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

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

Deposition of BERNARD WEINTRAUB,
M D., taken on behalf of the Plaintiff,
at 11755 Wilshire Boulevard, Suite 1170,
Los Angeles, California, commencing at
11:35 a.m., on Friday, March 16, 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.: 0016-VCD

1 APPEARANCES:

2 For the Plaintiff:

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6

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- and -

12

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I N D E X

WITNESS: BERNARD WEINTRAUB, M D.

Examination by:	Page
Mr. Piuze	5

E X H I B I T S

1 - Curriculum vitae of Bernard Weintraub, M D. ; 4 pages	6
2 - Handwritten list of articles read by Bernard Weintraub, M D. for the Boekin case; 4 pages	54
3 - Photocopy of staging criteria for lung cancer; 1 page	88
4 - Handwritten record of time spent on Boekin case by Bernard Weintraub, M D. ; 1 page	92

INSTRUCTION NOT TO ANSWER

PAGE	LINE
13	24
15	15
15	22

MARKED QUESTIONS
(None)

INFORMATION REQUESTED
(None)

1 Los Angeles, California
2 Friday, March 16, 2001
3 11:35 a.m
4

5 BERNARD WEINTRAUB, 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 Good morning.
13 A Good morning.
14 Q What's your name?
15 A Bernard Weintraub.
16 Q Your occupation?
17 A I'm a physician.
18 Q What kind?
19 A I'm a pulmonologist.
20 Q Do you have a C.V. with you?
21 A Yes.
22 Q Can I see it.
23 Up to date?
24 A Yes.
25 MR. PIUZE: This is No. 1 here.

1 (The document referred to was
2 marked by the C. S. R. as Plaintiff's
3 Exhibit 1 for identification and was
4 attached to and made part of this
5 deposition.)
6 BY MR. PIUZE:
7 Q Who are the two people sitting on
8 the side of the table with you?
9 A Cindy and Chris.
10 Q Cindy and what?
11 A Cindy Williams and Chris Johnson.
12 Q Okay. How do you know Cindy?
13 A I know her through my interactions
14 regarding this case.
15 Q Well, that's what I want to know,
16 about your interactions. So how do you know
17 her? How did you get introduced to her?
18 A Can you be more specific?
19 Q No, that's pretty specific. How
20 did you get introduced to her? Did Joe Smith
21 say this is Cindy or did Mitsy Dobson say this
22 is Cindy or how did you get introduced to her?
23 A I was introduced to her by Chris.
24 Q Okay. When?
25 A Approximately two months ago, I

1 believe.
2 Q Who does Cindy work for?
3 A I'm not sure which firm she
4 represents.
5 Q Who does Chris work for?
6 A He worked for Shook Hardy & Bacon.
7 Q Who does Shook Hardy & Bacon work
8 for?
9 MS. WILLIAMS: Objection. Calls
10 for speculation.
11 THE WITNESS: I'm sure they work
12 for a lot of employers.
13 BY MR. PIUZE:
14 Q Well in this case, who do they
15 work for?
16 A They work for one or more of the
17 tobacco owe companies.
18 Q Which one?
19 A I'm not sure certain.
20 Q Do you know the name of this case?
21 A Could you be more specific.
22 Q This lawsuit -- do you know the
23 name of the lawsuit?
24 A The name of the lawsuit or the
25 name of the party involved.

1 Q Well, there are two parties. It's
2 A vs. B. Smith vs. Joan, someone vs. someone.
3 Do you know the name of this case?
4 A It's Boekin vs. -- Lorillard.
5 Q Okay. How do you know Chris?
6 A I know Chris because he works with
7 Shook, Hardy & Bacon, and has asked me to
8 consult on this case.
9 Q How were you introduced to Chris?
10 MS. WILLIAMS: Objection. Lacks
11 foundation.
12 THE WITNESS: I was introduced to
13 him at a meeting some number of months ago.
14 BY MR. PIUZE:
15 Q Okay. Who introduced you to him?
16 A Another attorney who was present
17 at the time.
18 Q And that attorney had a name?
19 A Correct, which I don't recall at
20 the moment.
21 Q A woman?
22 A No.
23 Q Okay. What firm was the other
24 attorney from?
25 A Shook Hardy & Bacon .

1 Q Okay. Curtis, right?
2 MS. WILLIAMS: Objection. Lacks
3 foundation.
4 THE WITNESS: That would be
5 correct.
6 BY MR. PIUZE:
7 Q What?
8 A That is correct.
9 Q Curtis Lemay?
10 A I believe that's correct.
11 Q Okay. Two for two.
12 How did you get in touch with
13 Curtis.
14 MS. WILLIAMS: Objection. Lacks
15 foundation.
16 THE WITNESS: I'm sorry, repeat
17 the question, please.
18 BY MR. PIUZE:
19 Q How did you get in touch with
20 Curtis? How did you and Curtis hook up?
21 A I received a phone call at some
22 point.
23 Q From?
24 A From possibly Curtis or possibly
25 another party, and I can't recall at this

1 point.
2 Q Before this lawsuit involving my
3 client, Richard Boekin, had you ever had any
4 dealings with Shook, Hardy & Bacon before?
5 A Yes.
6 Q When?
7 A Last fall.
8 Q What?
9 A A case I was consulting on.
10 Q Tobacco case?
11 A Correct.
12 Q What was your role?
13 MS. WILLIAMS: Objection. Calls
14 for information protected by the attorney work
15 product.
16 MR. PIUZE: I don't think so.
17 MS. WILLIAMS: To the extent he
18 was not disclosed as an expert in that case.
19 BY MR. PIUZE:
20 Q Have you ever given a deposition
21 in a tobacco case before?
22 A No.
23 Q Have you ever given a deposition
24 before?
25 A Yes.

1 Q In what kind of case?
2 A In malpractice cases.
3 Q How many?
4 A Approximately five.
5 Q Do you remember for what side?
6 A Plaintiff and defense, depending
7 on the case.
8 Q Who's hired you from the plaintiff
9 side?
10 A Specifically, which attorneys?
11 Q Yeah.
12 A I don't remember the names of the
13 attorneys at this point.
14 Q The firms?
15 A Again, I don't recall the names of
16 the firms at this point.
17 Q Who's hired you from the defense
18 side?
19 A Kurtz, Feldman and Rubin.
20 Q Only?
21 A There was another case, and I
22 can't remember for that case who the attorney
23 was.
24 Q How many times have you consulted
25 in medical malpractice cases -- I'm not talking

1 about giving depos now, I'm talking about
2 consulting?
3 A Approximately six.
4 Q And in five out of those six
5 cases, you've given a deposition?
6 A Correct.
7 Q How many tobacco cases have you
8 consulted in or on?
9 A Including this one?
10 Q Yes.
11 A Two.
12 Q Okay. Shook, Hardy was your
13 sponsor in both?
14 MS. WILLIAMS: Objection. Vague
15 and ambiguous as to "sponsor."
16 BY MR. PIUZE:
17 Q Shook, Hardy hired you on both?
18 A I've consulted for them both
19 cases.
20 Q What was your role in the other
21 case?
22 A I acted as a consultant to review
23 records.
24 Q What was the bottom line?
25 MS. WILLIAMS: Objection. Calls

1 for information protected by the attorney work
2 product.
3 (Interruption in proceedings.)
4 (A discussion was held off the
5 record.)
6 BY MR. PIUZE:
7 Q Go ahead.
8 A I'm sorry, what was the question?
9 Q Well, I'm not sure because she was
10 objecting, she was talking, she was typing, and
11 you were looking at me, and I was
12 discombobulated. But we'll find out.
13 MR. PIUZE: Yeah, that same
14 objection, if the reporter wants to read that
15 back to you.
16 (The record was read by the
17 reporter as follows: "
18 THE WITNESS: Could you be more
19 specific.
20 BY MR. PIUZE:
21 Q Yes. Did the cancer get caused by
22 tobacco, is that it?
23 MS. WILLIAMS: Objection.
24 Instruct the witness not to answer.
25 MR. PIUZE: You can't instruct not

1 to answer for a non-client. First of all, you
2 don't have a privilege --
3 MS. WILLIAMS: I'm protecting the
4 privilege of my clients --
5 MR. PIUZE: Who are your clients?
6 MS. WILLIAMS: Phillip Morris.
7 BY MR. PIUZE:
8 Q Was Phillip Morris involved in the
9 other case?
10 A I don't recall at this point.
11 MR. PIUZE: So you can't do that.
12 That's B.S. You're pulling it out of the sky,
13 plus your client isn't Phillip Morris. He's
14 already told you the name of the case is
15 Lorillard.
16 MS. WILLIAMS: You know who my
17 client is.
18 MR. PIUZE: He told you it's
19 Lorillard.
20 MS. WILLIAMS: You know who my
21 client is. Don't be cute.
22 MR. PIUZE: I can't help it if I'm
23 cute. You don't have a right to do that. I
24 have an exact right to cross-examine this
25 witness for bias and prejudice, and if you

1 don't know the name -- there are 40,000 people
2 who are going to die. How are they ever going
3 to figure out which one they're consulting out.
4 MS. WILLIAMS: You don't have a
5 right to figure that out.
6 MR. PIUZE: I know we're close to
7 trial, and I know you're saying, "He's not
8 going to make a motion." But you're wrong.
9 You can't instruct him not to answer. He's not
10 your client. I can instruct him to do
11 anything.
12 Q Now, I want you to answer my
13 question. What was the bottom line of the case
14 whether or not tobacco caused lung cancer?
15 MS. WILLIAMS: My instruction
16 stands.
17 BY MR. PIUZE:
18 Q I'm telling you that she doesn't
19 have any right to be instructing you to do
20 anything, and I want you to answer my question,
21 Doctor, please.
22 MS. WILLIAMS: Same instruction.
23 BY MR. PIUZE:
24 Q Are you going to answer my
25 question?

1 A I've been instructed not to answer
2 the question.
3 Q By whom?
4 A Cindy.
5 Q So what? So she's instructing you
6 not to, and I'm instructing you to. Why do you
7 go for her? I'd be interested to explore this
8 under oath. Why are you listening to her,
9 cause she's paying you?
10 A No, because it feels appropriate
11 to.
12 Q It does? Well, I'll guess I'll
13 have to get around it. Tell you what
14 pulmonology feels like, cause I don't know
15 anything about it. So I wouldn't be so
16 presumptuous to tell you about it?
17 MS. WILLIAMS: Objection.
18 Argumentative.
19 BY MR. PIUZE:
20 Q How does it feel appropriate,
21 Doctor?
22 A I'm not sure what you're asking.
23 Q Well, you told me it feels
24 appropriate to do what she tells you to do. I
25 want to know why is that?

1 MS. WILLIAMS: Objection.
2 Argumentative.
3 BY MR. PIUZE:
4 Q Why?
5 A Because you appear to be somewhat
6 hostile.
7 Q Somewhat hostile.
8 That's what they say about the
9 Indians.
10 MS. WILLIAMS: Maybe they're
11 right.
12 BY MR. PIUZE:
13 Q Is that your answer?
14 A Yes.
15 Q Okay. You're probably right. But
16 you're not right not to answer the question.
17 Who introduced you to the Shook,
18 Hardy firm originally?
19 MS. WILLIAMS: Objection. Lacks
20 foundation.
21 THE WITNESS: I received a phone
22 call at some point in time and as I believe I
23 mentioned it may have been Curtis Lemay who
24 called me but I am not certain about that at
25 this point.

1 Q Now, I'm back earlier than that,
2 Curtis and Shook, Hardy. I want to know how
3 you got contacted from Shook, Hardy?
4 A That's correct.
5 Q Do you know who Mitsy Dobson is?
6 A Yes.
7 Q Do you know who she is?
8 A She's an attorney.
9 Q Who works for Bonne Bridges?
10 A Yes.
11 Q Who does med. mal.?
12 A That's correct.
13 Q Now that I put her name out here,
14 does that refresh your recollection that she
15 might have been the conduit between you and
16 Shook, Hardy?
17 MS. WILLIAMS: Objection. Lacks
18 foundation, assumes facts not in evidence.
19 THE WITNESS: I'm not certain.
20 BY MR. PIUZE:
21 Q Anyway, I'd like to hear about
22 your dealings with the lawyers in this case,
23 the Boekin case. Curtis was the first person
24 who called you and told you what?
25 A My recollection of the

1 conversation was that he asked or whoever
2 called me asked if I would be interested in
3 doing consulting work for their law firm
4 Q Okay. Did you ask what kind of
5 consulting work?
6 A Yes.
7 Q What did he tell you?
8 A He told me that they are a firm
9 who represents some of the tobacco companies in
10 tobacco litigation.
11 Q Sure. So what kinds of consulting
12 work did he tell you about.
13 A Generally, my recollection was it
14 was a brief conversation. He asked me if I was
15 interested in reviewing cases.
16 Q For what?
17 A For defense in tobacco companies.
18 Q What was your issue going to be?
19 What were you looking for?
20 MS. WILLIAMS: Objection. Assumes
21 facts not in evidence.
22 THE WITNESS: There was no
23 specific issue addressed in that conversation
24 as far as I can recall.
25 BY MR. PIUZE:

1 Q Okay. So what did you think you
2 were going to be looking at the records for?
3 A I assumed I would be looking at
4 the records for evidence of tobacco-related
5 disease or lack of evidence.
6 Q Okay. Did you feel you're
7 qualified to do that?
8 A Yes.
9 Q What makes you qualified to do
10 that?
11 A I'm a physician by training. I'm
12 a pulmonary specialist.
13 Q Okay.
14 A I think those are reasonable
15 qualifications.
16 Q Well, aside from litigation, here,
17 when in the real world do you ever get called
18 upon, if ever, in your day-to-day practice, to
19 determine whether or not a disease process
20 tobacco related?
21 A Could you rephrase that question
22 for me.
23 Q I could, but it's a pretty clear
24 question.
25 When you're not consulting with

1 tobacco companies, when in the real world in
2 your everyday practice do you ever get called
3 to render an opinion whether a disease process
4 is tobacco-related?
5 A Do you mean formally called upon?
6 Q Well, let's start with formally
7 called upon.
8 A Infrequently.
9 Q Well, what does that mean? Ever?
10 Never?
11 A Sometimes.
12 Q When?
13 A Sometimes patients ask.
14 Q What?
15 A They may ask whether smoking
16 caused their illness.
17 Q You mean, whether smoking caused
18 their lung cancer?
19 A Among others.
20 MS. WILLIAMS: Objection. Lacks
21 foundation.
22 BY MR. PIUZE:
23 Q What others?
24 A What others?
25 Q You said "among others." Your

1 phrase. "What others," emphysema?
2 A Correct.
3 Q What others?
4 A Chronic bronchitis.
5 Q What else?
6 A Heart disease.
7 Q That's far afield for a
8 pulmonologist, isn't it?
9 A No.
10 Q Okay. That's four. Anything
11 else?
12 A Peripheral vascular disease.
13 Q 5. I hope you remember these
14 because I'm not writing them down, and I'm
15 going to ask you about these.
16 Anything else?
17 A Other cancers.
18 Q That's 6. All of the above.
19 Let's go through them
20 How often has a patient of yours
21 with lung cancer said, "Doctor, is this a
22 tobacco-related illness?"
23 A Occasionally.
24 Q About how often? I'd like your
25 best estimate.

1 A That would be difficult for me to
2 quantify in any of those situations.
3 Q Okay. I'd like your best
4 estimate.
5 A I'm not sure I can give you an
6 estimate.
7 Q Would it fit in a bread box?
8 A I'm not sure what you're asking
9 me.
10 Q Is it less than 100?
11 A I don't know what the number is.
12 Q I'm asking for your best estimate.
13 I'm entitled to that best estimate. It may be
14 important to your testimony.
15 Has this happened less than 100
16 times?
17 A I would be guessing.
18 Q Has it happened more than 10
19 times?
20 A Yes.
21 Q More than 50 times?
22 A Yes.
23 Q More than 75 times?
24 A Probably.
25 Q More than 100 times?

1 A Probably.
2 Q More than 150 times?
3 A We're getting into the range of
4 more guesswork.
5 Q Between 150 and 100, is that
6 comfortable?
7 A I don't know specifically.
8 Q Less than 200?
9 A I think I'm giving you my best
10 answer.
11 Q Well, you haven't, yet you've told
12 me this probably happened more than 100 times.
13 Now, I want to put an upper parameter on it.
14 Was it less than 200?
15 MS. WILLIAMS: Objection. Asked
16 and answered. He's told you he's guessing at
17 this point.
18 BY MR. PIUZE:
19 Q Go ahead.
20 A As a guess, I'd say an upper
21 parameter of 3 to 400.
22 Q I don't want you to guess, though
23 I'm entitled to your best estimate here. I'm
24 not playing games. I've got other things to
25 do. I'm not trying to waste your time. I'm

1 entitled to your best estimate, and I don't
2 want you to guess.
3 A But I would be guessing at this
4 point. That's the problem that I have.
5 Q So the best estimate you can give
6 is it's something more than 100?
7 A I think that is my best answer.
8 Q And you can't put an upper limit,
9 correct?
10 A Yes.
11 Q So what has your answer been?
12 MS. WILLIAMS: Objection. Vague
13 and ambiguous.
14 THE WITNESS: I'm sorry?
15 BY MR. PIUZE:
16 Q The question was, "I've got lung
17 cancer, was it tobacco related?" What was your
18 answer?
19 MS. WILLIAMS: Objection. Vague
20 and ambiguous.
21 THE WITNESS: I would say, in
22 general, the answer was, yes.
23 BY MR. PIUZE:
24 Q Well, have you ever said no --
25 A Yes.

1 Q -- to a patient?
2 A Yes.
3 Q Can you picture that patient?
4 A More than one patient.
5 Q Okay. So you can picture who it
6 is, right?
7 A Specifically the name?
8 Q No, just picture, a face. I'm not
9 going to ask you a name. Can you picture a
10 face?
11 A Yes.
12 Q Okay. How many faces?
13 A Somewhere between 5 and 10.
14 Q So what I'm hearing is at an
15 absolute minimum, if 100 is the right number of
16 people that ask that question, 90 to 95 percent
17 of the people, you say to, "Yes, your lung
18 cancer is tobacco related"?
19 A That would be correct.
20 Q And if it turned out that the
21 upper limit would be 3 or 400, 98 percent would
22 be, "Yes, your cancer is tobacco related,"
23 correct?
24 MS. WILLIAMS: Objection. Vague
25 and ambiguous.

1 MR. PIUZE: No, just good math.
2 THE WITNESS: That is correct.
3 MR. PIUZE: That was doing it on
4 the fly.
5 Q Of it's 300 and you get 295 out of
6 300, we're talking about 99 percent. And if
7 it's 400 and you get 395 out of 400, we're
8 talking about more than 99 percent.
9 So, okay. Now, what about the
10 people with emphysema, how many people have
11 said to you, "Doctor, I've got emphysema. Is
12 my emphysema tobacco related?"
13 A I'm sorry. The question is how
14 many patients have asked?
15 Q Yeah.
16 A I don't know the exact number.
17 Some have; some haven't.
18 Q I'm sure. Does this have a
19 feeling of familiarity to it? Why don't you
20 give me your best estimate, range as to how
21 many people have asked you this, please.
22 A As a percentage, I would guess
23 probably 30 percent may have asked that
24 question.
25 Q Okay. Well, that means nothing to

1 me because, of course, I don't know how many
2 people you have treated with emphysema. How
3 many people have asked?
4 A I'm not sure.
5 Q Your best estimate, please.
6 A My best guess would be probably
7 somewhere between 150 and 200.
8 Q Okay. Now, you heard me say at
9 least three or four times try not to give
10 guesses. I'd like your best estimate. Tell us
11 your best estimate. You heard all of that
12 before?
13 A Yes.
14 Q Okay. Why do you choose to use
15 the word "guess," then?
16 A Because I don't have recall of the
17 numbers of patients that I've seen or the
18 percentages who have asked those questions.
19 Q Is that your best estimate?
20 A That is the best I can think of at
21 this point.
22 Q Okay. Let's go back to the lung
23 cancer. The 5 to 10 people to whom the answer
24 was no, I'd like to know why the answer was no.
25 A In those situations, because they

1 were either non-smokers or they were people who
2 had had smoking history either in the remote
3 past or at a very low level.
4 Q Let's eliminate those 5 to
5 10 -- excuse me.
6 Of those 5 to 10 people, let's
7 eliminate the ones who never smoked. Let's
8 eliminate the ones who had a remote smoking
9 history. Let's remove the ones who smoked very
10 little. Are we left with 0?
11 A Left with 0 in terms of?
12 Q "No, patient, your lung cancer is
13 not tobacco related."
14 A I think that would be correct.
15 MR. PIUZE: Do I have some shoes
16 here?
17 Q So, believe it or not, all of that
18 came off of an answer of yours, and your answer
19 was "formally." Do you remember that answer
20 where you said formally?
21 A Yes.
22 Q Okay. Let's go to "informally."
23 If formally, f-o-r-m-a-l-l-y -- if
24 formally -- I mean -- I hate this. I'll be
25 doing this in trial. They show me my card.

1 Nobody knows this and perhaps it's boring.
2 If "formally" is when a patient of
3 yours flat out asks, what is "informally"?
4 MS. WILLIAMS: Objection. Lacks
5 foundation.
6 THE WITNESS: "Informally" would
7 be to me a situation in which perhaps another
8 physician asked or someone who was interested.
9 BY MR. PIUZE:
10 Q Under what circumstances would
11 another physician ask?
12 A Generally, a physician who was
13 involved in taking care of the patient.
14 Q Would ask whether or not the
15 patient's lung condition was related to
16 tobacco?
17 A Rarely.
18 Q I mean, why would a treating
19 physician care about that, seriously?
20 A I think, in general, physicians
21 are interested in what their patients are doing
22 and what's made them sick.
23 Q Is that your best answer?
24 A Yes.
25 Q So what kind of a physician would

1 be asking you, a pulmonologist, what -- whether
2 or not your mutual patient's lung cancer was
3 tobacco-related?
4 A Any physician who was curious.
5 Q I know. But I'm trying to figure
6 out how it works. In the real world, would it
7 be who -- it wouldn't be a pathologist, would
8 it? It wouldn't be a radiologist. Who would
9 it be?
10 A It would be anybody who's
11 interested.
12 Q And who has that been?
13 A Generally physicians who were
14 taking care of the patients.
15 Q I know. What kind of physicians,
16 seeing that you're the lung specialist?
17 A Well, generally, it would include
18 either internists or family practitioners most
19 commonly.
20 Q Okay. Anyone else that you can
21 recall?
22 A Perhaps, rarely, another
23 subspecialist on the case.
24 Q Such as?
25 A Any subspecialist.

1 Q Okay. When you were talking about
2 the physicians generally, you used the word
3 "rarely" or a synonym, didn't you?

4 A Correct.

5 Q Now, when we're talking about a
6 subspecialist, we're talking about rarely of
7 rarely, a double negative, rarely to the second
8 degree.

9 MS. WILLIAMS: Objection. Vague
10 and ambiguous.

11 BY MR. PIUZE:

12 Q Do you understand that?

13 A No.

14 Q The physicians are rarely
15 subspecialists, correct?

16 A Yes.

17 Q Of the physicians who ask, the
18 physicians who rarely ask are subspecialists?

19 A Well, subspecialists are generally
20 less involved than general physicians.

21 Q Can you think of any case where
22 you actually have a memory of another physician
23 asking you in regards to a mutual patient, "Is
24 Patient X's lung cancer related to tobacco?"
25 Can you actually remember a time when that

1 happened?
2 MS. WILLIAMS: Objection. Lacks
3 foundation.
4 THE WITNESS: I don't remember a
5 specific time.
6 BY MR. PIUZE:
7 Q Okay. Back to "informally."
8 Besides the situation where perhaps another
9 doctor treating the same patient might have
10 asked you that question, does "informally"
11 encompass anything else?
12 MS. WILLIAMS: Objection. Vague
13 and ambiguous.
14 THE WITNESS: Not that I can think
15 of.
16 BY MR. PIUZE:
17 Q Okay. If No. 2 was emphysema,
18 what was No. 3?
19 A I'd have to ask for the next one
20 on the list.
21 Q This is like one of these tests
22 where you go to some college where they say,
23 "Remember these things because I'm going to ask
24 you again."
25 Do you remember No. 4?

1 A Not in order.
2 Q Okay. Where's your office?
3 A In Santa Monica.
4 Q Where do you have privileges,
5 Santa Monica Hospital, St. Johns?
6 A Correct.
7 Q Anyplace else?
8 A Daniel Freeman, Marina; UCLA,
9 Westwood and Vencor, Los Angeles.
10 Q What is that?
11 A Vencor is a chronic respiratory
12 care center.
13 Q Where?
14 A In Culver City.
15 Q Where in Culver City?
16 A On Slauson.
17 Q Who goes there, people with what
18 kind of problems?
19 A Patients go there with many
20 different kinds of problems, medical problems,
21 respiratory problems, generally fairly sick
22 patients who require longer term care than the
23 average hospital patient.
24 Q And how long a term does the
25 average hospital patient have, just generally

1 speaking?
2 A I'm not sure.
3 Q How long does the Vencor
4 patient -- we're talking about somebody that
5 goes down there for months at a time?
6 A It's usually weeks to months at
7 that facility.
8 Q Are those people on machines down
9 there?
10 A Many of them are.
11 Q Why don't you tell me some of the
12 types of problems that you treat problems for
13 down at Vencor.
14 V-e-n-c-o-r?
15 A Correct.
16 Q Tell me what types of problems you
17 treat people down there for, please.
18 A We treat patients there for
19 respiratory failure, pneumonia bacteremia,
20 sepsis syndrome, other types of infections,
21 patients with wounds that require chronic
22 long-term care.
23 Q Why do you put your malpractice
24 carrier on your C.V.?
25 A I think it's parts of the relevant

1 information.
2 Q Why?
3 A I just try to be as inclusive as
4 possible.
5 Q As what?
6 A As inclusive as possible.
7 Q Do you know Judith Brill?
8 MS. WILLIAMS: Objection. Vague
9 and ambiguous.
10 THE WITNESS: No.
11 BY MR. PIUZE:
12 Q Carlos Maggi, M-a-g-g-i?
13 MS. WILLIAMS: Same objection.
14 THE WITNESS: No.
15 BY MR. PIUZE:
16 Q Is there a board certification in
17 pulmonary diseases?
18 A Yes.
19 Q Is that what it's called,
20 pulmonary diseases?
21 A Correct.
22 Q And you're board certified in
23 critical care?
24 A Correct.
25 Q Critical care doctors are often,

1 in fact, strictly pulmonologists, correct?
2 A That's correct.
3 Q Have you ever practiced as a
4 critical care doctor?
5 A Critical care is a significant
6 part of my practice.
7 Q What do you do critical care wise?
8 A Can you be more specific.
9 Q Yeah. I'm just trying to picture
10 what setting you're being a critical care
11 doctor in and what you're doing as a critical
12 care doctor. I think I got a pretty good idea,
13 but I want to make sure we're on the same
14 wavelength?
15 A Generally, in critical care, we
16 take care of patients who are generally in the
17 intensive care unit or are going into the
18 intensive care unit, and they generally have
19 life-threatening diseases of one type or
20 another. And we try to manage their problems.
21 Q Frequently on respirators?
22 A Correct.
23 Q You're in charge of people on
24 respirators, aren't you? You're in charge of
25 that care, aren't you?

1 A Correct.
2 Q Do you do critical care at all of
3 the hospitals you've listed on your C.V.?
4 A Yes.
5 Q How do you get privileges at UCLA,
6 Westwood?
7 A The process is the same as any
8 other hospital, to my understanding.
9 Q If you were not -- let's see. It
10 says that for -- says, meaning on Exhibit 1,
11 your C.V., that for 10 years, you were an
12 assistant clinical professor at UCLA School of
13 Medicine, correct?
14 A Correct.
15 Q What if you hadn't been? Could
16 you have privileges at UCLA, Westwood if you
17 hadn't been a clinical professor there?
18 A I don't know the answer to that.
19 Q To put it differently, can some
20 doctor -- you know, otherwise reputable with no
21 problems and no past affiliation with the med.
22 school, get privileges at UCLA Med. Center?
23 MS. WILLIAMS: Objection. Calls
24 for speculation.
25 THE WITNESS: I don't know.

1 BY MR. PIUZE:
2 Q Do you know Dr. Cryer, C-r-y-e-r?
3 A No.
4 Q Who is the head of critical care
5 over at UCLA?
6 A I believe it's still Paul Bellamy,
7 although he might have stepped down recently.
8 Q When's the last time you had a
9 critical care patient over at UCLA?
10 A Last week.
11 Q What were you doing for that
12 patient?
13 A Can you be more specific?
14 Q Yeah, re-managing their airway?
15 A The patient was on a ventilator.
16 Q How did you get involved with that
17 particular patient over there? Was it your
18 preexisting patient who went to UCLA?
19 A That's correct.
20 Q Okay. And do you ever get
21 cold-called from UCLA when they see we have
22 someone here, Mr. X and Mrs. X, and we need a
23 critical care specialist? Can you come over?
24 A Cold-called by whom?
25 Q The hospital.

1 A Well, the hospital, as far as I
2 know, doesn't call consultants. Individual
3 doctors would be the ones who called the
4 consultants.
5 Q Okay. There are critical care
6 doctors on staff at UCLA, right?
7 A Yes.
8 Q Name a couple.
9 A Paul Bellamy goes there. Streiter
10 goes there, Mike Levine, Bob Shpinner, they all
11 do critical care.
12 Q What percentage of your time do
13 you do critical care medicine?
14 A Total?
15 Q Yeah.
16 A I would say 20 to 25 percent as a
17 guess.
18 Q You mean as an estimate, don't
19 you?
20 A Maybe you could explain to me the
21 difference between a guess and an estimate for
22 this purpose.
23 Q Guesses aren't allowed in court.
24 Estimates are.
25 A I see.

1 MS. WILLIAMS: Objection. Vague
2 and ambiguous.
3 THE WITNESS: That would be an
4 estimate.
5 BY MR. PIUZE:
6 Q Okay. What takes up the remaining
7 75 -- excuse me. I apologize. Withdraw that.
8 How long has critical care
9 accounted for 25 percent of your practice?
10 A I would say for at least 10 years,
11 probably longer.
12 Q And prior to that, was it more or
13 less of your practice, less, right?
14 MS. WILLIAMS: Objection. Lacks
15 foundation.
16 THE WITNESS: I think it's stayed
17 more or less the same to the best of my
18 recollection.
19 BY MR. PIUZE:
20 Q When were the first boards in
21 critical care?
22 A I believe that was in 1989.
23 Q Okay. So you were in there pretty
24 quickly after the specialty had its own
25 individual book?

1 A Correct.

2 Q What makes up the 0.75 percent of
3 your medical practice?

4 A Some of it is taking care of
5 non-critical pulmonary patients. Some of it is
6 in involvement with doing hospital internal
7 medicine, not always pulmonary. And then I
8 have the office part of my practice, which is
9 almost 100 percent pulmonary.

10 Q What kinds of non-pulmonary
11 internal medicine do you practice in hospitals?

12 A We admit patients with other
13 medical problems and take care of them

14 Q Such as?

15 A Congestive heart failure, GI
16 bleeding, patients with other cardiac issues.

17 Q So for GI bleeding, you don't call
18 a gastroenterologist to do that?

19 A Generally, I do.

20 Q And with congestive heart failure,
21 you don't call in a heart specialist?

22 A Generally, it would depend on the
23 severity of the problem

24 Q You said "we" on several of your
25 answers. Who is the "we"?

1 A The "we" includes my office
2 associates.
3 Q Other doctors?
4 A Correct.
5 Q How many doctors are in your
6 office?
7 A Three, including me.
8 Q The other two are pulmonologists
9 also?
10 A Yes.
11 Q Critical care specialists also?
12 A Yes.
13 Q Is there a name for the group?
14 A No.
15 Q Are you partners?
16 A No.
17 Q Do you just share expenses as far
18 as managing the practice is concerned?
19 A Correct.
20 Q Okay. And cover for each other?
21 A Correct.
22 Q How long have you been at 2021?
23 A I believe it's been approximately
24 eight-and-a-half years.
25 Q Do you do any pediatric pulmonary

1 medicine?
2 A No.
3 Q Do you do any pediatric critical
4 care medicine?
5 A No.
6 Q Back to Curtis, how many times
7 have you met Curtis, if at all?
8 A I've met him two times that I can
9 recall.
10 Q Where?
11 A In my office.
12 Q Has it ever been just the two of
13 you in a meeting?
14 A No.
15 Q Who's been present?
16 A At the first meeting, Chris was
17 there. At the second meeting, Chris was there,
18 and, I believe, Cindy was there.
19 Q Cindy, meaning the lady next to
20 you?
21 A Correct.
22 Q I've seen a blonde, tall, thin
23 blonde from Kansas City who sometimes is part
24 of the group. Do you recall her?
25 A Yes.

1 Q What's her name?
2 A Pat.
3 Q Pat what?
4 A Mary Pat, actually, I believe.
5 Marry Pat Riordan.
6 Q That's very good. What does she
7 do?
8 A She's an R.N.
9 Q What did she say?
10 A I'm sorry?
11 Q What did she ever say to you?
12 A Could you be more specific?
13 Q No. That's pretty specific.
14 A I think I need a more specific
15 question.
16 Q What did she say to you?
17 A I think I need a little more
18 direction to your question.
19 Q Why?
20 A Cause I'm not sure what you're
21 asking.
22 Q Did you ever hear her say
23 anything?
24 A Yes.
25 Q Other than a pleasantry, like,

1 "Hi, " "by"?"
2 A Yes.
3 Q "Nice day, " nice seeing you, " have
4 you ever heard her say anything?
5 A Yes.
6 Q What?
7 A She's been at several of the
8 meetings.
9 Q Okay. What's the answer to my
10 question? What has she said to you?
11 A I can't remember any specific
12 information or discussion with her.
13 Q What about Chris, what has Chris
14 ever said to you?
15 A He's said a number of things to
16 me.
17 Q Tell me. I don't want
18 pleasantries. Obviously, we can forget "Hi, "
19 "by, " "I'm Chris. I'm from San Francisco.
20 She's from Kansas City. She's from Ontario."
21 Did you know she's from Ontario?
22 A No.
23 Q Do you know how far Ontario is
24 from here?
25 Listen to this answer. Listen to

1 this answer. How far is Ontario?
2 A Which Ontario?
3 Q Good answer. What has Chris said
4 to you?
5 A We've had discussions about the
6 two cases that I was reviewing.
7 Q I'm not interested in your
8 discussions in the Boekin case. I'm only
9 interested in discussions about the other case
10 with Chris.
11 MS. WILLIAMS: Are you asking for
12 the substance of those conversations?
13 Objection. Calls for information
14 protected by the attorney work product
15 privilege.
16 BY MR. PIUZE:
17 Q What information did Chris tell
18 you about the Boekin case?
19 A He didn't tell me anything
20 specific. He asked me to review the case.
21 Q Well, he obviously said more than
22 "just review the case," cause I know his M O.
23 cause all the other doctors have told me what
24 he's said.
25 MS. WILLIAMS: Objection. Assumes

1 facts not in evidence.
2 THE WITNESS: I could try to
3 answer the question if you could be a little
4 more specific.
5 BY MR. PIUZE:
6 Q What did he say about the Boekin
7 case?
8 A He asked me to review the records
9 and asked me what I thought about the case, and
10 we discussed that on several occasions.
11 Q Was your answer always the same?
12 MS. WILLIAMS: Objection. Lacks
13 foundation.
14 THE WITNESS: Answer to what?
15 BY MR. PIUZE:
16 Q The question. You just
17 said -- didn't you just say he discussed what
18 did you think about the case on several
19 occasions?
20 A Yes.
21 Q Was your answer always the same?
22 A I believe my answer was
23 consistent.
24 Q Was it always the same?
25 MS. WILLIAMS: Objection. Lacks

1 foundation.
2 THE WITNESS: Yes, to the best of
3 my recollection.
4 BY MR. PIUZE:
5 Q Okay. And what about your lawyer
6 here who's objecting here for you and
7 instructing you? Has she ever said anything to
8 you other than pleasantries, obviously?
9 A Yes.
10 Q What?
11 A Again, she was involved in the
12 discussion of the case to a lesser extent.
13 Q Okay. What did she say?
14 A I don't really recall specific
15 comments.
16 Q All right. What did you tell her?
17 A About?
18 Q The case.
19 A I told her that my opinion
20 depended upon the pathology of the case, and
21 that if the diagnosis in this case is an
22 adenocarcinoma, that I felt that that was
23 smoking-related.
24 Q That would be non-controversial,
25 wouldn't it?

1 A I think so.
2 Q Other specialists from the local
3 area retained by Phillip Morris -- it's not
4 Lorillard, it's Phillip Morris -- on this case
5 have testified about relationships or
6 correlations with statistics where both smoking
7 and adenocarcinoma are involved. Have you been
8 told about what any of the other consultants
9 for Phillip Morris have said?
10 A No.
11 Q Do you have in mind some kinds of
12 statistics that link tobacco and
13 adenocarcinoma?
14 A I have general impressions of the
15 statistics.
16 Q Tell me, please.
17 A In the majority of cases of
18 adenocarcinoma, smoking is the cause and
19 effect.
20 Q Majority covers a lot of
21 territory, specifically between 51 and 100.
22 Can you be more specific?
23 A It's much higher than 51 percent,
24 and it's less than 100 percent, and my best
25 estimate would be that it's somewhere between

1 75 and 90 percent.
2 Q One of the consultants, I
3 believe -- I hope I'm not misstating this --
4 for Phillip Morris made some kind of a
5 statement like, "Smokers are blank times" -- I
6 don't want to tell you the number of times
7 because I don't want to close in on your
8 thought process -- "are blank times more likely
9 to get adenocarcinoma than non-smokers." Do
10 you have a number that you feel comfortable in
11 filling in the blank?
12 A No, I don't have a number.
13 Q If I suggested a number that over
14 20 times, that smokers are 20 times more likely
15 to get adenocarcinoma than non-smokers to you,
16 does that sound like a reasonable number to
17 you?
18 A That does not sound unreasonable.
19 Q You would not disagree?
20 A I wouldn't disagree with it. I
21 wouldn't have a basis for stating or rendering
22 whether that actual number is correct.
23 Q I'm with you.
24 Could you find out?
25 MS. WILLIAMS: Objection. Vague

1 and ambiguous.
2 THE WITNESS: I could look into
3 the literature and try to get a best estimate
4 of what that number would be.
5 BY MR. PIUZE:
6 Q Has Chris given you a reading
7 assignment?
8 MS. WILLIAMS: Objection. Vague
9 and ambiguous as to "reading assignment."
10 THE WITNESS: No.
11 BY MR. PIUZE:
12 Q Has Chris given you a list of
13 publications that he thought you might be
14 interested in reading?
15 A No.
16 MS. WILLIAMS: Objection. Vague
17 and ambiguous.
18 BY MR. PIUZE:
19 Q Has Chris actually given you
20 publications he thought you might be interested
21 in reading?
22 A Yes.
23 Q Are they on the table?
24 A Some of them are on the table --
25 well, let me rephrase that.

1 Everything I've looked at for this
2 particular case is on the table except for the
3 MEDLINE search that I did.
4 Q Is the stuff that's on the table a
5 mixed bag of Chris's articles and your
6 articles, or is it all Chris's articles?
7 A It's a mixed bag.
8 Q What percentage of it is Chris's?
9 A Most.
10 Q And as we already discussed, that
11 covers a lot of territory, like 51 to 100. Can
12 you be more specific?
13 A I would guess probably 80 to 90
14 percent.
15 Q That would be your estimate?
16 A Correct.
17 MR. PIUZE: Let's just go off the
18 record for a second.
19 (A discussion was held off the
20 record.)
21 BY MR. PIUZE:
22 Q What did you choose to review
23 that's on the table?
24 A Everything.
25 Q You read everything that's on the

1 table?
2 A Correct.
3 Q Which of those articles on the
4 table did you choose as opposed to Chris
5 choosing?
6 MS. WILLIAMS: Objection. Vague
7 and ambiguous as to "choose."
8 THE WITNESS: I don't remember at
9 this point.
10 BY MR. PIUZE:
11 Q Okay. How can we identify this
12 stuff on the record so it never goes away? Do
13 you have a list of -- a title list that's on a
14 page so we can just attach it to the record?
15 A Yes, I do.
16 Q Can I have it, please.
17 Was your handwriting like this
18 before you were a doctor?
19 A It was best better, slightly.
20 MR. PIUZE: The list is Exhibit 2.
21 (The document referred to was
22 marked by the C. S. R. as Plaintiff's
23 Exhibit 2 for identification and was
24 attached to and made part of this
25 deposition.)

1 BY MR. PIUZE:
2 Q Now, just so I can be clear, is
3 this list only the documents that you've given
4 me in the box?
5 A That's correct.
6 Q So whatever you got off of MEDLINE
7 is not on Exhibit 2?
8 A Correct.
9 Q What did you get off of MEDLINE?
10 A I reviewed on MEDLINE
11 approximately 250 titles and tried to sort
12 through those on the computer and read what
13 appeared to be appropriate for this topic.
14 Q How many did you get?
15 A Only about three or four.
16 Q Did you print them out?
17 A No, I didn't.
18 Q What do you do as an independent
19 medical examiner for the State of California?
20 A I occasionally, very occasionally
21 see workers' compensation patients in the
22 office for an evaluation.
23 Q That's it?
24 A Yes.
25 Q What are the MEDLINE articles that

1 you chose to read, do you know?
2 A No. I don't remember the titles
3 at this point.
4 Q Author?
5 A No.
6 Q So anyway, you were telling me if
7 it was adenocarcinoma, there's probably a
8 relationship between the lung cancer and
9 tobacco, correct?
10 MS. WILLIAMS: Objection.
11 Misstates his testimony.
12 THE WITNESS: Repeat the question
13 for me.
14 (The record was read by the
15 reporter as follows: "So anyway, you were
16 telling me if it was adenocarcinoma,
17 there's probably a relationship between
18 the lung cancer and tobacco, correct?)
19 THE WITNESS: I think in cases of
20 adenocarcinoma, I think there is probably a
21 relationship between adenocarcinoma and the
22 tobacco use.
23 BY MR. PIUZE:
24 Q Just so I'm not confusing you
25 necessarily here, I'm back 10 minutes in our

1 conversation. You were discussing Mr. Boekin's
2 case with one or more of these lawyers. I
3 asked you what you told them, and you started
4 out by saying it was dependent upon what the
5 path slides said. And if the path slides were
6 read to be adenocarcinoma, then there's a
7 relationship between lung cancer and the
8 tobacco someplace between 75 and 90 percent.
9 Is that a pretty good characterization?
10 A Correct.
11 Q What was the other choice?
12 A The other choice was based upon
13 the review of this case and if this would be a
14 bronchoalveolar carcinoma, rather than a
15 adenocarcinoma.
16 Q What if it was BAC?
17 MS. WILLIAMS: Objection vague and
18 ambiguous.
19 BY MR. PIUZE:
20 Q Just so that we're on the same
21 wavelength.
22 A Fine. So can you repeat that last
23 question.
24 BY MR. PIUZE:
25 Q "What if it was BAC" -- I think

1 that was the question -- then what's your
2 opinion?
3 A Well, if this were a
4 bronchoalveolar carcinoma, my opinion about
5 that is the relationship between that and
6 smoking is not consistent, and it would be much
7 less likely to be related to the tumor.
8 Q Your opinion regarding
9 adenocarcinoma being a 75 to 90 percent
10 probable relationship to smoking and BAC being
11 a much less clear, jury's out kind of situation
12 in relationship to smoking, are opinions that
13 are widely held by specialists of your
14 specialty, pulmonology, correct?
15 A That's my understanding.
16 Q Okay. In other words, you're not
17 on the periphery for either of these issues,
18 you're, rather, in the mainstream for them?
19 A I believe so.
20 Q Okay. So let's talk about BAC a
21 little bit. What out there now and days in
22 current literature is there that you think
23 links BAC with smoking, and then I'm going
24 to -- I wouldn't ask you now, but I'll
25 subsequently ask you what out there tends not

1 to link BAC with smoking?
2 So let's go for the first one.
3 First, what out in the literature now, if
4 anything, tends to link BAC with smoking?
5 A Well, there are some reports I've
6 seen which suggest that there may be some
7 incidence related to BAC and smoking, that it
8 may depend in part on how recent or how remote
9 the smoking was. But it seems to be less
10 related, as far as I can tell, to the amount of
11 smoking done by the patient.
12 Q Okay. The more recent, the more
13 likely the like?
14 A The more recent for?
15 Q Smoking.
16 A Smoking. The more likely the
17 link. There is some information that would
18 suggest that, and I've also seen some
19 information that seems to suggest that even
20 with people who smoked, but stopped, there may
21 be some relationship.
22 Q Okay. We're on a probability kind
23 of question now. Is the general feeling that
24 if there is a relationship between BAC and
25 smoking, it's more likely to exist where the

1 smoking is recent?
2 A I didn't get that out of my
3 review. I'm not sure I got an answer to that
4 question one way or the other.
5 Q Fine. And you've already told me
6 that there doesn't seem to be any thought that
7 the amount of smoking is a variant, right?
8 A Right.
9 Q Well, all that sort of boils down
10 to so far is some people think that smoking and
11 BAC are related, right?
12 A Correct.
13 Q Okay. Let's go to -- and is that
14 your whole answer?
15 The question was what out there in
16 the current literature links BAC and tobacco
17 smoke, and is the answer simply that some
18 authors do?
19 A Some authors and some studies.
20 Q And can you quantify the link in
21 these studies?
22 A I don't think I can quantify it
23 based on what I've seen.
24 Q Strong, weak, moderate, big,
25 little, numbers, anything like that?

1 A I wouldn't be able to come up with
2 numbers. I think the quantification in terms
3 of general description would be weak or a
4 little bit more than weak was my impression in
5 reading it.

6 Q Okay. What out there in the
7 literature now and days tends to say that there
8 is no link between BAC and tobacco smoke?

9 A What I've seen in terms of
10 describing a lack or relative lack of
11 relationship is data regarding either
12 genetic -- possible genetic links, possible
13 viral etiology, such as oncogenes,
14 o-n-c-o-g-e-n-e-s, potential toxic exposures.
15 Sugarcane workers would be one example.

16 Q Give me others -- let me interrupt
17 you.

18 What other kinds of exposures?

19 A Motor workers.

20 Q What is a motor worker?

21 A Someone who works on engines. Oil
22 petroleum products, I believe, is one potential
23 exposure.

24 Q Are motor workers sometimes known
25 in the real world as mechanics?

1 A Right.
2 Q Okay. What else?
3 A Scars, scar carcinomas.
4 Q I'm sorry. I apologize. We were
5 on toxic, subset of toxic. You've told me the
6 kinds of stuff you get out in the sugarcane
7 fields. You told me the kind of stuff you get
8 from running motors. Are there any other kinds
9 of toxic stuff linked to BAC?
10 A There are others, and
11 unfortunately, I can't recall all of them at
12 the moment.
13 Q What's an oncogene?
14 A An oncogene, to my understanding,
15 is a gene or particle that's transmitted
16 potentially by a virus, and the virus, then, is
17 able to enter a cell of whatever type and
18 essentially change the DNA of the cell that it
19 enters.
20 Q Okay. So off of toxics now, you
21 were saying genetics, scars, oncogenes, toxics.
22 Anything else?
23 A Those would be the ones I can
24 think of right now.
25 Q Okay. And those all fall into the

1 category of the other potential causes for BAC?
2 A Correct.
3 Q So are they ranked?
4 A Are they ranked in terms of?
5 Q Probability.
6 A I have not seen a ranking like
7 that.
8 Q So what if I could find a person
9 and the person never worked around motors and
10 never worked in sugarcane field, and somehow we
11 know the person doesn't have a scar but the
12 person smokes, what do you do with that?
13 MS. WILLIAMS: Objection. Vague
14 and ambiguous.
15 THE WITNESS: What do we do with
16 that in terms of what?
17 BY MR. PIUZE:
18 Q Figuring out if the tobacco and
19 the BAC are related.
20 A Well, the question -- the other
21 difficult question that I think would be
22 difficult to answer in a case like that would
23 be whether the patient could have had another
24 genetic predisposition at that point or whether
25 there was the presence of viral oncogenes.

1 Q Well, no one could ever prove that
2 there were tracks of a viral oncogene?
3 A I'm not an expert in this stuff.
4 Q It's like an ice ball. It does
5 its damage and leaves no tracks, right?
6 A I don't know.
7 Q What about genetics? What if
8 someone is genetically disposed to lung cancer,
9 what does that mean?
10 A It means to me that they're more
11 likely to get a lung cancer if they're
12 genetically predisposed.
13 Q More likely, but something has to
14 occur, does it not, to start the cancer off?
15 MS. WILLIAMS: Objection. Lacks
16 foundation.
17 BY MR. PIUZE:
18 Q Or does nothing have to occur, an
19 oncogene virus, a sugarcane, a motor or
20 something?
21 A I don't know of the answer to
22 that.
23 Q First of all, is it established
24 that there is genetic predisposition to lung
25 cancer?

1 A Based on what I've reviewed, there
2 appears to be in some patients.
3 Q And what would we be looking for?
4 MS. WILLIAMS: Objection. Vague
5 and ambiguous.
6 THE WITNESS: In the history, we'd
7 be looking for evidence in the family,
8 possibly, of a similar malignancy.
9 BY MR. PIUZE:
10 Q Okay.
11 A That would be one piece of
12 information one would want to get.
13 Q What other information?
14 A If it were feasible to do genetic
15 studies, then that would certainly be relevant.
16 I don't know if that's the case at this point.
17 Q What about Mr. Boekin's history
18 for genetics for lung cancer?
19 MS. WILLIAMS: Objection. Vague
20 and ambiguous.
21 BY MR. PIUZE:
22 Q Do you know anything about that?
23 A I'd be happy to read his history
24 and tell you. Again, I don't recall whether or
25 not there was a family history or not.

1 Q Okay. Whether or not he has a
2 family of lung cancer or not plays no role in
3 your opinions that you've expressed thus far,
4 correct?
5 A Repeat the question for me.
6 (The record was read by the
7 reporter as follows: "Okay. Whether or
8 not he has a family of lung cancer or not
9 plays no role in your opinions that you've
10 expressed thus far, correct?")
11 BY MR. PIUZE:
12 Q Family history of lung cancer.
13 A Can you just rephrase that for me.
14 Q Sure. If you don't know if there
15 is any kind of family history of lung cancer in
16 Mr. Boekin's family, then, therefore, whether
17 there is or isn't, does not play a role in the
18 opinions that you've expressed thus far
19 obviously.
20 A Correct.
21 Q Okay. What if someone is
22 genetically predisposed to lung cancer, that
23 fact wouldn't rule out something else like
24 sugarcane, oncogenes, working around motors,
25 smoking from being a causative factor of the

1 lung cancer, would it?
2 A I would agree with that.
3 Q I'm sorry?
4 A I would agree with that.
5 Q Okay. Have you told me all that
6 you can say right now about the current
7 literature in regard to BAC not caused by
8 tobacco smoke?
9 A I think I've given a fair synopsis
10 for that issue.
11 Q Fine. What percentage of lung
12 cancers are BACs?
13 A In general, what I've read is in
14 the range of approximately 3 percent, give or
15 take some.
16 Q What percent of lung cancers are
17 adenocarcinomas?
18 A My reading suggests that
19 adenocarcinomas at this point are the most
20 common or have become the most common lung
21 cancer. So that would be probably over 50
22 percent.
23 Q I'd caution you that the fact that
24 they're most common doesn't necessarily put
25 them in the majority. You may know that

1 independently, but one doesn't necessarily
2 follow the other.

3 My having stated that to you, do
4 you want to say probably over 50 percent?

5 A I've seen numbers that I can
6 recall right now in the range of 40 percent to
7 45 percent. So they would still perhaps be the
8 most frequent tumor, although I agree, it
9 doesn't have to be over 50 percent.

10 Q I've heard over the last few days
11 from Phillip Morris consultants that have given
12 depositions in this case that the number of BAC
13 diagnoses seem to be going up with time.

14 MS. WILLIAMS: Object to the use
15 of "Phillip Morris consultants" as vague and
16 ambiguous.

17 BY MR. PIUZE:

18 Q Is that the impression you get
19 from the reading?

20 A What I've seen suggests that BACs
21 have gone up in frequency as well as the
22 adenocarcinomas in general.

23 Q And do you have a feeling for
24 whether or not that is simply due to newer,
25 better or different diagnostic slash reporting

1 techniques as opposed to the fact that there
2 are literally, truly more such cases than there
3 used to be?
4 A I'm not sure.
5 Q Okay. Have you ever seen BAC in
6 your clinical practice?
7 A Yes.
8 Q How?
9 A How, meaning --
10 Q How do you see it on a path
11 report?
12 A I've seen several patients who
13 came in for a diagnostic evaluation who ended
14 up having BAC.
15 Q Who decided that they ended up
16 having BAC?
17 A The pathologist.
18 Q That's the pathologist's job,
19 right?
20 A Correct.
21 Q Have you ever overruled or counter
22 ruled a pathologist on that call?
23 A No.
24 Q Describe a BAC to me.
25 MS. WILLIAMS: Objection. Vague

1 and ambiguous.
2 THE WITNESS: Can you be more
3 specific?
4 BY MR. PIUZE:
5 Q What does it look like?
6 MS. WILLIAMS: Objection. Vague
7 and ambiguous.
8 THE WITNESS: I need a little more
9 specific guidance for the question.
10 BY MR. PIUZE:
11 Q Sure. I can guide you.
12 There's a jury that you're going
13 to be in front of or that may be -- I'm going
14 to read this very question to, and a lot of
15 them have probably never looked through a
16 microscope to see what cancer looks like. So
17 for us -- and neither have I. And so for us
18 folks who have never done it -- you know, maybe
19 I can say what does a dog and a cat look like
20 and you can describe a dog and you can describe
21 a cat. And then we would know the difference,
22 or what does a dog look like or what does a
23 fish look like. And after you've described it
24 to us, if we've never seen one of those, we'd
25 know the difference. And I want you to

1 describe what a BAC looks like under that
2 microscope versus what an adenocarcinoma looks
3 like under a microscope.
4 A I see. I'm not a pathologist, so
5 I don't have expertise of a pathologist. But
6 from my understanding under the microscope of
7 BAC is that, number one, the tumor cells are
8 lined in the alveoli. They grow along the
9 walls of the alveoli. They can grow up through
10 the airways, and they tend to do -- frequently,
11 they tend to be not invasive. In other words,
12 they don't tend to invade the walls of the
13 alveoli or septi. They grow in that fashion.
14 Q Okay. Do you want to make any
15 comments on size, whether they travel in packs,
16 how they're grouped together, anything like
17 that?
18 MS. WILLIAMS: Objection. Vague
19 and ambiguous.
20 THE WITNESS: Under the
21 microscope?
22 BY MR. PIUZE:
23 Q Yeah, sure.
24 A I'm not sure I have any other
25 comments on that issue.

1 Q Describe an adenocarcinoma for
2 this jury that may be listening to this
3 question.
4 MS. WILLIAMS: Objection. Vague
5 and ambiguous.
6 THE WITNESS: Again, as a
7 non-pathologist, my description of an
8 adenocarcinoma would be under the microscope
9 that there are cells which tend to grow in
10 small formations. They tend to be invasive for
11 the most part. There may or may not be scar
12 formation either within the tumor or around the
13 tumor.
14 Q End of answer?
15 A Yes.
16 Q Okay. So if BACs are currently
17 having grown in popularity up to 3 percent of
18 lung cancers -- that's right so far, isn't it?
19 A That's my best estimate, is about
20 3 percent.
21 Q And if adenocarcinomas are
22 someplace in the vicinity of 50 percent, the
23 most frequent type, that's right, isn't it?
24 A I think that's approximately
25 correct.

1 Q What's left?
2 A What's left in terms of?
3 Q Sounds like there's about 47
4 percent left?
5 A Oh, other kinds of cancers?
6 Q Yeah, lung cancer.
7 A Squamouscell, large cell and small
8 cell would be the main categories.
9 Q Can you put an approximate
10 percentage or frequency of total lung cancers
11 on those three categories, please.
12 A I believe that squamouscell is the
13 next most frequent, which to my recollection is
14 in the range of approximately 30 percent or so
15 and then small cell and then large cell.
16 Q Besides the lawyers for the
17 tobacco company, have you talked to anyone else
18 about this case?
19 A No.
20 Q What else do you have on the table
21 with you?
22 A I have a copy of the notes I made
23 regarding the time I've spent on the case.
24 Q How much?
25 A I have not added it up yet.

1 Q Are the numbers there?
2 A Yes.
3 Q Go ahead and take 30 seconds and
4 add it up, please.
5 A So far, it looks like
6 approximately 28 hours.
7 Q "So far," meaning right up until
8 the minute today?
9 A Up until before today.
10 Q When did you meet with the lawyers
11 today?
12 A Before this deposition.
13 Q I know. I figured that part out
14 all by myself. Starting when?
15 A 10:00 o'clock.
16 Q Okay. How much do you get paid by
17 the hour to be doing this consulting work
18 please?
19 A \$300.
20 Q How much do you get paid by the
21 hour to be doing the deposition?
22 A \$500.
23 Q What percentage of your
24 professional income -- I don't want to know
25 about your stocks, bonds, and I wouldn't want

1 to put you through the pain of telling me.
2 What percent of your professional income is
3 derived from legal activity?
4 A It's very low. I'm trying to
5 figure out what the number would be.
6 Q Is it smaller than the percentage
7 of BAC to all lung cancers?
8 A Yes.
9 Q That is very small then, right?
10 A Correct.
11 Q Who was the pathologist who stated
12 what type of lung cancer Mr. Boekin had?
13 MS. WILLIAMS: Objection. Vague
14 and ambiguous.
15 THE WITNESS: Does your question
16 refer to the medical record?
17 BY MR. PIUZE:
18 Q No. It's actually open-ended. Do
19 you know of more than one pathologist who has
20 stated what type of lung cancer Mr. Boekin has?
21 A No.
22 Q So I guess if you don't know more
23 than one, who is that one?
24 A I believe it was Dr. Geller, to my
25 recollection.

1 Q Do you know Dr. Geller?
2 A Not personally.
3 Q By reputation?
4 A Yes.
5 Q What's his reputation?
6 A He has a reputation as a competent
7 pathologist.
8 Q Is he the head over at Cedars?
9 A I believe that's correct.
10 Q How big of a hospital is Cedars?
11 A It's a very large hospital.
12 Q In this town, this major world
13 city of Los Angeles, is it the largest or one
14 of the three largest? Do you know where it
15 ranks?
16 A It's one of the largest. I don't
17 know if it's the absolute largest.
18 Q Do you have any idea how many
19 pathologists are on staff over at Cedars?
20 A No.
21 Q Did you read his pathology report?
22 A Yes.
23 Q What did he say?
24 A He said in the final diagnosis
25 that this was a papillary adenocarcinoma, and

1 there was a frozen section which had a
2 diagnosis of a bronchoalveolar carcinoma.
3 Q From your position, do you have
4 any idea if one of those two should outrank the
5 other?
6 A Well, generally, a frozen section
7 would be less reliable --
8 Q Why?
9 A -- than a final report.
10 Q Why?
11 A As a non-pathologist, my
12 understanding is that the fixation is done
13 differently -- fixation of the tissue, and
14 because it's usually done at the time of
15 surgery, there's less time taken to review the
16 specimen and the slides.
17 Q But if that specimen -- is that
18 specimen typically preserved?
19 A I'm not sure what the question is.
20 Q Well, so they don't take a lot of
21 time doing it, but can't you get the specimen
22 at some later date and take an hour to look at
23 it?
24 A From a frozen section?
25 Q Yeah.

1 A I believe a frozen section is to
2 be done right on the spot. That's my
3 understanding.
4 Q And then what happens then? It's
5 like the ice ball, it melts?
6 A I don't know.
7 Q I'm not asking to be facetious.
8 Let me ask you something, does the
9 frozen section get destroyed, discarded? What
10 happens to it?
11 A I don't know.
12 Q With respect to there was not as
13 much time to look at the frozen section,
14 explain other reasons you think it might not be
15 as accurate to look at the frozen section.
16 MS. WILLIAMS: Objection. Vague
17 and ambiguous.
18 BY MR. PIUZE:
19 Q One of the things you said is
20 fixation. Explain that.
21 A When a section is taken and it
22 goes to pathology, usually the specimen is
23 placed in a fixative, and a frozen section is
24 not placed in a fixative.
25 Q How does the fixative make it

1 variable? How does it make it more or less
2 accurate?
3 A I don't know the answer to that.
4 Q I appreciate you are not a
5 pathologist cause you've said that many times,
6 and you've prefaced your answer with that. And
7 I appreciate that you will bow to and not
8 question the opinion of a pathologist cause
9 you've stated that in your previous testimony.
10 And understanding that, what do
11 you think about the possibility that a lung
12 cancer tumor can have a mixed set of
13 sub-cancers such as, maybe, a little papillary
14 adenocarcinoma and maybe a little BAC strain in
15 the adenocarcinoma. From your standpoint as a
16 pulmonary specialist, do you think that's
17 possible?
18 A Yes.
19 Q And why do you think that's
20 possible?
21 A Because I've seen cases like that,
22 and I've read about cases like that.
23 Q What if it happens like that and
24 now you've got a tumor that's adenocarcinoma
25 which you now say in your own mind, "Uh-huh, 75

1 to 90 percent probably linked to tobacco," but
2 it's also got some features to BAC, and you say
3 but much less of a probability comes up there.
4 Then the question comes up, "Does this tumor
5 relate to tobacco smoke smoking?" Where does
6 your thinking go from there?

7 A I would have to depend on the
8 pathologists to give me a reading to make that
9 kind of assessment. I don't think I'm capable
10 of doing that.

11 Q So let's talk about Mr. Boekin,
12 then. Let's assume that I never pushed you to
13 say, "Hey, Doctor, remember you told me that a
14 frozen section is less accurate than the final
15 diagnosis," and instead I ask you to assume
16 that in Mr. Boekin's case, there is some
17 papillary adenocarcinoma and there is also some
18 BAC in this tumor. You wouldn't be able to
19 give me any kind of an opinion as to whether or
20 not his tumor was related to smoking, or would
21 you?

22 A I would have a very difficult time
23 doing that.

24 Q Okay. This is your chance. If
25 you want to have a difficult time, go ahead and

1 have it right in front of me so I'll know about
2 it at trial. If you're going to defer it
3 totally, let me know that?
4 A I would defer to the pathologists.
5 Q Okay. What other opinions do you
6 have in this case, please.
7 A The other issue or opinion that I
8 have is relating to his presentation
9 clinically.
10 Q Please, tell me.
11 A I think his clinical presentation
12 is consistent with either of the two potential
13 types of cancer that he appears to have based
14 on the medical record.
15 Q When you say "either of the two,"
16 what are the two candidates?
17 A Either a papillary adenocarcinoma
18 or a bronchoalveolar carcinoma based on the
19 pathology reports.
20 Q What are all of the features of
21 his presentation that are consistent with BAC,
22 please?
23 A Those features were that he had a
24 lesion, which was less than 3 centimeters, and,
25 we believe, it was about 1 ½ to 2 centimeters

1 in size. It was a fairly peripheral lesion,
2 and the CT report commented that there was a
3 lobar bronchus which appeared to go towards the
4 tumor. But there was no comment on any
5 compression of the bronchus by tumor.

6 Q Is that the end of your answer?

7 A Yes.

8 Q Your on the spot now. I'd like to
9 hear that.

10 (The record was read by the
11 reporter as follows: "Those features were
12 that he had a lesion, which was less than
13 3 centimeters, and, we believe, it was
14 about 1 ½ to 2 centimeters in size. It
15 was a fairly peripheral lesion, and the CT
16 report commented that there was a lobar
17 bronchus which appeared to go towards the
18 tumor. But there was no comment on any
19 compression of the bronchus by tumor.")

20 BY MR. PIUZE:

21 Q That's pretty good, wasn't it?

22 A I liked it.

23 Q I mean, she got it word for word,
24 right?

25 A Correct.

1 Q What does compression have to do
2 with it?

3 A There have been some descriptions
4 in the literature regarding some of the
5 radiology findings regarding bronchoalveolar
6 carcinoma commenting that there's something
7 called an "open airway sign," which is
8 something that there's an airway that goes
9 towards or to the lesion but is not compressed
10 or altered in any significant way.

11 Q Now, have you told me all of the
12 factors which tend towards a diagnosis of BAC
13 in Mr. Boekin?

14 A Well, I think this presentation is
15 consistent with either one.

16 Q I recall that. I'm just -- let me
17 say my question more artfully.
18 Have you told me all of the
19 factors that make his presentation consistent
20 with BAC?

21 A Yes, I think so.

22 Q Tell me the factors that make his
23 presentation consistent with adenocarcinoma or
24 papillary adenocarcinoma, if you'd rather?

25 A I think they're really the same

1 factors. It's peripheral, which
2 adenocarcinomas tend to be. The size is
3 consistent with that type of a lesion, and it
4 would be, in my opinion, a fairly typical
5 presentation for an adenocarcinoma.

6 Q If that's true -- and I'm not
7 questioning you on that; I'm not challenging
8 you on that. If that's true and if we put the
9 path slide aside, the odds of it being
10 adenocarcinoma versus BAC are approximately 45
11 to 3, correct?

12 MS. WILLIAMS: Objection.

13 Misstates his testimony.

14 THE WITNESS: Well, if you take
15 the clinical presence in terms of the chest
16 X-ray and the CAT scan and you try to make an
17 estimate as to the percentage of it being BAC
18 versus an adenocarcinoma, it would be much more
19 likely to be an adenocarcinoma.

20 Q Right. But I'm putting numbers on
21 it, 45 adeno, 3 BAC based on your own
22 testimony.

23 A Well, those are the percentages
24 based on -- as far as I know, those tumors
25 relative to the entire lung cancer spectrum

1 Q Right.
2 A So in that context, I think that
3 would be correct.
4 Q Well, do you have another context?
5 A Not that I'm thinking of.
6 Q Okay. Well, what about -- so
7 that's the opinion you wanted to give me
8 regarding his presentation, correct?
9 A Correct.
10 Q Is that the extent of your opinion
11 regarding his presentation?
12 A Yes.
13 Q Can we determine whether or not
14 this lung cancer is BAC versus papillary
15 adenocarcinoma by looking at his films?
16 A Not in my opinion.
17 Q We have to look at the slides in
18 order to make the final determination?
19 A Correct.
20 Q Who's Dr. Hammer? Did you ever
21 hear of Dr. Hammer?
22 A I don't know that name.
23 Q Okay. He's got a museum about
24 four blocks down that way.
25 A Arm & Hammer?

1 Q Well, that's Dr. Hammer, isn't it?
2 A That's one Dr. Hammer.
3 MR. PIUZE: Do you have your
4 expert witness designation by any chance?
5 MS. WILLIAMS: I don't think I
6 brought it.
7 MR. PIUZE: Let me take a minute
8 and go get it. I'm almost done.
9 MR. JOHNSON: I might have it.
10 MS. WILLIAMS: Can we talk for a
11 sec? Don't get scared.
12 (Recess taken.)
13 MR. PIUZE: Where were we, the
14 disclosure?
15 MR. JOHNSON: I don't have your
16 disclosure. I have the notice, if you want the
17 names.
18 BY MR. PIUZE:
19 Q Do you have any opinions regarding
20 the treatment of Mr. Boekin?
21 A As to what treatment issues?
22 Q Any opinions whatsoever. I mean,
23 I don't want you to just recite the history to
24 me. From what I remember from the disclosure
25 statements, all the expert witnesses who were

1 consultants on this case had similar
2 qualifications.
3 "Diagnosis. "
4 We talked about all your opinions
5 on diagnosis, right?
6 A Right.
7 Q Treatment.
8 Do you have any opinions regarding
9 his treatment?
10 A No.
11 Q "Etiology" on the cancer of this
12 patient.
13 Have you told me all of the
14 opinions on the etiology?
15 A Yes.
16 Q "Prognosis. "
17 It's a fatal disease, correct?
18 A Based on my review of his records
19 that I've seen so far, I think it will prove to
20 be fatal.
21 Q Do you have any opinion yourself
22 about how long he's going to live?
23 A No. I don't know that.
24 Q What else do you have on the
25 table, please.

1 A I have a copy of the staging
2 criteria for lung cancer.

3 MR. PIUZE: Let's make that
4 Exhibit No. 3.

5 (The document referred to was
6 marked by the C. S. R. as Plaintiff's
7 Exhibit 3 for identification and was
8 attached to and made part of this
9 deposition.)

10 BY MR. PIUZE:

11 Q What stage was his lung cancer at
12 presentation?

13 A His pathologic staging was a 3-A
14 to my recollection.

15 Q Why do you answer it in terms of
16 pathological staging as opposed to just saying
17 staging?

18 A Cause there's also clinical
19 staging which occurs when the patient is
20 initially seen before the patient had a surgery
21 or an actual condition.

22 Q What was the clinical staging?

23 A My recollection of the clinical
24 staging was that it was a Stage 2. If I
25 remember correctly, it was a Stage 2.

1 Q What else do you have?
2 A I have a copy of my fee schedule.
3 Q Okay. You can have that. I'll
4 give it back.
5 What else?
6 A A few notes that I made on
7 reviewing the records.
8 Q Could you just read those notes,
9 please.
10 A "80 pack years." "10 slash 20,"
11 "PET" --
12 That's P-E-T.
13 Q What's 10 slash 20?
14 A The date.
15 Q Okay.
16 A "PET positive." "Mediastinoscopy.
17 "Right peritracheal nodes negative." "10/28/99
18 surgery" -- I'm having trouble reading my own
19 writing.
20 Q I don't blame you.
21 A Underneath that it says,
22 "2AT1N1M." "
23 Q What does that mean?
24 A That refers to the staging that
25 was done at that time, "12/14/99, Sarna,"

1 S-a-r-n-a. "First visits, 3-A, 12 slash 00,
2 brain lesions dash MRI. "
3 Q Do you know Sarna?
4 A No. Her personally?
5 Q I apologize for interrupting. Do
6 you know any of the plaintiff's treating
7 doctors?
8 A I know Dr. Heifetz.
9 Q What specialty is Dr. Heifetz?
10 A He's an oncologist.
11 Q Do you know him personally?
12 A I have known him personally in the
13 past.
14 Q Is there a pulmonologist in
15 Mr. Boekin's history?
16 A Yes.
17 Q Who?
18 A Bob Wolf.
19 Q When?
20 A Bob saw him, I believe, after his
21 surgery.
22 Q Where?
23 A At Cedars.
24 Q Why?
25 A Because of some postop

1 bronchiospasm to my recollection.
2 Q You obviously know Dr. Wolf.
3 A I do know him
4 Q Personally?
5 A Yes.
6 Q What, if anything, did he say
7 about Mr. Boekin?
8 A He felt that the patient had
9 destructive airway disease and needed
10 respiratory treatments and postop mobilization.
11 Q Mtil --
12 A Mobilization.
13 Q Meaning, just that, getting up and
14 moving around?
15 A Correct.
16 Q Did he treat the cancer at all?
17 A Not to my recollection.
18 Q Have you read all of the notes on
19 that one page?
20 A Yes.
21 Q And I'm going to give that page
22 back to you.
23 The last page that's up on the
24 table, what's that?
25 A This is the page of my time

1 sheets, essentially the time that I've spent on
2 this case.

3 Q Right. Let me make that
4 Exhibit 4, please.

5 (The document referred to was
6 marked by the C. S. R. as Plaintiff's
7 Exhibit 4 for identification and was
8 attached to and made part of this
9 deposition.)

10 BY MR. PIUZE:

11 Q Have you told me all of the
12 opinions that you intend to give at the time of
13 the trial in this case?

14 A Yes.

15 MR. PIUZE: I'm done.

16 Did you get a stipulation from the
17 other evening?

18 Do you want to use the stipulation
19 from the other evening? It's the one you
20 insisted on 15 days.

21 MS. WILLIAMS: Yes. That would be
22 fine.

23 (The stipulation from the
24 deposition of Peter J. Julien, M.D., was
25 incorporated as follows:

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

1 days from the time that I get it
2 to you.
3 "THE WITNESS: Okay.
4 "MR. PIUZE: Two weeks from
5 your receipt -- that's what you
6 just agreed to -- which is less
7 than 15 days.
8 "MS. WILLIAMS: I think we
9 should do 15 days since that's
10 been the standard so far.
11 "MR. PIUZE: Excuse me?
12 "MS. WILLIAMS: 15 days has
13 been the standard. That's what we
14 just said this morning.
15 "MR. PIUZE: Okay.")
16 MR. PIUZE: So we're done.
17 (Whereupon, at 1:23 p.m., the
18 deposition of Bernard Weintraub, M.D., was
19 concluded.)
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I, BERNARD WEINTRAUB, 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)

BERNARD WEINTRAUB, 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 19, 2001

24
25 _____
VIVIAN C. DERNBURG
CSR No. 11339