conference.  
13 Q What percentage of your patients get presented  
14 at these conferences?  
15 A Well, it depends on -- let's see. Percentage  
16 of patients? Probably about -- probably 5 to 10 percent.  
17 Q What percent of your nonbreast cancer patients  
18 get presented at the City of Hope conference?  
19 A I'd say about the same.  
20 Q What percentage of your lung cancer patients  
21 get presented at these conferences?  
22 A Again, the cases -- there isn't a lung cancer  
23 conference. It will be the same as all the others.  
24 Q 5 to 10 percent?  
25 A Yeah.

1 Q And aside from those 5 to 10 percent of  
2 patients that get presented at those conferences, the  
3 only time that you get involved with path slides, now, in  
4 the '90s, in the '80s, is when you're trying to figure  
5 out where the primary tumor is?

6 Do I have that right?

7 MS. TANG: Objection. Misstates what his prior  
8 testimony was.

9 THE WITNESS: I think it would be fair to say that  
10 that's the most frequent time that I'm presently looking  
11 at slides. That's the most common reason for me to look  
12 at slides.

13 BY MR. PIUZE:

14 Q Okay. Another reason? So far I haven't heard  
15 one. I mean --

16 A Well, there are reasons, but it depends on an  
17 individual case. I've indicated that in cases of breast  
18 cancer I will often look at them more, because of the  
19 difficulty with trying to determine aspects of breast  
20 cancer pathologically. But I can't honestly tell you a  
21 specific reason right now why I would go to look at a  
22 particular slide in some of the other diseases.

23 Q What pathology service do you use, pathology  
24 company?

25 A The only pathology department I work with is

40

1 primarily St. John's. I do work with Santa Monica, UCLA,  
2 as well.  
3 Q Who is the boss over at St. John's pathology?  
4 Do you know?  
5 A Yeah. David Krazney.  
6 Q What about UCLA?  
7 A Used to be Dean Harvey. And UCLA is -- no,  
8 over there I'm not sure who is in charge.  
9 Q Over where?  
10 A At Santa Monica.  
11 Q When you mentioned UCLA, you were talking about  
12 Santa Monica Hospital as opposed to the medical campus?  
13 A Yes.  
14 Q Have you talked to any physicians about this  
15 litigation?  
16 A No.  
17 Q Aside from the lawyers with whom you've come  
18 into contact, have you talked to anyone else about this  
19 litigation?  
20 A No.  
21 Q What other lawyers besides Ms. Dobson, Chris  
22 and Ms. Tang have you come into contact with in this  
23 litigation?  
24 A I'm not aware of any others. There may have  
25 been one other woman, but I don't remember now her name.