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

RICHARD BOEKEN )  
 )  
Plaintiff, ) Case No. BC226593  
 )  
vs. )  
 )  
PHILLIP MORRIS, INCORPORATED, )  
a corporation; INTERNATIONAL )  
HOUSE OF PANCAKES, )  
INCORPORATED, a corporation; )  
DOES 1-100, inclusive, )  
 )  
Defendants. )  
\_\_\_\_\_ )

Deposition of PETER J. JULIEN,  
M D., taken on behalf of the Plaintiff,  
at 11755 Wilshire Boulevard, Suite 1170,  
Los Angeles, California, commencing at  
6:45 p.m., on Wednesday, March 14, 2001,  
reported by Vivian C. Dernburg, CSR  
No. 11339, a Certified Shorthand Reporter  
in and for the State of California  
pursuant to Notice.

Reported by: Vivian C. Dernburg, CSR No. 11339  
Job No.: 0014-VCD

1 APPEARANCES:

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- and -

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I N D E X

WITNESS: PETER J. JULIEN, M D.

Examination by:	Page
Mr. Piuze	5

E X H I B I T S

1 - Curriculum vitae of Peter J. Julien, M D. ; 17 pages	5
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INSTRUCTION NOT TO ANSWER

(None)

MARKED QUESTIONS

(None)

INFORMATION REQUESTED

(None)

1 Los Angeles, California  
2 Wednesday, March 14, 2001  
3 6:45 p.m.  
4

5 PETER J. JULIEN, M.D.,  
6 called as a witness by and on behalf of the  
7 Plaintiff was duly sworn by the reporter and  
8 testified as follows:  
9

10 EXAMINATION

11 BY MR. PIUZE:

12 Q Hi.

13 A Hi.

14 Q Tell me your name.

15 A Is Peter J. Julien, J-u-l-i-e-n.

16 Q You live right around the corner?

17 A Yes.

18 Q Is this C.V. up to date?

19 A I believe it's up to date. There  
20 might be a couple of lectures that are not on  
21 there. But for the purposes of our discussion  
22 today, it's up to date.

23 Q So I'll make it Exhibit No. 1.

24 (The document referred to was  
25 marked by the C.S.R. as Plaintiff's

1 Exhibit 1 for identification and was  
2 attached to and made part of this  
3 deposition.)

4 BY MR. PIUZE:

5 Q What are the purposes of our  
6 discussion today, as you see it?

7 A I think the purposes of our  
8 discussion today are for me to discuss whatever  
9 issues you'd like to discuss in relationship to  
10 the radiology on this particular individual.

11 Q Okay. What are the issues  
12 concerning radiology on Mr. Boekin?

13 A The issues with regards to  
14 radiology have to do with the fact that is this  
15 lung cancer that he presented with, is this  
16 consistent with a bronchoalveolar cell  
17 carcinoma, or is it more consistent with  
18 another type of lung cancer.

19 Q Who posed that question, you?

20 A Well, that's been the discussion  
21 that, as I understand, that is centered around  
22 the radiology in this case. In other words,  
23 what does this abnormal look like to me.

24 Q What does it look like to you?

25 A It looks like a primary cancer of

1 the lung.  
2 Q What else does it look like to  
3 you? Is that it?  
4 A It looks -- like I said, it looks  
5 like a primary carcinoma of the lung, and it is  
6 certainly consistent with any number of  
7 possibilities, one of which is that it could  
8 represent a bronchoalveolar cell carcinoma.  
9 Q That's one, with the application  
10 that there's others?  
11 A Absolutely. It could be a  
12 squamouscell carcinoma. It could be an  
13 adenocarcinoma.  
14 Q I'm sorry, are you done, or are  
15 there more?  
16 A No. Those would be the three  
17 major types of carcinomas, and I think it is,  
18 first and foremost, consistent with a primary  
19 carcinoma of the lung.  
20 Q Primary as opposed to what?  
21 A As opposed to a metastatic as  
22 opposed to an infection as opposed to a benign  
23 lesion of the lung.  
24 Q I hope it's not a benign -- I hope  
25 it wasn't a benign lesion of the lung, but if

1 it was, then a lot of doctors have done a lot  
2 of bad things to this man for no reason; is  
3 that right?

4 A Right.

5 Q I mean, the same thing with  
6 regards to an infection. Then a lot of doctors  
7 have done a lot of bad things to this gentleman  
8 for nothing, right?

9 A You asked me what are the  
10 possibilities, and I'm giving you the  
11 possibilities so far.

12 Q So you're ruling out things so  
13 far?

14 A I would be ruling out things when  
15 I tell you it's most consistent with a primary  
16 carcinoma of the lung.

17 Q Okay. Let's go from there. How  
18 many primary carcinomas of the lung are there?

19 A Well, we would break it up into  
20 several different categories: You have  
21 squamouscell carcinoma, you have  
22 undifferentiated carcinoma, you have a large  
23 cell carcinoma, you have -- there's an  
24 adenocarcinoma, there's a bronchoalveolar cell  
25 carcinoma, there's a small cell carcinoma, and

1 then there are mixtures of these cancers where  
2 one is not necessarily a pure cell type. There  
3 is -- there are mixtures, for example, an  
4 adeno-squamous carcinoma.

5 Q Which of the above can you rule  
6 out, if any?

7 A Well, it's very hard to rule out  
8 any of those based on the radiology images.  
9 What you can do is say it's more consistent  
10 with one type as opposed to another type.

11 Q Rank them in order, would you?

12 A All right. Years ago -- years  
13 ago, meaning 20 years ago, if I had this CT  
14 scan, my number one ranking on this would be a  
15 squamouscell carcinoma. Specifically, because  
16 of the spiculated irregular margins of the  
17 cancer in the right upper lobe. However, there  
18 has been a definite change in the incidence of  
19 squamouscell carcinoma. Squamouscell carcinoma  
20 has decreased in incidence while adenocarcinoma  
21 and large cell carcinoma have increased in  
22 incidence.

23 That being said, 20 years ago, I  
24 would have expected this to be a squamouscell  
25 carcinoma. Now, in today's images, this

1 patient presented to me with these images as a  
2 patient, I would be favoring that this is  
3 certainly consistent with a bronchoalveolar  
4 cell carcinoma of a particular type,  
5 a -- there's several different types of  
6 bronchoalveolar cell, but there's a certain  
7 type, what is referred to as a  
8 squamouscell -- secure us form of  
9 bronchoalveolar cell carcinoma, meaning scar,  
10 as a very definite possibility, or an  
11 adenocarcinoma. The irregular margins of this  
12 have an appearance that is more consistent with  
13 the squamous form of bronchoalveolar cell  
14 carcinoma, then a simple adenocarcinoma. But  
15 it could be an adenocarcinoma, but I think that  
16 in radiology you -- if you're going to use  
17 radiology at all to help with a  
18 diagnosis -- and what I mean by that is it's  
19 very easy to say, "Look, there's a mass in the  
20 lung." You find out what it is.

21 Q You, who?

22 A You depending, on you, the  
23 surgeon, you, the internist, find out what it  
24 is. I can't help you any more. There's a mass  
25 in the lung. I think it's cancer. I can't

1 help you any more. You can take that approach  
2 or you can use very specific findings on the CT  
3 scan or on the chest X-ray. But in this  
4 situation, the CT scan is much more definitive  
5 in terms of helping with the differential  
6 diagnosis than a chest X-ray would be, and you  
7 can use a CT scan to help narrow this  
8 differential diagnosis down. And the one bit  
9 of information we have on the CT scan, which I  
10 do feel is of help, are these irregular  
11 margins. And again, nothing is by any means is  
12 100 percent. But these irregular margins are  
13 more suggestive of bronchoalveolar cell than  
14 they are of a non-bronchoalveolar cell;  
15 adenocarcinoma.

16 Q Okay. You said the same thing  
17 twice in slightly different ways, and what you  
18 said is more suggestive of BAC, then simple  
19 adeno is what you first said. And then your  
20 very last statement was more consistent with  
21 BAC than non-BAC carcinoma. Is that what you  
22 said?

23 MS. WILLIAMS: Objection.

24 Mischaracterizes his testimony.

25 MR. PIUZE: You can't object

1 because I'm asking if that's what he said.  
2 It's not a mischaracterization.  
3 Q That's what you said?  
4 A Correct.  
5 Q So let's assume you're dealing  
6 with straight or simple or non-BAC  
7 adenocarcinoma. Let's just assume that for a  
8 minute?  
9 A Correct.  
10 Q In your mind, rank the  
11 probabilities of BAC versus simple  
12 adenocarcinoma.  
13 MS. WILLIAMS: Objection. Vague  
14 and ambiguous.  
15 A Given -- only allowing for the  
16 fact that one of two exists --  
17 Q Okay.  
18 A -- not any of the others that I've  
19 talked about.  
20 Q Yeah?  
21 A -- I would give it probably a 70  
22 percent, like 75 percent likely -- somewhere  
23 around that range of it being more consistent  
24 with bronchoalveolar cell than non  
25 bronchoalveolar cell carcinoma.

1 Q And when you say non-BAC  
2 carcinoma, again, that's what you're referring  
3 to, simple adeno?  
4 A That is correct.  
5 Q Okay. Let's take all the other  
6 possible suspects and put them back in. Now  
7 rank the two of them please, BAC vs. simple  
8 adenocarcinoma.  
9 A Including the other prospects?  
10 Q Yes.  
11 A Well, in this day and age, I would  
12 favor, again, that this is consistent with BAC,  
13 number one. Number two, I would say  
14 squamouscell carcinoma. Number three I would  
15 put as an adenocarcinoma.  
16 Q Do you want to put numbers on  
17 those three choices?  
18 A Percentage-wise.  
19 Q In other words, the same way you?  
20 Put 75/25, 70/30, whatever it is, if can you  
21 give them a number, if you can.  
22 A I would probably put it in the  
23 order of 50 to 60 percent BAC; maybe 25 percent  
24 squamouscell and 25 percent adeno -- something  
25 of that order. I hadn't thought about that,

1 but that is pretty close to what I would assume  
2 this to be.

3 Q Also, as part of your longer  
4 answer before, you said, "If one were to  
5 diagnosis based on the films." Why did you say  
6 "if"?

7 A In other words, as I mentioned  
8 before, there are -- there are two ways to look  
9 at the films. One way is to extract some very  
10 basic information from the films, which is  
11 simply you have a mass which is roughly 2  
12 centimeters in size, approximately, in the  
13 right upper lobe. It's entirely consistent  
14 with cancer. Let's find out what it is, and  
15 that's it.

16 There's another approach to the  
17 films which is to say I have a mass approximate  
18 2 centimeters in size in the right upper lobe  
19 and there is or there is not evidence of  
20 spread. The lymph nodes have the following  
21 characteristics.

22 The mass itself has the following  
23 characterization, and those characteristics are  
24 calcium/no calcium, cavitation/no cavitation,  
25 air bronchograms, spiculated margins/no

1 spiculated margins, smooth margins/no smooth  
2 margins. So there's lots of data that can be  
3 extracted by careful analysis of the films. I  
4 do a lot of work in this area and my approach  
5 is to do a careful analysis and to try to  
6 correlate as much of the imaging with the final  
7 pathology, I'm always doing that constantly.

8 Q Okay, thanks. You're a diagnostic  
9 radiologist?

10 A I am only. I've trained in  
11 internal medicine also in addition to  
12 diagnostic radiology, but I practice diagnostic  
13 radiology exclusively.

14 Q I asked a bad question. You don't  
15 practice therapeutic radiology for treatment  
16 purposes?

17 A I do therapeutic radiology, but I  
18 don't do therapy in terms of therapy for  
19 cancer.

20 Q Okay. So where were Mr. Boekin's  
21 X-rays -- chest X-rays taken?

22 A Well, many of them were taken at  
23 Cedars-Sinai Medical Center.

24 Q Who read them?

25 MS. WILLIAMS: Objection. Calls

1 for speculation.

2 THE WITNESS: A number of my  
3 associates read them

4 BY MR. PIUZE:

5 Q When did you become involved in  
6 this litigation?

7 A Oh, I think I was contacted maybe  
8 two -- two months ago.

9 Q Prior to two months ago?

10 A Uh-huh.

11 Q And if it turns out you were  
12 contacted prior to three months ago, prior to  
13 when you were contacted had you ever seen these  
14 films?

15 A I don't believe I had -- I mean, I  
16 certainly didn't -- I mean I see a lot of  
17 patients, so it wouldn't have surprised me if I  
18 had seen them. They do not look familiar to me  
19 at all, and I didn't see my name on any of the  
20 reports, although it wouldn't have surprised me  
21 if it did appear that I read a chest X-ray  
22 somewhere down the road. But I didn't see  
23 that.

24 Q How many groups exist over at  
25 Cedars for diagnostic radiology, just Tower?

1           A       Tower radiology used to be the --  
2       was the old group, and we separated from Tower  
3       and took the hospital contract in 1992. And  
4       since 1992, it's a separate business entity.  
5       It took over Tower Radiology.  
6           Q       What is it?  
7           A       It's called Cedars-Sinai Medical  
8       Imaging Group.  
9           Q       And does Cedars-Sinai have the  
10      radiology diagnostic for the whole hospital?  
11          A       Yes.  
12          Q       So whoever read these were  
13      necessarily partners, associates or employees  
14      of yours?  
15          A       Correct.  
16          Q       Who read them?  
17          A       Oh, I -- let me think. I saw a  
18      number of names on there. I think Dr. Richard  
19      VanAllen read some X-rays. That's one name I  
20      remember. I believe it might have been  
21      Dr. Kate Haker H-a-k-e-r who might have read  
22      some of the X-rays. I don't remember all of my  
23      associates that read the films.  
24          Q       Don't you have X-ray reports here  
25      with you?

1           A       I do.  
2           Q       Take a look would you. I  
3 appreciate it -- you can look and answer at the  
4 same time, can't you?  
5           A       I can.  
6           Q       Sometimes the use of associates is  
7 as a term of art, as I'm sure one of the  
8 lawyers in this office can tell you right now,  
9 and it connotes a subordinate. Is that how  
10 you're using it now?  
11          A       No, not at all.  
12          Q       Are all of the radiologists who  
13 work at your group at Cedars part-owners of the  
14 group?  
15          A       Not all of them, no.  
16          Q       Some are straight employees?  
17          A       Some are employees, right.  
18          Q       When you give me the names of  
19 these people, if you could tell me their status  
20 within the group, whether they're owners or  
21 employees or other. Would you do that?  
22          A       Absolutely.  
23          Q       Okay. And while you're still  
24 looking, where are you in the hierarchy of this  
25 company?

1           A       Senior partner.  
2           Q       How many senior partners are  
3 there?  
4           A       Six.  
5           Q       How many radiologists are there?  
6           A       Total 24, 25.  
7           Q       How many are non-owners?  
8           A       Change -- we fundamentally changed  
9 the business structure of the business, oh, two  
10 years ago, so it's changed over that period of  
11 time. But there are owners. Probably 15, 16  
12 are now owners of the business.  
13          Q       And the use of "owner" is  
14 synonymous with "partner"?  
15          A       Yes. There's two categories,  
16 partners -- but all partners are owners of the  
17 business.  
18          Q       Thanks.  
19          A       Well we have one Dr. Dan Berman,  
20 who read the FDG scan.  
21          Q       Date?  
22          A       10/20/99.  
23          Q       And his status is what?  
24          A       Senior partner. A number of the  
25 images were done either at St. Johns or at

1 Tower or at Santa Monica Hospital. Here's one  
2 that was done at Cedars. It was a CT of the  
3 chest dated 3/8/2000 read by Jeffrey Silverman.  
4 Q And he is a what?  
5 A He's a B partner.  
6 Q That's like of counsel, huh?  
7 A We have a chest X-ray read by  
8 Roger Weinhouse.  
9 Q Date?  
10 A 6/12/2000.  
11 Q First name again, please?  
12 A Roger.  
13 Q All right.  
14 A A chest X-ray read by Michelle  
15 Melany.  
16 Q Spell that.  
17 A M-e-l-a-n-y. Date of chest X-ray  
18 is 8/9/2000.  
19 Q And she is what rank?  
20 A She's an employee.  
21 Q Okay.  
22 A I have a bone scan eight, 10/2000  
23 read by Alan Waxman. He's a senior partner, MR  
24 of lumbar spine, 8/16/2000 read by Marcel Maya,  
25 M-a-y-a.

1 Q And Marcel is a what?  
2 A Marcel is an employee. CT of the  
3 chest abdomen and pelvis dated 8/21/2000 read  
4 by Jeffrey Silverman. Another PET scan  
5 8/22/2000 read by Alan Waxman.  
6 Q And what was that scan of?  
7 A That was a whole body PET scan.  
8 Q Whole body PET scan?  
9 A And we have a lumbar spine CT  
10 dated 9/19/2000 read by Franklin Møser,  
11 M-o-s-e-r. He's an A partner. Another CT scan  
12 of the lumbar spine 10/16/2000, also read by  
13 Franklin Møser. Bone scan, 10/18/2000 read by  
14 Alan Waxman.  
15 Q Sounds like your group made a lot  
16 of money on this guy so far, huh?  
17 What does a bone scan cost?  
18 A Total price -- oh, probably 1,000  
19 or \$1,100.  
20 Q What about a PET scan?  
21 A Total price -- we're not talking  
22 about the physician's fees. Total price is  
23 about \$2,200.  
24 Q Does your group own CT scans, CT  
25 machines?

1           A       No.  
2           Q       PET machines, bone machines?  
3           A       No.  
4           Q       None of the above?  
5           A       No.  
6           Q       So where do you get them? Do you  
7 lease them?  
8           A       No, the hospital owns the  
9 equipment, and we separately bill for a  
10 professional fee for the interpretation of each  
11 of these diagnostic studies. And the hospital  
12 bills the great majority of it because they're  
13 supplying the equipment, the space, most of the  
14 expenses with the operation of the equipment.  
15          Q       I take it that all of the charges  
16 associated with Mr. Boekin's diagnostic  
17 radiology treatment over at Cedars was  
18 reasonable and necessary?  
19          A       I would imagine it is.  
20          Q       That's something that I, as the  
21 plaintiff's attorney, am supposed to show. You  
22 guys didn't bill too much, did you?  
23          A       I am sure we did not.  
24          Q       Okay. Are you -- thank you for  
25 the interlude.

1                   Can we keep going there, please.  
2           A        There's a CT chest, abdomen and  
3 pelvis dated 10/18/2000 by Dr. Douglas Brown.  
4           Q        So let's stop again. Why would  
5 Waxman and Brown both be doing different scans  
6 on the same day?  
7           A        Because Waxman is a nuclear  
8 medicine specialist and Douglas Brown is a  
9 radiologist, but both of us -- all of us are in  
10 the same imaging group, but we have different  
11 subspecialty or specialty areas within the same  
12 imaging group.  
13          Q        Is a nuclear medicine specialist a  
14 radiologist?  
15          A        In some cases he is, but in this  
16 case, he isn't. Dr. Alan Waxman is not trained  
17 as an internal medicine man.  
18          Q        Are you board certified in  
19 internal medicine?  
20          A        I am not.  
21          Q        Are you certified in any  
22 specialty?  
23          A        No.  
24          Q        You're certified in clinical  
25 radiology, or is there such a thing? Is there

1 different certifications of radiology?  
2 A Well, there's actually two forms.  
3 One is therapeutic and the other is diagnostic.  
4 I'm board certified in diagnostic.  
5 Q Thank you we're up to 10/18 it  
6 looks like, or we're stuck on 10/18.  
7 A Looks like there's an FDG scan  
8 done on 11/1/2000 by Dr. Alan Waxman.  
9 Q What is that?  
10 A That's another tumor scan.  
11 Q Okay.  
12 A CT scan of the lumbar spine  
13 11/15/2000. And then --  
14 Q By whom?  
15 A I'm sorry. By James Tourje.  
16 Q Spell it.  
17 A T o-u-r-j-e.  
18 Q And his ranking is?  
19 A He's an A partner.  
20 Q Okay.  
21 A And then we have a 1/9/2001 right  
22 rib series read by Dr. Douglas Brown.  
23 Q Is that the latest and the last  
24 one you've got?  
25 A That's the last one I have.

1 Q Okay. In re the chest films,  
2 whether they are scans or plain films, I'd just  
3 like to go through them now and have you tell  
4 me what your associates, as you call them,  
5 wrote --  
6 A Uh-huh.  
7 Q -- please. Just the just films  
8 now -- just the chest films or chest scans.  
9 A From the reports or --  
10 Q Yes, from the reports. I want to  
11 know what their words were.  
12 A I'm trying to separate it out.  
13 (A discussion was held off the  
14 record.)  
15 THE WITNESS: Well, the reports  
16 that I have that we did begin with the  
17 postoperative status. I don't think we  
18 were -- I have to look -- but I don't think we  
19 were involved preoperatively. I think the  
20 preoperative scans were done either at Tower  
21 Radiology or Santa Monica Hospital, and I think  
22 the first CT scan, I believe, was at Santa  
23 Monica Hospital. I could be wrong, but I think  
24 that's the situation.  
25 BY MR. PIUZE:

1 Q Where is Tower now and days, in  
2 Beverly Hills?  
3 A Well, Tower has the contract at  
4 St. Johns hospitals and has an imaging facility  
5 on Robertson and Wilshire.  
6 Q And who of your former partners  
7 run that place now?  
8 MS. WILLIAMS: Objection. Lacks  
9 foundation.  
10 THE WITNESS: One of my former  
11 partners is now chairman of radiology at  
12 St. Johns. That's Dennis Sarti, S-a-r-t-i, and  
13 I really don't know who's in charge of Tower  
14 Radiology any longer. I've lost track  
15 of -- they've gone through several people, and  
16 I don't know who's in charge now.  
17 Q Did you read the radiology records  
18 from Tower?  
19 A Yes.  
20 Q Did you recognize the names of any  
21 of the doctors who wrote those reports?  
22 A Oh, yes.  
23 Q Yes. Who?  
24 A Dr. Barry Rothman, Dr. Robert  
25 Ledner, L-e-d-n-e-r.

1 Q Were you ever in business with  
2 either of those two?  
3 A Yes.  
4 Q At Tower?  
5 A Yes.  
6 Q What about the guy who heads up  
7 St Johns, were you in business with him, too?  
8 A Yes.  
9 Q And spell the last name again,  
10 S-a-r- --  
11 A T-i.  
12 Q Okay.  
13 A This is Dr. Marshall Bein,  
14 B-e-i-n, who was also a partner of mine several  
15 years at Tower Radiology.  
16 Q And he is where now?  
17 A He is at -- I think spends most of  
18 his time at the Tower Radiology office on  
19 Wilshire and Robertson.  
20 Q Okay. So you saw their names on  
21 the reports?  
22 A Correct.  
23 Q And have you finished telling me  
24 about the names that you recognized on the  
25 Tower reports?

1           A       No. Dr. Charles Schatz,  
2 S-c-h-a-t-z.  
3           Q       And he also a former partner of  
4 yours?  
5           A       Yes.  
6           Q       Okay.  
7           A       Okay. That looks like all of them  
8 in this pile of data that I have here.  
9           Q       And when you say "this pile,"  
10 which pile is that?  
11          A       There is a list of radiology  
12 reports that was supplied to me by Mr. Johnson.  
13          Q       Who is Mr. Johnson?  
14          A       This gentleman here.  
15          Q       How do you know him?  
16          A       I was introduced to him through an  
17 attorney by the name of Mitsy Dobson from Bonne  
18 Bridges.  
19          Q       When?  
20          A       This was about two months ago, I  
21 think it was.  
22          Q       How do you know Mitsy Dobson?  
23          A       Mitsy and I have worked on several  
24 defense malpractice cases together.  
25          Q       With you being her consultant or

1 designated expert?  
2 A That is correct.  
3 Q How many?  
4 A Maybe three.  
5 Q How many times have you consulted  
6 with Bonne Bridges?  
7 A For malpractice?  
8 Q What else do they do?  
9 A Well, as far as I'm concerned, my  
10 only knowledge is malpractice.  
11 Q They actually do a few little  
12 other things now and days, but, okay. The  
13 answer is yes to malpractice to my question?  
14 A Your question to me is how many  
15 cases.  
16 Q Yeah.  
17 A Maybe 10.  
18 Q Over what period of time?  
19 A Four years, five years.  
20 Q How many times have you been  
21 involved in litigation, medical malpractice  
22 litigation as a consultant --  
23 MS. WILLIAMS: I'm sorry. Can we  
24 close this door?  
25 MR. PIUZE: If you want.

1 THE WITNESS: 60 or 70 times.  
2 BY MR. PIUZE:  
3 Q All defense?  
4 A No.  
5 Q How much defense?  
6 A Probably 40 percent defense and  
7 about 60 percent plaintiff work.  
8 Q For whom, plaintiff?  
9 A Um, well, there have been a number  
10 of attorneys, but just -- I can't remember all  
11 the names, believe me, but just one to bring up  
12 is John Contos from Contos and Bunch and I he's  
13 in Westlake Village and there have been several  
14 over the years.  
15 Q Can you think of anyone else other  
16 than Contos and bunch?  
17 A Jeff Bouma, B-o-u-m-a, out of  
18 Phoenix. Rebecca Walsh, W-a-l-s-h, who is in,  
19 I believe -- she's in a large firm in Michigan.  
20 Oh, there's somebody in San Diego -- a woman in  
21 San Diego. I'm blocking out her name, but -- I  
22 have to think about these for a while.  
23 Q That's good enough. In the small  
24 world that we inhabit, I send malpractice cases  
25 to Costos & Bunch cause suing doctors is pretty

1 boring most of the time.  
2 What did Mitsy tell you?  
3 A Mitsy said that, that there was a  
4 case involving a tobacco-related issue, and did  
5 I have any objection to looking at that.  
6 Q What's a tobacco-related issue,  
7 did you ask her?  
8 A Yeah.  
9 Q What does that mean?  
10 A She said that there was a patient  
11 or client -- or client-related issue that had  
12 to do with lung cancer --  
13 Q Right?  
14 A -- and a smoker, and would I take  
15 a look at this case and advise the parties  
16 involved in this case.  
17 Q Advise them of what?  
18 A Advise them of my opinions in  
19 regards to the imaging analysis of the tumor.  
20 Q Well, did she explain to you where  
21 this was going?  
22 MS. WILLIAMS: Objection. Vague  
23 and ambiguous.  
24 THE WITNESS: I don't know what  
25 that is referring to.

1 BY MR. PIUZE:

2 Q Well, did you say, "Hey, Mitsy,  
3 who cares what the tumor looked like in the  
4 smoker's chest?"

5 MS. WILLIAMS: Objection,  
6 argumentative.

7 BY MR. PIUZE:

8 Q "Who cares what the lung tumor  
9 looked like in a diagnostic film in this  
10 smoker's chest?"

11 A Well, considering that I spend my  
12 entire day dealing with people who do care what  
13 a cancer looks like in a chest, and most of my  
14 patients who come to me care about what that  
15 cancer looks like to me in a chest and their  
16 family cares about what a cancer looks like in  
17 a chest, I think that would be totally  
18 inconsistent with my daily work and my evening  
19 work for the last 20 years, if I took that  
20 attitude.

21 Q What do your patients -- when you  
22 say your patients and their family care what  
23 the tumors look like, what do you mean by that?

24 A The patients that I deal with only  
25 a daily basis care very much about my attention

1 to detail, and if I take the attitude, "Look,  
2 you have a lung cancer, next," and I just send  
3 them out of the office, for example, and I  
4 didn't offer them any detail, what does it look  
5 like, what is the stage of the cancer as best I  
6 can tell as a radiologist, I think that would  
7 be the last time I would see those people.

8 Q You weren't asked in this case to  
9 determine what stage the lung cancer was in  
10 this person, were you?

11 A No. I think we have pathologic  
12 proof of that.

13 Q Your client -- your patients want  
14 to know, excuse me, "Bottom line, what are my  
15 chances, no excuses," don't you think?

16 A Well they want to know what my  
17 opinions are before we know exactly what's  
18 going on. I see people well before the  
19 diagnosis is made, and in that time frame, they  
20 want to know exactly what do I think. And in  
21 order to give my patients an honest opinion  
22 about what I think, I have to analyze the  
23 details of the -- of the abnormality in  
24 question, and not just superficially say "Oh,  
25 there is a lung cancer. That's the way it is."

1 Q Well, in Mr. Boekin's case, who  
2 was the radiologist who uncovered the lung  
3 cancer?  
4 A I think it was -- I believe it was  
5 seen in the chest X-rays by Barbara Kadell from  
6 UCLA, K-a-d-e-l-l.  
7 Q Do you know her?  
8 A Yes.  
9 Q So do you see where she sat down  
10 and discussed with Mr. Boekin about all of the  
11 details of this tumor?  
12 A Oh, I have no idea whether she sat  
13 down with him and met him I don't know.  
14 Q That's just the point. She  
15 probably never laid eyes on him, did she?  
16 MS. WILLIAMS: Objection. Calls  
17 for speculation.  
18 THE WITNESS: I have no idea.  
19 BY MR. PIUZE:  
20 Q It's not uncommon at all for  
21 radiologists diagnosing lung cancer on a chest  
22 X-ray never to meet with the patient, is it?  
23 A That's frequently the situation,  
24 absolutely.  
25 Q Okay. Why in your situation is it

1 different?

2 A Well, a lot of patients want to  
3 meet with me personally because they know of  
4 me, know people who know me, know my reputation  
5 in town, and are referred specifically to me  
6 for a chest evaluation by doctors that I deal  
7 with all the time that specialize in the lung  
8 disease. And in this community, many of our  
9 patients are very bright and very aware of  
10 what's going on, and they want to meet the  
11 radiologist. And we're in a position now where  
12 in order to give service that is appropriate to  
13 the patients and in order to be competitive in  
14 our environment, such as with Tower Radiology  
15 right down the street, that we have to give the  
16 service that is required, whatever that is, and  
17 if it means meeting with patients and  
18 discussing the findings on the X-ray, then  
19 that's what is expected of me to do.

20 Q So what percentage of your  
21 patients get to meet with you to discuss the  
22 X-rays you are looking at for diagnostic  
23 purposes.

24 A Of the chest X-rays, very few. Of  
25 the chest CT scans, I'd say about 30 percent.

1 Q Okay. Well I wasn't limiting it  
2 to chest. Let's just keep it an open-ended  
3 question so far -- do you just diagnosis chest  
4 stuff?  
5 A No.  
6 Q Is there such a person?  
7 A I am the expert at Cedars in chest  
8 disease from an imaging standpoint.  
9 Q And what percentage of your time  
10 do you spend with chest as opposed to other  
11 parts of the body?  
12 A Probably in the order of about 25  
13 percent.  
14 Q Okay. And is that the area that  
15 you spend the most time on?  
16 A It's about equal to my experience  
17 with mammography.  
18 Q Which is close to the chest?  
19 A Yes.  
20 Q When you said "imaging" in your  
21 second to last answer, did you mean including  
22 plain films and scans, or did you mean just  
23 scans?  
24 A No, both.  
25 Q Both, okay. So anyway, of the

1 whole gamma of all of the patients whose X-rays  
2 you're looking at, what percentage do you meet  
3 with?

4 A Well, if you take into  
5 consideration the breast practice, which is  
6 approximately a quarter of my time --

7 Q Yeah?

8 A -- I probably meet with 50 to 60  
9 percent of the patients I see during the time  
10 I'm in the breast practice, and I meet with, as  
11 I said, about 30 percent of the patients  
12 dealing with CT scans.

13 Q Of the chest?

14 A Of my chest practice.

15 Q Why is that? What's the reason  
16 for the different percentages?

17 A Well, I think that to a large  
18 degree, women are more inquisitive and  
19 concerned about their breasts than they or men  
20 are about the chest. And it's for varying  
21 reasons, and it's what they assume is more  
22 available to them to have a radiologist in a  
23 place to discuss the breast-related issues.  
24 And many patients don't realize that there is a  
25 radiologist that might be able to discuss a CT

1 of the chest with them  
2 Q Why would that be?  
3 A Just historical, and there's also  
4 a -- a law called "The Medical Quality  
5 Standards Act" which was put into effect in  
6 1998, I believe, in which patients who come in  
7 for diagnostic mammograms have a right, as part  
8 of the fee charged for the diagnostic  
9 mammogram, to meet directly with a radiologist  
10 if they so choose.  
11 Q And that's not the case with chest  
12 X-rays, I take it?  
13 A No.  
14 Q Do you charge extra when you have  
15 to sit down and talk to people about their  
16 chest X-rays?  
17 A No.  
18 Q That's part of being competitive  
19 that you were discussing before?  
20 A Not just being competitive, but  
21 being compassionate and giving quality care.  
22 Q Okay. So back to Mitsy, what did  
23 you think your role in this case was going to  
24 be?  
25 A To discuss the radiology findings,

1 particularly on the CT scan, the original CT  
2 scan, and to, um, discuss whether or not it  
3 would be compatible with one form of lung  
4 cancer versus another form of lung cancer or  
5 whether I could make that statement at all.

6 Q Why particularly the CT scan as  
7 opposed to plain films?

8 A Because it's much more exacting,  
9 much more in detail in regards to the  
10 characteristics of the lung cancer than the  
11 chest X-ray is.

12 Q Why particularly with regards to  
13 the first CT scan as opposed to subsequent CT  
14 scans?

15 A Well, the patient went to surgery  
16 shortly after that, after that first CT scan.  
17 So the tumor after that, which the -- excuse  
18 me, the primary tumor after that was gone, was  
19 removed. So I really only would be discussing  
20 the characteristics of the original  
21 presentation and the more detailed presentation  
22 is that of the CT scan as compared to the chest  
23 X-ray.

24 Q Was the X-ray and the scan done on  
25 the same day?

1           A        I don't believe it was.  
2           Q        Were they reads by the same  
3 person?  
4           A        I don't think so, but I'd have to  
5 look at the chart again to be sure.  
6           Q        I'm going to give you a shot. Do  
7 you remember the name of either person, if it  
8 turns out there's more than one?  
9           A        Yes. I told you, I believe  
10 Barbara Kadell read the original chest X-ray at  
11 UCLA.  
12          Q        You did tell me.  
13          A        At Santa Monica.  
14          Q        You did tell me, okay.  
15          A        And the chest CT, I don't remember  
16 now.  
17          Q        Okay. So exactly, what did  
18 Barbara Kadell say?  
19          A        Barbara said that there was a  
20 suspicious spot in the right upper lobe, and  
21 she recommended a chest CT.  
22          Q        What is her capacity at UCLA?  
23          A        I believe Barbara is a -- I  
24 believe is a professor of radiology at UCLA.  
25          Q        Clinical?

1           A       Yes. I think she's a clinical  
2 professor, but I'm not sure that is her actual  
3 title as opposed to a full professor. She is  
4 full time at UCLA, so she's probably a full  
5 professor, not a clinical professor.

6           Q       Got it, okay. So she's a medical  
7 professor at UCLA?

8           A       Correct.

9           Q       So why don't you now please check  
10 to see who did the scan.

11          A       The scan, which was done on  
12 10/7/99 at Santa Monica UCLA Medical Center,  
13 was read by Nazanin Yaghmai. I don't know who  
14 that is.

15          Q       Why don't you spell those two  
16 names so the court reporter doesn't break her  
17 fingers here.

18          A       The first name is N-a-z-a-n-i-n.  
19 Last name, Y-a-g-h-m-a-i.

20          Q       Do you know that person?

21          A       No, I do not.

22          Q       Do you know -- I guess this is  
23 irrelevant, but what the heck? Is that a man  
24 or a woman?

25          A       Is that a man or a woman, is that

1 your question?  
2 Q Yeah.  
3 MS. WILLIAMS: Objection. Calls  
4 for speculation.  
5 MR. PIUZE: That, it does.  
6 MS. WILLIAMS: I couldn't resist.  
7 MR. PIUZE: The record will  
8 reflect a quizzical look on the witness's face.  
9 Q Anyway, it was irrelevant, and I  
10 probably should apologize for the question.  
11 But what did -- say the last name again,  
12 please.  
13 A Yaghmai.  
14 Q What did Dr. Yaghmai say in his or  
15 her report about the findings?  
16 A Do you want me to read the  
17 conclusion, or do you want me to read the whole  
18 report?  
19 Q Well, let's hear the conclusion.  
20 A The conclusion is "approximately  
21 two centimeter spiculated mass in the posterior  
22 segment of the right upper lobe as described  
23 above; highly suggestive of malignancy."  
24 Q Spiculated, meaning?  
25 A As I originally talked about this

1 evening, irregular margins with linear  
2 striations coming from the primary mass.

3 Q What words or phrases in the body  
4 of the report are consistent with your feelings  
5 that this is most likely or more likely BAC, if  
6 any?

7 A The words spiculated is the most  
8 consistent word -- description that's in the  
9 reports that would be consistent with BAC.

10 Q I appreciate it's the most  
11 consistent, but I'm not looking for just the  
12 most consistent. I'm looking for any words or  
13 phrases within the body of the report --

14 A Uh-huh.

15 Q -- that you think you would point  
16 to and say, "See, this word and/or this phrase  
17 is consistent with my thoughts that this is  
18 likely BAC."

19 A Spiculation.

20 Q Only?

21 A Yeah, that's all.

22 Q Okay.

23 A Now, you have to understand that  
24 part of my feeling about it being more likely  
25 to be BAC has to do with the fact that I know,

1 based on the pathology report, that it is not a  
2 squamouscell carcinoma. If I didn't know that,  
3 then I would have to say that we still have to  
4 concern ourselves with the possibility that it  
5 may be squamouscell carcinoma. However, I feel  
6 that today BAC is more likely, but squamouscell  
7 is a very definite possibility right behind  
8 BAC, as I said earlier.

9 Q What happened over the last 20  
10 years that squamous has fallen out of  
11 popularity?

12 MS. WILLIAMS: Objection.

13 Mischaracterizes his testimony.

14 BY MR. PIUZE:

15 Q You understand what I mean by  
16 that?

17 A Yeah. It's not a popularity  
18 contest. Do you understand that?

19 Q Yes, of course, I do.

20 A But the statistical facts are that  
21 there has been a significant decrease in  
22 squamouscell carcinoma, probably related to two  
23 factors. One factor is that there's definitely  
24 an increased incidence of lung cancer in women,  
25 and that there seems to be -- there's an

1 overall decrease in the smoking experience of  
2 the population. Now, whether it's the women  
3 are more likely to be non-smokers and still  
4 getting lung cancer or it has something -- some  
5 other factor with women that is not known, but  
6 it probably is a combination.

7 Q What does smoking got to do with  
8 it? I didn't follow you.

9 A In other words, that we're seeing  
10 a change in cell types as the population is  
11 decreasing their smoking habits.

12 Q From what to what?

13 A From squamouscell to either an  
14 adeno cell carcinoma or to a bronchoalveolar  
15 carcinoma, and we're seeing a shift over to  
16 these other types of cancer mostly -- most  
17 likely -- number one related to smoking and the  
18 change in smoking habits and also, a higher  
19 incidence in women that probably is related, in  
20 part, to the fact that women are not --  
21 percentage-wise are not smoking as much as men  
22 over the last 20 years. And also, there might  
23 be some other factor that we don't know about  
24 that -- in which women are clearly getting far  
25 more adeno and bronchoalveolar carcinomas than

1 squamouscell carcinomas.  
2 Q So if you hadn't seen the path  
3 reports, your ranking would still be the same?  
4 It's just that the gap between the first two  
5 contenders wouldn't be so great?  
6 A That is correct. It would still  
7 be most likely that in 1999, that I would put  
8 BAC as number one, and number two would be  
9 squamous. Number three would be adeno.  
10 Q Okay. So what did this doctor  
11 over at St. Johns say? What did he or she  
12 choose?  
13 A She -- or he said it was highly  
14 suggestive of malignancy.  
15 Q Only?  
16 A Only.  
17 Q I thought that's what we heard  
18 over at UCLA. Are you saying we heard the same  
19 thing over at St. Johns?  
20 A No. I believe this is Santa  
21 Monica Hospital.  
22 Q I apologize, Santa Monica  
23 Hospital. Let's start again.  
24 What did the doctor at Santa  
25 Monica Hospital say, if anything, as far as

1 BAC, squamous, adeno?  
2 A Said nothing about that.  
3 Q Do you usually say something about  
4 that?  
5 MS. WILLIAMS: Objection. Vague  
6 and ambiguous.  
7 THE WITNESS: I certainly do, if  
8 it's appropriate if I -- based on the radiology  
9 the of appearance of a lesion, I do and I will  
10 use that but only -- but realizing that  
11 pathology needs to be obtained to make a  
12 definitive diagnosis, that one cannot make a  
13 definitive diagnosis on the basis of the  
14 X-rays.  
15 Q No one can?  
16 A No one can.  
17 Q It's not your job, is it?  
18 A Well, it would be nice if it was  
19 our job. If we could have specific radiology  
20 findings that would significantly help and  
21 avoid the need for invasive procedures to the  
22 tissue, that would be wonderful, but we cannot  
23 do that.  
24 Q So the question was that's not  
25 your job?

1           A       That's not my job.  
2           Q       So where is the CT scan, here?  
3           A       I brought it with me.  
4           Q       Do you have a shadow box?  
5           A       No, I do not.  
6           Q       Can you hold it up to the light  
7           and show me spiculation?  
8           A       I can.  
9           Q       Please.  
10          A       We're going to be looking at the  
11          CT scan of the chest done 10/7/99 -- um, let's  
12          see -- yeah. This was taken at UCLA  
13          Santa Monica Hospital imaging center.  
14          Q       When the plain film was taken and  
15          you say UCLA, I always envision Westwood, the  
16          Westwood Medical Center at UCLA. Is that how  
17          you understand it?  
18          A       I don't believe that -- I believe  
19          Barbara Kadell over at UCLA at Santa Monica  
20          reviewed it with a resident over at Santa  
21          Monica. So the faculty may be spending some of  
22          their time over at Santa Monica Hospital, I  
23          don't know.  
24                  Well. This says UCLA. It doesn't  
25          reference the Santa Monica -- it doesn't

1 reference Santa Monica Hospital, per se, but  
2 the doctor who referred to addresses Santa  
3 Monica Family Practice on 15th Street, and it's  
4 possible that there is a report that comes from  
5 both facilities.

6           It's a -- they don't make the  
7 distinction because in the letterhead of this  
8 radiology report is -- it includes UCLA Medical  
9 Center, UCLA Plaza, and Santa Monica, UCLA. So  
10 I would -- I would bet that this patient was  
11 not seen in the Westwood facility, but may have  
12 been seen in the Santa Monica facility. But  
13 I'm not absolutely sure.

14           Q       Okay, thank you. So we were -- we  
15 were on -- where is the speculation in the CT  
16 scan?

17           A       If we look at the mass which is  
18 approximately two centimeters in size in the  
19 posterior segment of the right upper lobe,  
20 you'll see a white -- you'll see a white dot  
21 right here -- actually larger than a dot, but a  
22 white spot that measures about two centimeters.  
23 If you look at the margins, the interface  
24 between that white spot and the grade along,  
25 you'll see striations, linear striations that

1 protect from the tumor into the surrounding  
2 lung.  
3 Q Do you agree that's two  
4 centimeters?  
5 A I measured it yeah pretty close to  
6 2 centimeters.  
7 Q Pretty close meaning more than or  
8 less than?  
9 A In one measurements I got two  
10 points two and another measurement I got 2  
11 centimeters but it's -- it's very close like I  
12 said to two centimeters. It is not three sent  
13 meters so it is certainly under that difference  
14 which affects staging as far as the tee class I  
15 have indication of tumors where here's a nor  
16 details view of this -- I think you can see  
17 these spiculations a little bit better there if  
18 you look at that white spot, and I think you'll  
19 see almost like sun's rays protecting that  
20 white spot.  
21 Q Artifact?  
22 A No.  
23 Q How long have you spent with these  
24 CT scans?  
25 A Well, there were a number of

1 images, quite a few images. I don't know,  
2 maybe two hours or so going over everything.

3 Q What are the other images?

4 A The postoperative CT scans. Then  
5 there are -- there are some spine films. There  
6 are some abdominal CT scans. The chest X-ray,  
7 I think two PET scans.

8 Q None of those have anything to do  
9 with your opinions that you've told me so far  
10 about BAC, do they?

11 A No. My major opinion is based on  
12 the characteristics of the CT scan.

13 Q Well your opinion is based on the  
14 CT scans?

15 A Yes.

16 Q Okay.

17 A Predominantly on that basis.

18 And -- I mean there is another finding, but  
19 again, it's not proving to be statistically  
20 valid, I don't know whether or not I used it in  
21 any way to formulate an opinion. It's hard to  
22 be sure.

23 I mean -- and that is on the PET  
24 scan, that one of the things we have found at  
25 Cedars is that the bronchoalveolar cell

1 carcinomas tend to have a lower affinity  
2 or -- for the glucose metabolite FDG than some  
3 of the smaller alveolar cells. By that, I mean  
4 those around a centimeter and a half or smaller  
5 have a higher likelihood of being negative on  
6 PET than any of the other primary cancers  
7 alone. And when I originally reviewed the PET  
8 scan, I was thinking that in light of the size  
9 of this lesion, which is, like I said, about  
10 two centimeters, that while the PET scan was  
11 positive, in that it wasn't as positive as I've  
12 seen with other malignancies of the lung and I  
13 was thinking in terms of, "Well, is that a  
14 helpful sign or not a helpful sign of  
15 bronchoalveolar cell carcinoma," my conclusion  
16 is that I can't really use that as a true  
17 objective finding. That it's more likely to be  
18 bronchoalveolar sell as opposed to any other  
19 type of lung cancer.

20                   It's an interesting type of  
21 observation, and it reminded of some of the  
22 other observations of the smaller lesions that  
23 I spoke about. And all I can say is, you know,  
24 while that's an interesting fact, let me see --  
25 put that in the back of my mind and hold that

1 in advance and see whether that has any role as  
2 a -- to do further analysis on this case.  
3 But my conclusion is that it  
4 probably does not play a role in making a  
5 distinction between whether or not this is more  
6 likely bronchoalveolar cell as opposed to adeno  
7 or as opposed to squamous cell carcinoma based  
8 on the intensity of the CAT scan.  
9 Q So here, I think, was my question  
10 someplace in there: When you give me  
11 probabilities, relative probabilities that  
12 include BAC, squamous, adeno as different  
13 subsets of cancer, chest cancer, you are basing  
14 that opinion on these cans, MRI scans of the  
15 chest only, correct?  
16 A No.  
17 Q Okay. What else?  
18 A It wasn't the MRI scans of the  
19 chest. It was the CT scans.  
20 Q Excuse me. I apologize. I meant  
21 to say CT. You are basing your opinion on the  
22 CT scans only?  
23 A Correct.  
24 Q Okay. Now, let's come on back  
25 to -- what's this man's name again?

1           A       Mr. Boekin, B-o-e-k-i-n.  
2           Q       No, this man.  
3           A       It's Chris Johnson.  
4           Q       How many times have you met with  
5           Mr. Johnson?  
6           A       Including today?  
7           Q       Yes.  
8           A       Three times.  
9           Q       Time number two was where and when  
10          and why and how?  
11          A       Time number two was in my office  
12          approximately three weeks ago.  
13          Q       Who was he with?  
14          A       It was -- I don't remember all of  
15          the attorneys. Let's see, there was another  
16          attorney there, the attorney with him here  
17          today.  
18                    What was your name again? I  
19          forgot.  
20                    MS. WILLIAMS: Cheryl Williams.  
21          BY MR. PIUZE:  
22          Q       Do you have any opinions as to why  
23          tobacco lawyers travel in packs?  
24          A       Probably for the same reason that  
25          Bananas are in bunches. I have no idea.

1 Q So we've got Chris and we've got  
2 Ms. Williams. Who else?  
3 A There was another attorney, and  
4 I'm blocking his name now. I don't remember  
5 his name.  
6 Q What firm?  
7 A I'll have to refer to them to find  
8 out who the other attorney was again, and I  
9 don't believe Mitsy Dobson was there that  
10 second meeting, she was there that first  
11 meeting.  
12 Q Was this third attorney from  
13 Southern California?  
14 A I don't know.  
15 Q Kansas City?  
16 A May have been from Kansas City.  
17 I'm not sure.  
18 Q Do you know what's in Kansas City?  
19 A Besides the Chiefs?  
20 Q Yeah.  
21 A Dorothy's shoes.  
22 Q How do you know that?  
23 A That Dorothy's shoes are in Kansas  
24 City?  
25 Well, when you have children, you

1 find these important facts out.  
2 Q Do you know the name of Chris's  
3 firm?  
4 A I don't remember the name of  
5 Chris's firm  
6 Q What about Ms. William's firm? Do  
7 you remember the name of that firm?  
8 A She mentioned it to me, but it  
9 didn't sound familiar to me.  
10 Q In other words, meeting number two  
11 Mitsy, who works at Bonne Bridges, was not in  
12 attendance, but there were three other lawyers  
13 in attendance with you?  
14 A That's correct.  
15 Q Anybody else?  
16 A No.  
17 Q Anybody else?  
18 A No.  
19 Q I saw a blonde woman from Kansas  
20 City, an RN in a deposition yesterday, was she  
21 in the cameo in your slot?  
22 A She was there in addition to the  
23 three lawyers. Yes, she was.  
24 Q What did she say to you?  
25 A What did she say to me.

1 Q Yeah.  
2 A She didn't say anything to me that  
3 I remember.  
4 Q What did the lawyers say to you?  
5 A Um, we discussed the case and the  
6 radiology issues in regards to the case, and  
7 told I them my preliminary feelings about the  
8 case. That was it. It was a shorts meeting.  
9 Q Are your preliminary feelings the  
10 same as your feelings today?  
11 A Yes.  
12 Q I was fortunate enough to take a  
13 deposition in the last couple days -- they're  
14 already running together here -- in which a  
15 board certified chief of pathology of a major  
16 hospital disclosed to Chris a couple of  
17 articles that he might be interested to reads?  
18 A Did I happen to be fortunate to  
19 get articles from Chris?  
20 Q Yes.  
21 A I received some articles, yes.  
22 Q Why?  
23 A Why?  
24 Q Yeah.  
25 A I think his concern was that they

1 wanted to be sure that I had -- if I had any  
2 questions in regards to my interpretation of  
3 these films, that I could reference the  
4 articles if I so chose to do that.  
5 Q Did you have any questions that  
6 needed back up?  
7 A No, no.  
8 Q How do you know that was his  
9 concern?  
10 A Well. I imagine that that's the  
11 concern. Why else would he send me the  
12 articles.  
13 Q Did he ask your permission first?  
14 A Ask my permission to send me  
15 articles?  
16 Q Yeah.  
17 A I wouldn't think he would need my  
18 permission to send me articles.  
19 Q You went to Yale?  
20 A I was -- yes, I trained in  
21 internal medicine at Yale.  
22 Q That's a pretty good school, isn't  
23 it?  
24 A I think so.  
25 Q West Haven, New Haven. Didn't you

1 think it was a little presumptuous for a lawyer  
2 to be sending a board certified radiologist,  
3 ex-professor Yale graduate article so you  
4 wouldn't get confused?

5 MS. WILLIAMS: Objection.  
6 Argumentative.

7 THE WITNESS: I don't think it's a  
8 matter of me getting confused. I think it's a  
9 matter of me getting references if I so chose  
10 to have references to whatever questions might  
11 come up.

12 BY MR. PIUZE:

13 Q So what I was saying is not don't  
14 you think that was a little presumptuous to be  
15 sending a board certified ex-professor who  
16 trained at Yale University articles?

17 MS. WILLIAMS: Same objection.

18 THE WITNESS: I have no objection  
19 to receiving articles from anyone who would so  
20 choose to send me articles. I don't get  
21 intimidated by that in the slightest.

22 BY MR. PIUZE:

23 Q What's the answer? Don't you  
24 think that's a little presumptuous?

25 A Absolutely not.

1 Q Who chose the articles?  
2 A I have no idea.  
3 MS. WILLIAMS: Objection. Calls  
4 for speculation.  
5 BY MR. PIUZE:  
6 Q The point is you didn't choose the  
7 articles, right?  
8 A Right.  
9 Q Don't you think that's a little  
10 presumptuous?  
11 A No? I think that it would be  
12 extremely presumptuous for me to assume that  
13 the -- that people dealing in tobacco-related  
14 issues haven't done an enormous amount of  
15 research on lung cancer, probably more than I  
16 have, and it would be very presumptuous for me  
17 to think more than a lot of investigators  
18 dealing with tobacco-related issues in a  
19 control setting.  
20 I've read a lot, but I have not  
21 read all of the articles. I do not claim I  
22 have read all of the. Relating to Yale, my  
23 experience at Yale taught me that I don't know  
24 everything, and the fool is the person that  
25 says, "Don't send me articles." I would never

1 be that presumptuous. If you want to send me  
2 articles, send me them and I'm tell you that  
3 I'll try to read them  
4 Q Did you read them?  
5 A No.  
6 Q Why not?  
7 A Because I didn't feel that there  
8 were any questions that I had in regards to the  
9 CT can in my opinions that I've expressed that  
10 I needed to reference articles.  
11 Q Do you have the articles?  
12 A No.  
13 Q What are they?  
14 A What are the articles?  
15 Q Yeah.  
16 A They're articles dealing with  
17 bronchoalveolar cell carcinoma. They are  
18 dealing with an overview of lung cancer  
19 from -- I believe there was a copy -- somebody  
20 copied them from Frasier and Praré, which is a  
21 pretty standard textbook in chest radiology.  
22 Q You were supposed to bring your  
23 whole file with you to tonight. You knew that,  
24 didn't you?  
25 A Yes.

1 Q How come you didn't bring your  
2 articles?  
3 A Cause I didn't use them I didn't  
4 use them in any way.  
5 Q Well, so what? It's part of your  
6 file, isn't it?  
7 A It's not part of my file in  
8 reference to this case because I didn't  
9 reference these articles at all.  
10 Q What part of your -- what part of  
11 your file is it in reference to if it's not in  
12 this case?  
13 A It's not in reference to anything.  
14 I haven't used the articles, so I don't -- it  
15 was not included in this case cause it's not  
16 something that I've used to formulate an  
17 opinion on this -- on this case.  
18 Q Where are they?  
19 A In my office.  
20 Q How many?  
21 A How many articles are there?  
22 I have no idea.  
23 Q Less than a million, more than  
24 six?  
25 A More than six.

1 Q More than ten?  
2 A I don't know. I didn't count.  
3 Q What are they labeled, filed,  
4 categorized, numbered, in your office under the  
5 ashtray?  
6 MS. WILLIAMS: Objection. Assumes  
7 facts not in evidence.  
8 MR. PIUZE: Well, excuse me. I'm  
9 sure he does not smoke in his office. It does  
10 assume facts not in evidence.  
11 MS. WILLIAMS: No. That they're  
12 labeled at all.  
13 BY MR. PIUZE:  
14 Q Shoot.  
15 A They're not labeled at all.  
16 They're just lying on the desk, and that's it.  
17 Q Okay. Is this the only case that  
18 you're working on that has tobacco as a  
19 centerpiece?  
20 A Yes.  
21 Q Have you been asked to look at  
22 other cases that has tobacco as a centerpiece?  
23 A I have looked at other cases.  
24 Q How many?  
25 A Three.

1 Q When?  
2 A Four.  
3 Q When?  
4 A In the last year.  
5 Q For whom?  
6 A For Mitsy -- well, through Mitsy  
7 Dobson and the Bonne & Bridges firm  
8 Q For tobacco companies?  
9 A For tobacco companies, yes.  
10 Q Getting sued?  
11 A I don't know anything about the  
12 legal status of these cases, I know what I told  
13 them about it in these cases, but other than  
14 that, I don't have any details in these cases.  
15 Q Did you do depositions?  
16 A Did I do depositions?  
17 Q Yes.  
18 A No. I told them that there were  
19 no issues here that I could help them with  
20 whatsoever and that these were clearly lung  
21 cancers and the -- there was no dispute --  
22 MS. WILLIAMS: I'm sorry. I'm  
23 going to have to object to the extent you're  
24 delving into work product information to which  
25 he has not been established as an witness in

1 this case. If you want to establish that he  
2 has been, you're welcome to, and then you can  
3 move on.

4 MR. PIUZE: No.

5 Q You turned them away, is that it?

6 A That's it.

7 Q And what was the issue on what you  
8 turned them away? I didn't quite follow what  
9 you were talking about. You said it was lung  
10 cancer, but this is lung cancer, meaning  
11 Richard Boekin.

12 A Right.

13 Q What was the reason that you  
14 turned this away?

15 A Well, as I understand it, that the  
16 issue for me is are these radiology findings  
17 that I've described, is it consistent or is it  
18 inconsistent with bronchoalveolar cell  
19 carcinoma, and that's what -- that's the core  
20 issue here for me.

21 Q Yeah. But where does that issues  
22 lead to, though?

23 A Where does it lead to?

24 Q Yeah.

25 A Well, it has the potential of

1 leading to whether it's more likely or less  
2 likely whether or not this cancer is smoking  
3 related --  
4 Q Right.  
5 A -- or not.  
6 Q Right. So on the other three -- I  
7 know that. I know you knew that. So now we  
8 acknowledge that we both know that.  
9 In the other three cases -- was it  
10 3 cases or was it more than three cases?  
11 A I think it was three cases.  
12 Q And in the other three cases which  
13 you turned away, are you saying that it was not  
14 BAC?  
15 A I don't even remember the  
16 histology on any of those cases, so I wouldn't  
17 even know. I expressed an opinion  
18 radiographically on those, and that was the  
19 last of my involvement in that.  
20 Q Well, sure. But you also have  
21 stated here on the record that you told them  
22 you couldn't help them. You remember saying  
23 that, don't you?  
24 A Correct.  
25 Q Okay. What did you mean by that,

1 that you could not help them?

2 A I said that these are clearly  
3 carcinomas of the lung and were certainly  
4 likely to be smoking related, and that was it.  
5 That was my statement, and I said thank you  
6 very much, and that was the last I was involved  
7 in those cases.

8 Q And in this case, you said clearly  
9 this is a carcinoma of the lung.

10 A Correct.

11 Q Okay. And then what did you say?

12 A And then I was informed that there  
13 may be or there is a feeling that this may be  
14 a -- or is a bronchoalveolar cell carcinoma and  
15 do I have an opinion as to whether or not the  
16 radiology appearance is consistent with a  
17 bronchoalveolar cell carcinoma.

18 Q What about the other three cases?  
19 Were you given similar information on each of  
20 the other three cases?

21 A I don't remember. I don't  
22 remember the histology on the other three  
23 cases. I do remember just meeting and  
24 discussing the radiology issues, and that was  
25 the end of my involvement.

1 Q Okay. Who did you discuss with --  
2 Mitsy was the common factor in all of the  
3 cases?  
4 A Mitsy was the common factor in all  
5 of those cases.  
6 Q Did you ever see Chris before in  
7 any of those other cases?  
8 A Did I ever see Chris before?  
9 MS. WILLIAMS: I'm going to have  
10 to object. I think you're delving into work  
11 product.  
12 MR. PIUZE: No, I'm not. It's  
13 called bias. It goes to bias if it turns out  
14 that he goes to the same clubs, drinks the same  
15 beer, dated the same women.  
16 Q My question is was Chris part of  
17 the other groups.  
18 MS. WILLIAMS: Okay. Which is why  
19 I objected to it?  
20 THE WITNESS: I don't think Chris  
21 was part of the earlier groups.  
22 BY MR. PIUZE:  
23 Q Who was?  
24 A No.  
25 Q Do you remember the names of law

1 firms?  
2 A No.  
3 Q Same attorneys each time?  
4 A I think there were two different  
5 attorneys, but I do not remember the attorneys'  
6 names or the law firms. One was from Kansas  
7 City, and I think one was from Winston, Salem  
8 Q Of course. Have you ever smoked?  
9 A Yes.  
10 Q When?  
11 A I smoked in -- two years in  
12 college and three years -- two years -- two  
13 years in medical school.  
14 Q What did you smoke?  
15 A What did I smoke? I don't  
16 remember.  
17 Q Cigarettes?  
18 A Yes.  
19 Q How much?  
20 A Well, I was probably up to three  
21 packs a day for a brief period of time during a  
22 very stressful times in medical school.  
23 Q Why did you stop?  
24 A Because I was -- I was a  
25 soon-to-be athlete, and I was very actively

1 involved in surfing for one, and I realized it  
2 was starting to interfere with my endurance,  
3 and I stopped.  
4 Q Where are you from?  
5 A Miami, Florida.  
6 Q And what's the significant  
7 athletics, surfing?  
8 A It was surfing, it was tennis, it  
9 was swimming.  
10 Q Do you still do all of those  
11 things?  
12 A Yes.  
13 Q Your knee is okay?  
14 A From surfing? Okay. You mean  
15 from surfing or from tennis?  
16 Q You're right. I'm sorry. Both.  
17 A Both, yes.  
18 Q So I'm looking at -- have you ever  
19 seen your expert witness designation, what it  
20 says about you and what you're going to say  
21 maybe?  
22 A I don't think I've seen that in  
23 this case. I don't think so.  
24 Q When you told me before about the  
25 splits between plaintiff and non-plaintiff

1 expert consultations, were you talking in med.  
2 mal. cases, or were you talking in just all  
3 kinds of cases?  
4 A Well, being that this is the  
5 second tobacco case that I've been involved  
6 with and it has gone to deposition, I don't  
7 think that adds very much to statistical  
8 analysis of the 60/40 split.  
9 Q Well, the world is composed of  
10 more than tobacco and malpractice.  
11 A Yes.  
12 Q So the answer is the statistics  
13 you were giving me were based on malpractice?  
14 A They were based on malpractice.  
15 Q You don't get involved in any  
16 other kind of litigation besides malpractice  
17 and the tobacco cases?  
18 A I have done some asbestos-related  
19 cases.  
20 Q For whom?  
21 A Well, I've been on both sides of  
22 the issue in regards to asbestos on the  
23 plaintiff's side. I've done work for a firm  
24 out of Nevada, a large firm --  
25 Q Let it go.

1           A       I can't remember that. And on the  
2 defense side, I've done work for a firm out of  
3 New Jersey by the name of -- his first name is  
4 Don.

5           Q       Okay. Let that slide, too.  
6                    How many asbestos cases have you  
7 been involved in, round numbers?

8           A       Ten.

9           Q       How many times have you testified  
10 in those cases in court.

11          A       I think twice.

12          Q       What was the other case in which  
13 you gave a deposition, a tobacco case?

14          A       Excuse me. I remember his name,  
15 the attorney's name from New Jersey, Don  
16 McLaughlin.

17          Q       We'll send Mr. McLaughlin a copy  
18 of the transcript. He'll be gratified to know  
19 that even at this late hour you can remember  
20 his name.

21          A       He's a very nice man.

22          Q       What was the name of the other  
23 tobacco case in which you gave your deposition?

24          A       It was a case about 15, 16 years  
25 ago, well-known case out of Santa Barbara, in

1       which I was an expert on the plaintiff side.  
2           Q       Melvin Belli, B-e-l-l-i?  
3                    He was so sure of his greatness,  
4       he thought no one would ever forget his name.  
5           A       It was one of the early cases I  
6       tried in California that was tried in Santa  
7       Barbara, and I was on the plaintiff side.  
8           Q       Who was it?  
9           A       I don't remember the name of the  
10       plaintiff.  
11          Q       So 16 years ago would have been  
12       1985?  
13          A       It's close.  
14          Q       Okay. What was your role?  
15          A       I was an expert on the plaintiff  
16       side in regards to radiology issues.  
17          Q       What were the issues?  
18          A       What my feeling was in regards to  
19       the abnormalities that were found on his chest  
20       X-ray and, I believe, CT scan. But I don't  
21       remember whether or not there was a CT scan.  
22       There was certainly chest X-rays that were  
23       involved.  
24          Q       Well, the bottom line was whether  
25       the person's lung cancer was smoking related,

1 right?  
2 A Yes.  
3 Q And you thought the answer was  
4 yes?  
5 A I thought the answer was yes.  
6 Q What type of tumor did that person  
7 have?  
8 A I believe it was a squamouscell  
9 carcinoma.  
10 Q What else did you bring here  
11 tonight with you besides your C.V., the films  
12 and the reports of the readings of the films?  
13 A There are medical records that are  
14 here that were sent to me, and that's it.  
15 Q That's the whole thing you brought  
16 with you?  
17 A Everything that's here, that's  
18 right.  
19 Q So if we consider the X-rays and  
20 the -- excuse me. If we consider the films and  
21 the reports of the films to be part of the  
22 medical records, which I do, what you brought  
23 with you tonight is your C.V. and the medical  
24 records?  
25 A That is correct.

1 Q What else have you left back at  
2 the office besides Chris's papers?  
3 MS. WILLIAMS: Objection. Assumes  
4 facts not in evidence.  
5 BY MR. PIUZE:  
6 Q If anything.  
7 A Nothing.  
8 Q There is nothing else?  
9 A There is nothing else.  
10 Q Okay. Early in the deposition  
11 when you were saying in your view, more likely  
12 it would be BAC than adeno -- do you  
13 remember -- I'll let squamous slide for now.  
14 BAC and adenocarcinoma -- for openers, the  
15 abbreviation BAC, is that one that you use?  
16 A Yes.  
17 Q And adeno, is that abbreviation  
18 that you use?  
19 A Yes.  
20 Q You were giving me, for the  
21 record, your preferences or priority rankings  
22 of BAC versus a simple adeno or a -- put a  
23 different way, a non-BAC adeno. Do you  
24 remember that?  
25 A I do.

1 Q Let's take out the simple part.  
2 A Uh-huh.  
3 Q Are there adenocarcinomas that  
4 aren't simple?  
5 A I don't know what you mean by  
6 that.  
7 Q Well, I'm using your term, so I'm  
8 sort of depend upon you. You were saying  
9 "simple adenocarcinoma." I want to know what  
10 other kinds of adenocarcinomas there are  
11 besides simple.  
12 A Well, you can have a mixed  
13 carcinoma where actually there is squamouscell  
14 carcinoma elements to it which is referred to  
15 as adeno-squamouscell carcinoma. You can have  
16 an adenocarcinoma that actually has more  
17 elements than bronchoalveolar cell carcinoma.  
18 Then you can have a non-bronchoalveolar cell  
19 adeno.  
20 When I use the simple cell adeno,  
21 what I mean is it's a non-bronchoalveolar cell  
22 adeno. The reason I say that is because some  
23 people think that bronchoalveolar cell is a  
24 form of adeno carcinoma. It has some different  
25 characteristics and has a different histology,

1 but nevertheless, it is a tumor that arises  
2 from the epithelial glands and therefore is an  
3 adenocarcinoma type. And what I'm saying when  
4 I use the term "simple," is really meaning a  
5 non-bronchoalveolar cell adeno, a true  
6 adenocarcinoma.

7 Q Do you know Dr. Hammer?

8 A Dr. Hammer?

9 Q Yeah.

10 A No.

11 Q Have you heard of him?

12 A Yes.

13 Q What have you heard?

14 A I believe -- isn't he -- I think  
15 he's a pathologist -- I don't know if he's at  
16 UCLA. I don't remember that, but I believe  
17 he's a pathologist.

18 Q Who told you that?

19 A It's in the records, but maybe I'm  
20 wrong.

21 Q Mr. Boekin's records?

22 A The medical records.

23 Q Mr. Boekin's medical records?

24 A Mr. Boekin's medical records.

25 Q Okay. Do you know anything about

1 his reputation?  
2 A No.  
3 Q So what, if we take away -- I'm  
4 sorry, let me withdraw that.  
5 An adenocarcinoma that has a  
6 mixture of squamous -- is that how you  
7 pronounce it, or is it squamous?  
8 A Squamous.  
9 Q Would you still consider that  
10 simple the way you're considering it, simple  
11 adeno?  
12 A No.  
13 Q How often do you find -- let's  
14 forget smoking and non-smoking -- let's forgets  
15 that issue. When you're talking about  
16 adenocarcinoma, how often do you find a simple  
17 adenocarcinoma, do you know?  
18 A You mean of those tumors that are  
19 diagnosed as adeno?  
20 Q Yeah.  
21 A My experience that it's -- it's  
22 fairly frequent that one would find a cancer of  
23 the lung that's an adenocarcinoma.  
24 Q Only?  
25 A Only.

1 Q Okay. Of all of the times whether  
2 someone gets -- excuse me.  
3 Of all of the times -- here it is.  
4 Three a in a mouth -- start over, new line.  
5 Of all of the times, whether  
6 there's a term that includes the term  
7 "adenocarcinoma," how often is it that it's  
8 simple adenocarcinoma?  
9 A Well, I don't want to play the  
10 role of the pathologist here. I think this is  
11 getting a little bit beyond my expertise. I  
12 have a feeling about it, but I'm certain that I  
13 wouldn't testify as an expert to the answer to  
14 that question.  
15 MR. PIUZE: Okay. Didn't we hear  
16 a lot about that this morning, Ms. Williams?  
17 MS. WILLIAMS: Yes, we did.  
18 BY MR. PIUZE:  
19 Q It says here that -- here, meaning  
20 the expert wants designation that Arnold &  
21 Porter, Ms. William's law firm --  
22 A Uh-huh.  
23 Q -- representing Phillip Morris  
24 gave me. It says, "Dr. Julien is expected to  
25 testify generally regarding his practice,

1 including the diagnostic methods and techniques  
2 used by radiologists." What does that mean,  
3 that you take X-rays and you take scans?  
4 A Well, it has to do with my  
5 expertise as an interpreter of those images.  
6 Q Okay. Have you told me about your  
7 expertise as an interpreter of those images?  
8 A Have I told you my expertise, you  
9 mean by background, my training?  
10 Q I'm just using your term  
11 A I'm not sure of the question. I  
12 mean, would you please rephrase the question.  
13 Q Sure. I'm looking at what they  
14 said, "methods and techniques used by  
15 radiologists," and I'm thinking, "What the heck  
16 does that mean does that mean, that  
17 radiologists' methods and techniques in looking  
18 at films, isn't that what radiologists do?"  
19 A No. That's part of what they do.  
20 They also direct to the images taken what is  
21 the test that is likely to give the highest  
22 diagnostic yield, and so we truly guide  
23 clinicians into a direction towards making the  
24 correct diagnosis.  
25 Q Okay. Is that an issue in this

1 case?  
2 A No.  
3 Q "He is expected to testify  
4 concerning his review of Mr. Boekin's radiology  
5 and radiological diagnosis, staging, treatment,  
6 and etiology of Mr. Boekin's medical  
7 condition." Let's just break it up. "He is  
8 expected to testify concerning his review of  
9 Mr. Boekin's radiology and radiological  
10 diagnosis." Have you told me all of your  
11 opinions on that?  
12 A Yes.  
13 Q "Staging," have you told me all of  
14 your opinions on that?  
15 A No. We have -- we have not talked  
16 much about the staging.  
17 Q Tell me your opinion.  
18 A Well, the CT scan suggests that  
19 this is a -- that this is a Stage 1-A lung  
20 cancer at the initial presentation with one  
21 exception, and that is there is a borderline  
22 enlarged lymph node in the pericardial lymph  
23 node chain on the right side of the chest, and  
24 if that was -- if that was definite, then that  
25 would be a significant change in the -- in the

1 staging.

2 Q To what?

3 A To at least a 3-A if not, a -- a  
4 4, but at least a 3-A lung cancer. However, we  
5 know from the surgery, although he was  
6 diagnosed initially as a -- as a 3-A lung  
7 cancer, that he had positive higher end  
8 mediastina nodes which would make him a 4.

9 The Santa Monica scans show the  
10 lymph nodes didn't get larger, didn't get any  
11 larger. They were borderline enlarged. They  
12 didn't get any larger. They were not PET  
13 positive, and I think more likely than not,  
14 they were not significant. So his original  
15 presentation was that of a Stage 3-A lung  
16 cancer based on the pathology the surgery and  
17 final pathology, not on the final CT scans.

18 Q Is that the entirety of your  
19 opinion, staging-wise?

20 A Yes, except that he eventually  
21 developed some metastatic disease, became a  
22 Stage 4. But that was not the original  
23 presentation.

24 Q Back to the expert witness  
25 disclosure. "He is expected to testify

1 concerning Mr. Boekin's treatment." You don't  
2 have any opinions on his treatment, do you?

3 A Only the radiology related issues  
4 in regard to his treatment.

5 Q Well, what are those?

6 A Just that his -- that the  
7 interpretation of the radiology scans, chest  
8 X-rays, seem to be appropriate.

9 Q Don't forget this isn't a  
10 malpractice case now.

11 A No, I understand that.

12 Q Right.

13 A But other than that, I wouldn't be  
14 discussing any issues with regards to  
15 treatment.

16 Q Okay. And last, "he is expected  
17 to testify concerning Mr. Boekin's etiology."  
18 So what, if any, opinions do you hold regarding  
19 etiology?

20 A Well, the -- while if you look at  
21 my early deposition that I quoted from Santa  
22 Barbara, I very well came out with a statement  
23 in that that there's no question that smoking  
24 is related to lung cancer. But of all the  
25 cancers, primary cancers in the lung, the one

1 that seems to have the least likely association  
2 with smoking is bronchoalveolar cell. But I  
3 don't -- I mean, that's my opinion from  
4 multiple conferences and readings over a long  
5 period of time. Whether I'm going to be asked  
6 to be -- which I don't suspect I will be asked  
7 to be an expert -- giving a definitive opinion  
8 in that, but that certainly is my general  
9 opinion from my years of practice involving  
10 chest radiology in which these issues have been  
11 discussed at multiple, multiple conferences.

12 Q But I didn't hear an opinion yet.

13 A Well, my opinion is that of all  
14 the lung cancers, the one that's least likely  
15 to be associated with smoking is  
16 bronchoalveolar cell.

17 Q Okay. So that's part of an  
18 opinion I think. Is that as far as the opinion  
19 goes, least likely?

20 A Yes.

21 Q Well, let me give you a bad  
22 analogy to start off this area of questioning.

23 I'm not going to give you that  
24 analogy.

25 Least likely. If you were

1 choosing between a 99 percent, 98 percent and a  
2 97 likelihood, you might point me at the least  
3 likely, but I wouldn't really care because once  
4 you get that high, the likelihood is so high,  
5 that I personally wouldn't care. Can you  
6 quantify any of these likelihoods?

7           And I don't want you guessing  
8 either. If you're not going to do that, tell  
9 me so, and we're done. But if you're going to  
10 do that, tell me so.

11           A       I don't have to guess, but  
12 generally speaking, it has been my opinion over  
13 a while since I've been involved in this  
14 area --

15           Q       Which area?

16           A       Chest imaging -- that if we take  
17 bronchoalveolar cell carcinoma and divide it  
18 into -- in terms of etiology, we're talking  
19 about, and we don't have any disputes -- it's  
20 clearly a bronchoalveolar cell carcinoma, and  
21 you look at a history of patients with  
22 bronchoalveolar cell carcinoma vis-a-vis  
23 smoking, minimal smoking or non-smoking, and we  
24 quantify the definite smokers as patients who  
25 have had, um, 10 pack years or more of smoking,

1 meaning one pack a day for 10 years --  
2 Q You came close to qualifying,  
3 didn't you, you personally?  
4 A I personally probably did come  
5 close to qualifying -- pretty close. I don't  
6 think I was quite there.  
7 Q On the cusp?  
8 A On the cusp. I don't want to be  
9 on anybody's cusp.  
10 Q I apologize for interrupting.  
11 Okay. 10 pack years indicates a definite  
12 smoker, correct?  
13 A 10 pack years is a definite smoker  
14 in most risk series, in other words, the  
15 analysis of most patients who are defined as at  
16 risk for developing smoking related lung  
17 cancer. And you say that the patients who are  
18 very minimal smokers are those smokers that are  
19 occasional smokers, less than a pack a day, and  
20 less than five pack years. And then there are  
21 non-smokers, truly non-smokers.  
22 And if you look at bronchoalveolar  
23 cell carcinoma and how it breaks down into  
24 those groups, it turns out about a third of  
25 patients are non-smokers, about a third have

1 had some smoking history, but by no means will  
2 be defined as the risk pool related to smoking,  
3 and about a third are smokers. And that's  
4 different than the breakdown of other forms of  
5 cancer. Whether it's adeno, whether it's  
6 squamouscell, whether it's small cell, whether  
7 it's undifferentiated carcinoma, the incidence  
8 of smoking in the histories of patients is  
9 significantly higher than that.

10 Now, all that means is that we  
11 have to look at this cancer, that is  
12 bronchoalveolar cell, to see if it has maybe a  
13 different entity, that it may be a different  
14 etiology. Maybe it's viral-related. Maybe it  
15 is related to some damage in the lung that  
16 produces a scar, and that scar leads to a  
17 change in the cell lining of an airway where a  
18 new population of cells develop and this  
19 population of cells takes over independently of  
20 the normal population of cells and doubles,  
21 doubles again, doubles again. It becomes  
22 totally independent of the normal responses of  
23 a cell and therefore is a malignant process.  
24 And that stimulus came all the way back before  
25 from some damage to the lungs that we may never

1 find out about. But that probably plays a very  
2 strong role in the development of these  
3 bronchoalveolar cell carcinomas.  
4           Anything more than that -- I mean,  
5 these are my general feelings about etiology.  
6 For example, for this tumor, it's more likely  
7 than not that it is not smoking related. But  
8 are there some patients in which it seems to be  
9 smoking related? Yes. But it's more likely  
10 than not to be not smoking related, and again,  
11 the significance of this is it really does seem  
12 to be different than the other lung cancers and  
13 does suggest a difference in etiology in many  
14 of these -- and, in fact, in the majority of  
15 these bronchoalveolar cell carcinomas.  
16           Q       End of statement?  
17           A       I think so.  
18           Q       That's a generic statement. Do  
19 you want to say that about Mr. Boekin?  
20           A       Well, I certainly can say that  
21 about Mr. Boekin. I mean, there's no reason  
22 why this would change if his tumor is a  
23 bronchoalveolar cell carcinoma, and in the  
24 medical reports that I have, that the original  
25 pathology -- the final pathology at Cedars

1 suggested -- I think it was referred to as a  
2 papillary adenocarcinoma. There it was some  
3 statement that in the frozen stage, that it was  
4 a bronchoalveolar cell carcinoma, and I don't  
5 know.

6 I'm not a pathology expert. So I  
7 assume that you have pathologists that are  
8 offering definitive opinions on both sides of  
9 what this tumor actually is, and all I can do  
10 is to address the radiology issues as I have  
11 for a while now, saying that it's certainly  
12 consistent with a bronchoalveolar cell  
13 carcinoma.

14 Q Among three other things?

15 A Among three -- among two other  
16 possibilities here.

17 Q State them again at this point in  
18 the record so we're sure that you remember what  
19 you're saying?

20 A Squamouscell carcinoma and  
21 adenocarcinoma.

22 Q You started to say something about  
23 the path diagnosis or path reports at Cedars,  
24 and it seemed to me that you went off on a  
25 slight tangent. Now, maybe I'm wrong, but

1 didn't you start saying something about the  
2 final diagnosis -- the final pathological  
3 diagnosis?  
4 A Well, in the records, the final  
5 report that was signed off at Cedars, at least  
6 the one I saw, said a papillary adenocarcinoma.  
7 Q Well, let's just assume for the  
8 sake of argument that that's true -- let's not  
9 assume that.  
10 Do you know the person that signed  
11 off on that?  
12 A Yes, I do.  
13 Q Who is that?  
14 A Steven Geller.  
15 Q Who is that?  
16 A Steve is -- head of pathology at  
17 Cedars.  
18 Q Do you know him personally?  
19 A Yes, I do.  
20 Q He's competent?  
21 A Yes.  
22 Q He's competent? He's an excellent  
23 doctor, is he not?  
24 A I would have no reason to doubt  
25 his competency, absolutely not.

1 Q You better not because he knows  
2 where you park your car?  
3 A He knows where I park my car.  
4 Q Okay. If he's right, and that's  
5 the diagnosis, then what you have to tell me  
6 about etiology here is not applicable, correct?  
7 A Well, if he's right about the  
8 diagnosis, then it changes some of the  
9 statistics as far as the etiology in terms of  
10 the incidence -- the relationship with smoking.  
11 It doesn't say that all patients who have  
12 adenocarcinoma are -- have their adenocarcinoma  
13 on the basis of a smoking relationship. As a  
14 matter of fact, there are some patients that I  
15 see with adenocarcinoma in the lung that seem  
16 to have no history of smoking.  
17 Q Right.  
18 A It only suggest that it's more  
19 likely than not that in this situation it -- it  
20 may be smoking related.  
21 Q This situation, meaning  
22 Mr. Boekin?  
23 A Meaning Mr. Boekin.  
24 Q And you don't mean maybe, you mean  
25 more likely than not smoking related?

1           A       It would not surprise me at all if  
2 it were smoking related, but the difference  
3 is -- a key difference in terms of when you  
4 look at the background in terms of whether it's  
5 an adeno, whether it's a bronchoalveolar cell.  
6 Neither is 100 percent related to smoking by  
7 any means.

8           Q       What is?  
9           MS. WILLIAMS:  Objection.  Assumes  
10 facts not in evidence.

11           MR. PIUZE:  It may.  We're about  
12 to find out.

13           THE WITNESS:  Well, I don't  
14 remember seeing a case of either a small cell  
15 or squamouscell in a non-smoker.

16 BY MR. PIUZE:

17           Q       You're not --

18           A       But I'd have to research that in  
19 more detail than that, but I can't remember  
20 seeing it in a non-smoker.

21           Q       I think that's the second time  
22 that Ms. Williams and I heard that today.

23                    Right?

24           MS. WILLIAMS:  I have to check the  
25 record.

1 BY MR. PIUZE:  
2 Q Anyway, if Dr, Geller was correct  
3 in his path reports, what, if any opinion, do  
4 you have now, regarding etiology?  
5 A Well, I've given you my opinion as  
6 far as bronchoalveolar cell goes. As far as  
7 adeno carcinomas go, if it is a  
8 non-bronchoalveolar cell adenocarcinoma, then  
9 the likelihood of a smoking relationship  
10 particularly in men, is definitely higher than  
11 we see in the bronchoalveolar cell situation.  
12 Q How high?  
13 A Um, I think -- it is the majority  
14 of the men who have adenocarcinoma have it  
15 related to smoking.  
16 Q But --  
17 A But it's not merely the  
18 relationship that we see in bronchoalveolar  
19 cell.  
20 Q You said as part -- as -- and on  
21 entry into your last answer -- well, I forget  
22 the exact words, so we're going to have the  
23 court reporter tell us because I know she's  
24 been paying attention.  
25 (The record was read by the

1 reporter as follows: "Well, I've given  
2 you my opinion as far as bronchoalveolar  
3 cell goes. As far as adeno carcinomas go,  
4 if it is a non-bronchoalveolar cell  
5 adenocarcinoma, then the likelihood of a  
6 smoking relationship particularly in men,  
7 is definitely higher than we see in the  
8 bronchoalveolar cell situation.")

9 MR. PIUZE: Thank you, stop.

10 Q Your phrase, "if it is non BAC  
11 adeno" --

12 A Correct.

13 Q -- what if it is -- what is  
14 non-BAC adeno versus -- as opposed to what, a  
15 mixture of BAC and adeno?

16 A No, as opposed to what people  
17 refer to as a subclass of adeno, meaning BAC.  
18 So I want to be very specific here so we're not  
19 confusing the histologic terms here. So that's  
20 why I use the term -- I'm trying to ensure that  
21 I'm not being confused in mixing histologic  
22 terms.

23 We're talking about an adeno and a  
24 non -- and a BAC, and even though most people  
25 feel that a BAC is truly a subcategory of

1 adeno, I want to make sure I'm speaking about  
2 them separately, distinctly, separately.

3 Q Can't you mix them together?

4 MS. WILLIAMS: Objection. Vague  
5 and ambiguous.

6 THE WITNESS: I don't understand  
7 what you mean by that.

8 BY MR. PIUZE:

9 Q Can't you have adenocarcinoma  
10 that's part BAC, partially BAC, partially  
11 something else?

12 A Well I have seen that where  
13 there's a mixture.

14 Q Okay. What if there is a mixture,  
15 what happens to your -- for instance, not that  
16 I'd make anything like that up, but because I  
17 was paying attention this morning when another  
18 expert was testifying, what if there was an  
19 adenocarcinoma that had some characteristics of  
20 BAC and some characteristics of papillary all  
21 like in a brew, what does that do for your  
22 etiological opinions?

23 A Well, I think it definitely raises  
24 the question as to whether or not this tumor is  
25 smoking related, and it means that we should

1 not automatically jump into the conclusion that  
2 it's smoking related.

3 As a matter of fact, if there are  
4 some people who feel -- I've heard a number of  
5 lectures over the years of people who feel that  
6 an adenocarcinoma, in general, is open to  
7 question as to whether or not it's smoking  
8 related. I don't have enough personal  
9 experience as a pathologist or as a  
10 statistician to be able to really get a handle  
11 on that. But I do know that it's -- it is open  
12 to controversy there as opposed to a  
13 bronchoalveolar cell, which seems to be more  
14 solidly against smoking etiology in the  
15 majority of their cases.

16 Q If this tumor was a mixed brew of  
17 adenocarcinoma, BAC papillary -- and again I'm  
18 not making that up I think I heard that today  
19 as a possibility -- is your opinion  
20 etiologically speaking that you can't tell  
21 whether it's related to smoking, that it's more  
22 likely than not related to smoking, that it's  
23 less likely than not related to smoking?

24 A I think it's it still raises the  
25 question as to whether or not this is smoking

1 related. It's still opened up a huge question  
2 mark in terms of the etiology.

3 Q When you say "it still," "it,"  
4 being the BAC?

5 A Yes.

6 Q Okay. And the question where do  
7 you fall, is it an open-ended question on which  
8 you have no opinion, or do you have an opinion?

9 A My opinion is that you can't be  
10 sure that it's smoking related. It may be.

11 Q Okay.

12 A But you cannot be sure that it is  
13 smoking related.

14 Q Earlier in the deposition at some  
15 point when you were describing your early  
16 interactions with the lawyers in this case, you  
17 said something to the effect that this was  
18 before I knew there was a pathology question or  
19 before I knew there was a pathology  
20 controversy. That's not meant to be a quote,  
21 but that was a thought that I believe you  
22 expressed. Do you recall saying something like  
23 that?

24 A Yes.

25 Q What was it that brought to your

1 attention the pathology question or  
2 controversy, please?

3 A Well, I believe I was asked the  
4 question whether or not the radiology findings  
5 are consistent after I described them, and I  
6 discussed my feelings about the findings and I  
7 was asked do I feel that these radiology  
8 findings are consistent with bronchoalveolar  
9 cell carcinoma, or is there anything about  
10 this, meaning the radiology findings, that  
11 would be inconsistent with bronchoalveolar cell  
12 carcinoma.

13 Q And you said, "Well, where does  
14 BAC fit into this particular picture."

15 MS. WILLIAMS: Objection --

16 THE WITNESS: No, I don't think  
17 I -- I don't remember challenging the question  
18 with that at all.

19 BY MR. PIUZE:

20 Q Well, until the lawyer said  
21 something like, "Does it match up with BAC,"  
22 you'd never seen BAC mentioned in this case,  
23 right?

24 MS. WILLIAMS: Objection. Lacks  
25 foundation.

1 THE WITNESS: Well, I knew that  
2 there was a -- there was a question of BAC, I  
3 believe, on the frozen section that was taken  
4 at the time of the original surgery by  
5 Dr. McKenna, um, so I knew that there was some  
6 controversy over that. But I was really paying  
7 more attention at that time to the radiology  
8 findings, what were the radiology findings,  
9 what did I feel about the radiology findings.  
10 And then I was asked "was there anything on the  
11 radiology findings that was consistent with  
12 bronchoalveolar cell carcinoma?"

13 BY MR. PIUZE:

14 Q Well, before you were asked that  
15 question, what did you think you were doing?  
16 What did you think you were looking for?

17 A Well, honestly what I thought I  
18 was looking for originally was whether or not  
19 my feeling was that this was consistent with a  
20 primarily cancer of the lung, as I had dealt  
21 with in some of the other cases.

22 Q Okay. And up until the point  
23 where this question is posed to you, what was  
24 your answer?

25 A My answer was that this -- that I

1 would be very surprised if this was not a  
2 primary carcinoma of the lung, and it's most  
3 consistent with being a primary carcinoma of  
4 the lung.

5 Q And then what happened to change  
6 that, to change that opinion or modify that  
7 opinion?

8 A Nothing changed that opinion.

9 MS. WILLIAMS: Objection. Assumes  
10 facts not in evidence.

11 BY MR. PIUZE:

12 Q Okay. You thought that was as far  
13 as your opinion was going to go?

14 MS. WILLIAMS: Objection. Lacks  
15 foundation.

16 THE WITNESS: I didn't have an  
17 opinion that that was going to be the only  
18 opinion, that that was going to be asked for,  
19 or I was going to be asked for more detail. As  
20 it came out, I was asked a bit more detail  
21 about the findings, what did I think about the  
22 characteristics of the findings and is this  
23 consistent or inconsistent with BAC.

24 BY MR. PIUZE:

25 Q You had to know before whoever

1 asked you the question, "Is this consistent or  
2 inconsistent," where this was all going?

3 MS. WILLIAMS: Objection. Lacks  
4 foundation.

5 BY MR. PIUZE:

6 Q You had to know going in that the  
7 reason you were in the case was to somehow fit  
8 into a larger picture of is it a coincidence  
9 that this guy who had 80 pack years of  
10 cigarettes has lung cancer.

11 A I'm sorry. I don't follow.

12 Q When Mitsy said, "Let me introduce  
13 you to some friends," or whatever words it was  
14 she said that led you to Chris and a tobacco  
15 client, you had to know that the ultimate  
16 bottom line was going to be is it a coincidence  
17 that he has lung cancer and smokes a lot or is  
18 there a cause and effect between lung cancer  
19 and smoking.

20 MS. WILLIAMS: Objection. Lacks  
21 foundation.

22 THE WITNESS: I don't -- I did not  
23 think that they would ask me that question  
24 because I know my opinion already about that.  
25 I've expressed it in a prior deposition. I've

1 expressed it in numerous lectures that I've  
2 given over the years. I've expressed it in  
3 various things that I've done over the years.  
4 They didn't -- I assume if they knew me at all  
5 and they've done some investigation about me,  
6 they wouldn't ask me that question because they  
7 know the answer to that question.

8 BY MR. PIUZE:

9 Q More than you can imagine.

10 A Well, that's fine.

11 Q They may even arrange for a  
12 different parking place for Dr. Geller. But  
13 the jury is out on that.

14 When did it change here for  
15 you -- you know now that your role is to fit  
16 into a larger picture, is it a coincidence that  
17 he has 80 pack years of cigarettes and has lung  
18 cancer, right?

19 MS. WILLIAMS: Objection. Lacks  
20 foundation.

21 THE WITNESS: As far as my role is  
22 to discuss the radiology findings and do -- is  
23 this consistent or inconsistent with  
24 bronchoalveolar cell carcinoma.

25 BY MR. PIUZE:

1 Q You know where that goes, though.  
2 You've already stated for the record. You've  
3 already stated it relates to cancer, right?

4 A Right.

5 MS. WILLIAMS: Objection.  
6 Argumentative.

7 BY MR. PIUZE:

8 Q When did you figure out that  
9 that's where your testimony is going to lead,  
10 namely, is this cancer related to smoking?  
11 Where along the line did you pick this up?

12 MS. WILLIAMS: Objection. Vague  
13 and ambiguous.

14 THE WITNESS: Well, I always made  
15 the assumption I would never be the primary  
16 expert dealing with that specific question,  
17 that I would be simply addressing the issue of  
18 whether or not the radiology is consistent with  
19 bronchoalveolar cell carcinoma and generally  
20 what are my feelings about -- if it is  
21 bronchoalveolar cell carcinoma, the etiology as  
22 you have asked me about tonight, and that would  
23 be the sum total of my expertise involved in  
24 this case. It would be discussed in the  
25 radiology findings. It would be discussed in

1 the radiology findings related to the pathology  
2 and it would be discussed if asked about  
3 etiology.

4 Q You've said in this deposition,  
5 acknowledged in this deposition, the bottom  
6 line is going to be whether or not the smoking  
7 in this case is related to this cancer, have  
8 you not?

9 MS. WILLIAMS: Objection.

10 Misstates his testimony.

11 BY MR. PIUZE:

12 Q Maybe I misheard you.

13 A I don't think that that is exactly  
14 what I said, but by any means -- nor do I think  
15 that that's necessarily what I'm going to be  
16 discussing here at all.

17 Q No, I didn't say --

18 A They have lots of other experts.

19 Q I didn't say you were going to be  
20 discussing that -- I guess we'll find out  
21 whether you are or not. That's not what I  
22 asked. I know you're a piece of a larger  
23 puzzle and you know that too and you know that  
24 your opinions fit into a larger puzzle and you  
25 know there are pathologists in this case.

1 You've already said that -- do you know who the  
2 other pathologist is by the way?  
3 A I do not.  
4 Q Okay. Do you know who any of  
5 their experts are?  
6 A No.  
7 Q Have you asked?  
8 A No.  
9 Q Have you been told?  
10 A No.  
11 Q Okay. Do you know who any of my  
12 experts are?  
13 A No.  
14 Q Have you asked?  
15 A No.  
16 Q Okay. When did you figure out  
17 that your testimony was going to be used in  
18 some respects by them on the issue of is this  
19 man's smoking related or not related to his  
20 cancer?  
21 MS. WILLIAMS: Objection. Lacks  
22 foundation. Asked and answered 15 times.  
23 MR. PIUZE: No. Asked 15,  
24 answered 0.  
25 MS. WILLIAMS: I think he's given

1 you an answer.  
2 THE WITNESS: Would you repeat the  
3 question.  
4 MR. PIUZE: No. But she will.  
5 (The record was read by the  
6 reporter as follows: "Okay. When did you  
7 figure out that your testimony was going  
8 to be used in some respects by them on the  
9 issue of is this man's smoking related or  
10 not related to his cancer?")  
11 MS. WILLIAMS: Same objections.  
12 THE WITNESS: Well, I never was  
13 certain that I would ever be dealing with those  
14 specific issues as opposed to the issue of the  
15 radiology correlation with the radiology and  
16 pathology and make some general statements as  
17 far as if it is a proper bronchoalveolar cell  
18 carcinoma, do you have a feeling or a relation  
19 to his smoking and that would be basically the  
20 sum total of any involvement in this situation.  
21 Q I don't mean this personally,  
22 Ms. Reporter, but if this was -- if this  
23 transcript was absolutely 100 percent word for  
24 word verbatim, I get you a small fortune that  
25 someplace along tonight you said words to the

1 effect that the lawyers came to visit you,  
2 probably on visit number two -- and we're  
3 talking about these lawyers -- and gave you  
4 some new information about the pathology that  
5 you had not heard before.

6 MS. WILLIAMS: Objection --

7 BY MR. PIUZE:

8 Q Did you say that?

9 MS. WILLIAMS: Lacks foundation,  
10 mischaracterizes his testimony.

11 THE WITNESS: I believe that it --  
12 it was at that time that the issue of  
13 bronchoalveolar cell carcinoma came up,  
14 although I knew before I met with them that  
15 there was some -- there seemed to be some  
16 controversy based on the medical records.

17 BY MR. PIUZE:

18 Q How did it come up at that meeting  
19 with these three lawyers?

20 MS. WILLIAMS: Objection. Lacks  
21 foundation, assumes facts not in evidence.

22 THE WITNESS: I was asked if the  
23 radiology findings were consistent or  
24 inconsistent with bronchoalveolar sell  
25 carcinoma and if this was bronchoalveolar cell

1 carcinoma, would I be surprised with these  
2 radiology findings. And that's -- that's how  
3 it came up.  
4 BY MR. PIUZE:  
5 Q That's the extent of it?  
6 A Yes.  
7 Q Never to rear it's head again?  
8 A Not until I gave my opinion  
9 tonight in regards to what my feelings are  
10 about the imaging of this -- in this  
11 individual.  
12 Q What you told them were your  
13 feelings about the imaging in this individual  
14 obviously?  
15 A Yes.  
16 MS. WILLIAMS: Objection. Lacks  
17 foundation.  
18 BY MR. PIUZE:  
19 Q Okay. Have you -- you obviously  
20 haven't talked to Dr. Geller about this?  
21 A No, no.  
22 Q You say that with a facial  
23 expression that the record can't pick up, but  
24 why did you use that facial expression?  
25 A Well, I wouldn't deal with this

1 with him because we're both very busy people,  
2 and I wouldn't bother him with any question  
3 about this. He wrote a report. I assume  
4 that's what he feels about this lesion.

5 Q What does he feel about the  
6 lesion?

7 MS. WILLIAMS: Objection. Calls  
8 for speculation.

9 THE WITNESS: His official report  
10 is that it was a papillary form of  
11 adenocarcinoma in the lung.

12 BY MR. PIUZE:

13 Q Okay. Would you like to go?

14 A If you'd like me to, certainly.

15 Q No. That was an easy question.  
16 Would you like to go?

17 A Sure.

18 Q I know you could say that. You  
19 can go.

20 I've got no further questions. I  
21 want to thank you very much. It's 9:00  
22 o'clock. We started at 6:30. It's two and a  
23 half hours. I think I paid him up front for an  
24 hour. That's one and a half hours.

25 THE WITNESS: I haven't got any

1 money.  
2 MR. PIUZE: I know I sent them a  
3 check.  
4 Anyway, here's the stipulation.  
5 You can go.  
6 The court reporter can be relieved  
7 of her duty to maintain the original under the  
8 Code of Civil Procedure.  
9 She will send the original of this  
10 deposition to whom, Ms. Williams?  
11 MS. WILLIAMS: To our offices.  
12 MR. PIUZE: To Arnold & Porter.  
13 And if there are any changes, additions  
14 deletions or corrections to the transcript, Ms.  
15 Williams will notify me within two weeks of her  
16 receipt. If not, I can use a -- my copy as if  
17 it's a signed original.  
18 MS. WILLIAMS: So stipulated.  
19 THE WITNESS: I have a right to  
20 review that and make any corrections?  
21 MS. WILLIAMS: Yes. 15 days from  
22 the time that I get it to you.  
23 THE WITNESS: Okay.  
24 MR. PIUZE: Two weeks from your  
25 receipts-- that's what you just agreed to --

1       which is less than 15 days.  
2                    MS. WILLIAMS: I think we should  
3 do 15 days since that's been the standard so  
4 far.  
5                    MR. PIUZE: Excuse me?  
6                    MS. WILLIAMS: 15 days has been  
7 the standard. That's what we just said this  
8 morning.  
9                    MR. PIUZE: Okay.  
10                   (Whereupon, at 9:15 p.m., the  
11 deposition of Peter Julien, M.D. was  
12 concluded.)  
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I, PETER J. JULIEN, M D., do hereby declare under penalty of perjury that I have read the foregoing transcript; that I have made any such corrections as appear noted, in ink, initialed by me, or attached hereto; that my testimony as contained herein, as corrected, is true and correct.

EXECUTED this \_\_\_\_ day  
of \_\_\_\_\_, 2001, at  
\_\_\_\_\_, \_\_\_\_\_.  
(City) (State)

\_\_\_\_\_  
PETER J. JULIEN, M D.

1 STATE OF CALIFORNIA )  
 : ss.  
2 COUNTY OF LOS ANGELES )  
3

4 I, the undersigned, a Certified  
5 Shorthand Reporter of the State of California, do  
6 hereby certify:

7 That the foregoing proceedings were  
8 taken before me at the time and place herein set  
9 forth; that any witnesses in the foregoing  
10 proceedings, prior to testifying, were placed  
11 under oath; that a verbatim record of the  
12 proceedings was made by me using machine  
13 shorthand which was thereafter transcribed under  
14 my direction; further, that the foregoing is an  
15 accurate transcription thereof.

16 I further certify that I am neither  
17 financially interested in the action nor a  
18 relative or employee of any attorney of any of  
19 the parties.

20 IN WITNESS WHEREOF, I have this date  
21 subscribed my name.

22  
23 Dated: March 18, 2001

24  
25 \_\_\_\_\_  
VIVIAN C. DERNBURG  
CSR No. 11339