

224451

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM SPARTANBURG COUNTY
Court of Common Pleas

J. Mark Hayes, II, Circuit Court Judge

Case No. 2013-CP-42-2404
Appellate Case No. 2015-001828

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SC Court of Appeals

Lisa McKaughan, Individually
and as Personal Representative
of the Estate of William Farr,

.....

Appellant

v.

Upstate Lung and Critical Care
Specialists, P.C. and Sau-Yin
Wan, M.D.

.....

Respondents.

RECORD ON APPEAL (VOLUME 2)

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William Woodruff - Direct examination
by Mr. McKinnon

1 Q Doctor, do you think it's possible for a reasonable
2 physician to confuse that abnormality with the heart or the
3 heart shadow?

4 A I don't see how personally.

5 Q Okay. Doctor, when you look at that, knowing what --
6 Mr. Farr's medical records, what you believe that
7 abnormality is from that x-ray?

8 A This is the cancer until proven otherwise.

9 Q So, in other words, doctor, when you look at an x-ray,
10 you can't tell for sure that's cancer?

11 A No, sir.

12 Q Okay. But what does it tell?

13 You see this.

14 A Okay. I see abnormal density. I have to figure out
15 what it is and sometimes it's easier than others and lots of
16 things can cause a density.

17 First of all, I'm obligated to think of okay, what's
18 the worst thing that this could be?

19 What, what could be the worst thing that Mr. Farr could
20 have and the answer is cancer.

21 Now, you know, what else could this be?

22 It could of been a pneumonia and that's in the
23 differ -- what we call a differential diagnosis, a list of
24 what other things could live here, and your main
25 differential here would be a tumor or cancer and unbeknown.

William Woodruff - Direct examination
by Mr. McKinnon

1 The point is, at this moment, it's not to say this is a
2 cancer a hundred percent sure or a pneumonia a hundred
3 percent sure. It's to say there is abnormality here. We
4 need to do something else. The one thing I can not do is
5 ignore it and not follow through with it.

6 Q Is it fair to say this should trigger a process of
7 figuring out what it is?

8 A Exactly. Yes.

9 Q Doctor, when I mailed you this x-ray---

10 A Yes.

11 Q ---originally. Our office mailed you this x-ray.

12 Did we tell you what we were looking for?

13 A No.

14 Q Okay.

15 A No, this was looked at what I call a blind read. You
16 know, it was sent to me. I was told you're gonna receive a
17 chest x-ray. I was told no history. So I looked at this
18 not knowing what subsequently transpired. I did not know,
19 when I first looked at this, that this man died of cancer.

20 Q Okay. And, Doctor Woodruff, when you received the
21 x-ray, was it a difficult x-ray to read?

22 A No, in fact, I remember this very well. These came to
23 me in an envelope and literally I remember very well taking
24 them out of the envelope and just, by chance, I reached for
25 the lateral first and literally -- of course, I, I, you

William Woodruff - Direct examination
by Mr. McKinnon

1 know, as I put it up before I even got it to my view box, I
2 saw this area of abnormality. So I actually saw this on
3 this lateral view before I even got it up to the view box.

4 Q Doctor Woodruff, you, yourself, are a radiologist.
5 Correct?

6 A I am.

7 Q What is the standard -- what does the law expect of a
8 radiologist who's reading x-rays?

9 A Okay. A reasonable -- the standard of care is that a
10 reasonable radiologist or anybody who's interpreting an
11 x-ray, I mean anybody that is, that is reading these and
12 giving a final read without showing it to a radiologist
13 establishes the radiologist standard of care. I mean -- so,
14 you know, anyone that looks at this, I'm speaking any
15 physician that chooses to, to take on my standard, I expect
16 them to, to practice at my standard.

17 My standard is a reasonable radiologist on an average
18 day practicing, in my opinion, should see this. It doesn't
19 mean -- don't misunderstand. It doesn't mean that all
20 lesions are gonna be picked up all the time. We all miss
21 things. I have missed things. But this one, I believe a
22 reasonable radiologist on a reasonable day should see this
23 every time.

24 Q Do you believe that Doctor Wan met the standard for
25 someone reading an x-ray in South Carolina for a doctor?

William Woodruff - Direct examination
by Mr. McKinnon

1 A I have seen her report. Her report does not describe
2 this lesion. So, therefore, in my opinion, she did not meet
3 the standard of care for interpreting -- reading this x-ray.
4 She did not.

5 Q Okay. Doctor, if you want to be -- unless there's more
6 you want to tell the jury, we need to move on from that.

7 A No.

8 Okay.

9 (Witness returns to the stand.)

10 Q Okay. Oops. That's not what I meant to do. I
11 apologize for that.

12 Okay. Doctor Woodruff, what I'm showing you here is
13 Doctor Wan's bill, and if you can see right here?

14 A Yes. Yes, sir, I see that.

15 Q That's January 11th, 2010, and it says read X, two
16 views.

17 Is that the read the x-ray?

18 A Yes, sir, and that is a -- it says chest, two views,
19 and that, that five digit number, the 71020, is the -- we
20 call it the CPT code. These are how -- what the computer
21 uses to tell what was done and that is the code for a two
22 view chest, what was done here, yes.

23 Q Okay. So what that means, doctor, is Doctor Wan billed
24 the patient for reading this and interpreting this x-ray?

25 A She billed the -- okay. Here's how it works. She

William Woodruff - Direct examination
by Mr. McKinnon

1 billed the patient both for obtaining, for taking the x-ray,
2 and for interpreting the x-ray, and, and the reason I know
3 that is we're allowed, in x-ray, to build the technical
4 component, the taking part, separate from the reading part,
5 and the reason that we do that like if -- like, for
6 instance, I practice a lot of my work is in the hospital.
7 So the hospital, you know, takes the x-ray and they, and
8 they send the bill, and then I read it, and then I send a
9 bill.

10 Now, the way that we tell the computer to get it right
11 is if it's just the technical component like what the
12 hospital would bill, it would be 71020 and then you'll say
13 point TC for technical, and that -- we call that point TC a
14 modifier.

15 Now then if you're, for me, like reading it alone, I
16 submit a 71020.26. That 26 is my modifier for interpreting.

17 Now, it turns out that if you add those two together
18 you get the combined charge. But, but if you're doing both
19 of those things, you don't need to split it out. You send
20 in just as a 71020 with no modifier. So that, that tells me
21 that what was charged was both for the taking of the x-ray
22 and the reading of the x-ray.

23 Q So did Doctor Wan read this x-ray for free?

24 A No.

25 Q Okay. I'm gonna swap that out now, doctor. Give me

William Woodruff - Direct examination
by Mr. McKinnon

1 just one moment.

2 (Pause.)

3 Q And I'm gonna swap that out with Doctor -- well, with
4 Doctor Wan's report. Oops. Let me zoom out just a little
5 bit.

6 A Okay.

7 Q Doctor Wan's report.

8 Do you recognize that document?

9 A Yes.

10 Q Okay. And it says -- it says interim report.

11 A Yes.

12 Q And this is the x-ray report.

13 All right. And what does it say for patient name,
14 doctor?

15 A Okay. Yes.

16 Am I okay to stand again?

17 Q Please.

18 A Okay.

19 Q Yeah.

20 A I'll talk loud.

21 (Witness comes down from the stand.)

22 A It says, you know, William Farr, Chart Number 31209, a
23 date of January 11, 2010, and then it says under -- it says
24 impression, chest PA and lateral. Those are the two views
25 we've talked about. And then under it says hyperinflation

William Woodruff - Direct examination
by Mr. McKinnon

1 and that zero with a line through it is sort of doctor's
2 shorthand for no. No infiltrates. So this is saying
3 hyperinflation, no infiltrate, and that's her signature and
4 that's it.

5 Q So she's saying there's no infiltrate in the lung and
6 there's only one thing abnormal on this x-ray and it's what?

7 A The lungs are, are a little bit hyperinflated. In
8 other words, the patient's able to take too deep of a
9 breath. That's to, to make a long story short and that's
10 real common with this COPD that you heard about earlier.
11 That's, that's one of the, the things that we look for, and,
12 by the way, I've reached the point that the patient does
13 have COPD.

14 Q Right.

15 A And I -- so she's basically saying my interpretation of
16 her report here is she's saying that there is the
17 hyperinflation and nothing else is wrong, which I disagree
18 with.

19 Q Is there anything missing on this report in your
20 opinion, doctor?

21 A Well, most definitely. There's no description of the
22 abnormality that I pointed out about the lesion that is
23 cancer until proved otherwise.

24 Q And what should it have said?

25 A Well, I think it was fine to mention the

William Woodruff - Direct examination
by Mr. McKinnon

1 hyperinflation, first of all. So let's go with what's
2 right. There should of said there was a -- an about -- an
3 approximately two and a half by two and a half centimeter
4 abnormal density in the region of the anterior segment of
5 the right upper lobe concerned. You know, major
6 considerations include cancer and pneumonia and how much of
7 that I mean. But the, the key thing is describing the
8 lesion.

9 Q With this report, is there any reason for a doctor to
10 follow-up about a possible tumor?

11 A There's nothing here whatsoever that mentions that
12 possibility.

13 Q Okay. And if it had been mentioned, would a doctor
14 have followed up?

15 A I would certainly hope so.

16 Q Okay. And, doctor, you mentioned the sizing. That
17 reminds me.

18 When you read -- when you looked at those x-rays just
19 now, can you tell the size of the, the mass you're looking
20 at on that?

21 A I can tell you approximately and I measured it at I
22 believe it was 2.6 by 2.5 centimeters. We're not exact. As
23 was correctly pointed out that, you know, we're not as good
24 as the pathologist in giving exact measurements and one of
25 the reasons is that there is a slight magnification factor

William Woodruff - Direct examination
by Mr. McKinnon

1 with, with these chest x-rays. It's just the nature of the
2 physics.

3 So we tend to slightly overestimate the size of lesions
4 on, on, on chest x-rays like this, and things -- you know,
5 if you said well, exactly how much it varies, I can't give
6 you an exact percentage. The average is said to be about
7 eight to ten percent. But I can't, I can't say, in this
8 particular patient, exactly what the magnification factor
9 would of been. But I can give you an approximation. But
10 I -- absolutely what was said earlier, the pathology, as far
11 as actual size, is the gold standard.

12 Q But your best---

13 A My best guess is that it's a little less than
14 3-centimeters.

15 Q Okay. And that would be around ten -- within
16 ten percent of the real number you think?

17 A Probably ten or so percent. Close to it.

18 Q Okay.

19 A Yeah.

20 Q To a reasonable degree of medical certainty?

21 A Oh, yes, to a reasonable degree of medical certainty.

22 Q Okay. Doctor, what would a reasonable radiologist or
23 reasonable pulmonologist reading this x-ray have done?

24 A Okay. Well, again, I mean I'm commenting as, as a
25 radiologist because in terms of what a pulmonologist might

William Woodruff - Direct examination
by Mr. McKinnon

1 do treatment wise I'm not qualified to say.

2 Q Okay.

3 A So let's, let's keep it to what I am, I am qualified to
4 testify to.

5 All right?

6 Q Yeah.

7 A (Witness returns to the stand.)

8 As a -- anyone reading this x-ray should have, number
9 one, described the lesion.

10 Number two, have made the connection that this -- that
11 cancer was a potential cause of what we see here. Pneumonia
12 too and there's a couple of ways that would of been
13 reasonable to go at this point.

14 Personally, I would have gone straight to a CAT Scan, a
15 CT Scan, to get a better look at it and that would of been
16 one way to go. If you were thinking, based on other like
17 patient's clinical history or whatever, that this is more
18 likely a pneumonia, I could of said it was entirely
19 appropriate to have, you know, treated the patient as if
20 they had a pneumonia like antibiotics with ten to fourteen
21 days and then re-x-ray. If it's a pneumonia, then after
22 about ten to fourteen days there should be significant
23 improvement.

24 I'm -- knowing what I know, I think to a reasonable
25 degree of medical certainty, had that been done this would

William Woodruff - Direct examination
by Mr. McKinnon

1 of looked the same. And then you -- then your suspicion for
2 cancer would be heightened. Then you're really obligated to
3 do something else and I mean, again, at that point, the CT
4 would, it be alternatively. If you're -- you wanted to go
5 straight to a PET CT and, and save a step, that would have
6 been reasonable.

7 I think one of those two -- I mean, at some point,
8 you're thinking about obtaining tissue, some kind of biopsy,
9 but personally I think it would of been reasonable to take
10 it to more of a, more of an advanced imaging study before I
11 went and put a needle in the man.

12 Q Okay. And, doctor, is there anyway it's reasonable for
13 a, a pulmonologist or radiologist reading this x-ray to do
14 nothing?

15 A No, that's the one thing that was wrong.

16 Q Okay. Doctor, I'm gonna put up something else here,
17 and this -- do you recognize this document, doctor?

18 A Yes, I do.

19 Q Okay. Can you tell the jury what it is?

20 A All right. Now, this -- can I stand up again?

21 Q Oh, yeah, and let me, let me move out a little bit so
22 that---

23 A Yeah.

24 Q Thank you.

25 A There we go.

William Woodruff - Direct examination
by Mr. McKinnon

1 (Witness comes down from the stand.)

2 Let me see if my glasses make it -- that's better
3 without them.

4 Okay. This is, again, patient William Farr. Date of
5 birth, you know. Referring doctor, Ronald Littlefield.
6 Date of the exam, October 7, 2010. So we've gone from
7 January to October.

8 It says chest x-ray. History, a 68-year old with
9 trouble breathing, a lot of smoking, and, again, two views,
10 PA and lateral upright.

11 Now, the one thing that I notice here that's missing
12 is -- and he doesn't actually make the statement, but it,
13 but, again, he doesn't refer to any old images. So he's
14 not -- he doesn't have anything to compare it to or at least
15 he didn't. I'm assuming he didn't have it because normally
16 we like to compare old to new and I mean the reason's
17 obvious because sometimes, you know, having the old study,
18 you see, you see the change. Sometimes having that to see
19 the change makes it easier to report. Plus you want to know
20 if something's growing quite honestly.

21 So there's mention of that. I think that's a pertinent
22 or relevant negative of what we don't see here.

23 Q So are -- you're saying that he -- it would of been
24 better if he'd had Doctor Wan's x-ray to look at?

25 A That would of been the ideal situation, yes.

William Woodruff - Direct examination
by Mr. McKinnon

1 But then he describes this confluent patchy and streaky
2 opacities. I mean, you know, something -- some people use
3 the word densities. Basically the white stuff when we're
4 talking about. You know, the, the patchy and streaky white
5 stuff seen in the anterior segment of the right upper lobe.
6 That's the area that we saw the abnormality back in January.
7 This is -- that I saw that on January.

8 You know, the -- extending anteriorly from the
9 pulmonary hilum. So, now, whatever this is is going back
10 further than this was. All the way to that hilum.

11 You remember I showed you where the pulmonary arteries
12 are on that lateral view?

13 That's where it starts going all that far back. There
14 is slight prominence in the central point at bronchovascular
15 markings and that's a sign of emphysema. The left, the left
16 and remaining right lung look, you know, basically are okay.

17 He doesn't really see any hyperinflation at that time.
18 You know, I did think there was some, was some on this one.
19 But, you know, the heart he saw was sort of at the upper
20 borderline, big, little calcification in the aortic arch.
21 That's just atherosclerotic disease. Bone's are okay. He
22 doesn't see any enlarged lymph nodes, and he's not seeing a
23 well defined mass knowing, of course, that when you have
24 that confluency, that could hide masses.

25 So, in other words, this does not exclude a mass. It

William Woodruff - Direct examination
by Mr. McKinnon

1 just says there's so much stuff he can't tell.

2 Q And what do you mean by mass?

3 A Tumor.

4 Q Tumor?

5 A Cancer.

6 Q So, in other words, doctor, there might be a hidden
7 tumor?

8 A Oh, certainly there may be, and, in fact, had he had
9 these radiographs we'll never know, but I think his
10 suspicion that there was an underlying tumor would of been
11 heightened in my opinion.

12 Q Does he make reference to that in his opinion?

13 A He says while this may be chronic, early, or evolving
14 pneumonitis, in addition, the possibility of an underlying
15 occult pulmonary lung mass can not be excluded. So he's
16 saying we need to do what I would of said needed to be done
17 in January. We need to be doing either short interval
18 follow-up like thinking about pneumonia or going straight
19 onto a CAT Scan.

20 Q So, in other words, the oh no it might be cancer is now
21 in October instead of January?

22 A Correct.

23 Q Okay. So, so what is the next study that's done,
24 doctor?

25 Do you remember?

William Woodruff - Direct examination
by Mr. McKinnon

1 A Yes, this was done on the 7th of October. This is four
2 days later the patient went for a CT or a CAT Scan of the
3 chest.

4 Q Okay. Doctor, I'm gonna try -- I know it's a two page
5 report.

6 A Yes.

7 Q I'm gonna try to get it where both pages -- is that --
8 if that's okay.

9 Well, that's not gonna work. We'll do it one page at a
10 time.

11 So, doctor, tell the jury, after he had that x-ray we
12 just looked at, what is the difference between a CAT Scan
13 and an x-ray?

14 A All right. Interestingly enough, both use x-rays, but
15 how they're used is, is quite different. With a -- again,
16 we've gone through a regular x-ray.

17 With a CAT Scan, the patient goes through this doughnut
18 shaped device and you have both tubes sending out the x-rays
19 and detector and it's going basically in 360. So you're
20 acquiring all of this x-ray data in a circle and the patient
21 passes through the circle, and at each little, little
22 interval -- in fact, we now have these continuous tubes.
23 It's acquiring just mountain loads of x-ray data.

24 What happens is it's, it -- it's, it's -- the, the, the
25 x-ray data is converted to mathematical formulas and then

William Woodruff - Direct examination
by Mr. McKinnon

1 you have this incredibly high speed computer that takes that
2 mathematical data and makes images out of it, and that's,
3 that's basically what a, what a CAT Scan is.

4 Q I'm gonna show you the second page of that report,
5 doctor.

6 A Yes.

7 Q And under impression, what does this radiologist say?

8 A Okay. Atelectasis with possibly adjacent infiltrate in
9 the right upper lobe. This could all be inflammatory of the
10 collapse and that's what the atelectasis, he's using that
11 word, and collapse. I think he's using those as essentially
12 what we call synonyms. Both atelectasis means volume loss.
13 Collapse does to. So I think that's what he's saying in so
14 many words.

15 He's saying the collapse is worrisome for an
16 endobronchial lesion, possibly a primary lung cancer, and
17 then he's saying that something else needs to be done to
18 find -- to answer this question.

19 Q And what was the date on this study?

20 A This was four days after the other one. This is the
21 11th of October, four days after the chest x-ray that
22 Doctor Salabis read.

23 Q And this one, the radiologist are using -- were worried
24 about cancer as a possibility?

25 A Cancer is mentioned as a possibility and I think that's

William Woodruff - Direct examination
by Mr. McKinnon

1 correct.

2 Q All right. Doctor, I'm gonna -- can you show the jury
3 a little bit of the actual CT scan and what that doctor
4 would of seen?

5 A Yeah.

6 Q I'm sorry. The magic of technology takes a second.

7 A Okay.

8 Q Okay.

9 A Yes.

10 Now, let's just talk for a minute. First of all, when
11 we do a CAT scan, we do what's called a Scout Topogram.
12 That's just words, but you see here what looks like that PA
13 and lateral and chest x-ray, and then what we do is, to
14 figure out like our slice thickness and to go like from the,
15 the top to the bottom, we tell the computer what to do. So
16 we have these slices and there's actually a lot of
17 information here.

18 You remember what nine months earlier that density
19 looked like?

20 Well, here's four days after what Doctor Sabalis --
21 it's gotten this big and it's gotten this big. Look at
22 that -- sort of that big old wedge shaped white thing up
23 there, but, again, it's still in that anterior aspect of
24 that right upper lobe. So it's the same area that we saw
25 nine months earlier. That's the thing that you got to

William Woodruff - Direct examination
by Mr. McKinnon

1 notice here is, but it's gotten a whole lot bigger.

2 Now -- and when you -- can you scroll down, scroll down
3 a little bit?

4 Q Sure.

5 A Okay. We're going -- now, just stop a second, Jordan.

6 We're going -- again, let's, let's orient ourselves.

7 The patient's -- what -- we're going from top to bottom.

8 We're going from top to bottom this way.

9 So, as we march -- as we're marching down, we're going
10 from top to bottom. But this up here, you know, it's,
11 it's -- at the top is the patient's front. The spine back
12 here's the patient's back. The patient left, patient right.
13 And then we're getting -- so, in other words, we've got our,
14 our depth going from top to bottom.

15 We've got our width going from the patient's right to
16 the patient's left. We get our height not in any one
17 picture, but in the sum of all the pictures marching down.
18 So I've got all three dimensions now with one step.

19 So now let's march on down if we could.

20 Stop.

21 This is this gray up here. You see -- I mean -- I'm
22 sorry. Just to orient you a little bit. Here is the --
23 what's called the ascending aorta. The descending aorta,
24 it's bright white cause we've given contrast material
25 through a vein.

William Woodruff - Direct examination
by Mr. McKinnon

1 This is the main pulmonary artery, the right pulmonary
2 artery, part of the left pulmonary artery. The hilum is
3 back here. Again, up front, anterior on the right side, is
4 this whole wad of stuff corresponding to that. There is
5 your, your lesion now. Much much bigger.

6 Q And, doctor, knowing what you know about Mr. Farr's
7 medical history, that wad of stuff is, in fact, what?

8 A That's cancer.

9 Now, I think there is a little bit of a, excuse me,
10 some inflammation around it. When cancer's get big, it's
11 real common for them to get some inflammation surrounding
12 it. That's gonna become important in just a minute.

13 So I -- it's a combination of mass and inflammation and
14 we know this was done on June 11th, less than two months
15 later, we know because of the pathology because, you know,
16 Doctor Nguyen's surgery that this was about a nine by eight
17 and a half centimeter tumor, and this is only a few weeks
18 before.

19 Q Do you remember, after this was done, doctor, do you,
20 you remember the next radiology study that was done?

21 A Yes.

22 Okay. One week later -- okay. This was certainly
23 suspicious---

24 Q Sorry.

25 A ---for cancer and the doctors, again, said we need to

William Woodruff - Direct examination
by Mr. McKinnon

1 take this to the next level thinking about the possibility
2 of cancer. So then was -- on the 18th was done a study
3 called a PET CT and you want me to talk about what a PET CT
4 is?

5 Q Please. Yeah.

6 A Yeah.

7 Okay. First of all, we do the CT again and there's a
8 reason that we do it and I'll explain all that in a minute.
9 Then what -- with the CT, we do what's called a PET Study.
10 Now PET's is for Positron Emission Tomography, which is a
11 fancy physics term. It's basically a nuclear medicine
12 study. The time we're trying to take the anatomic
13 information that we have with the CAT Scan and fuse it with
14 what we call physiologic or functional information.

15 What we do is we take a radioactive substance and we,
16 we chemically combine it with, with, with sugar or what's
17 called an analogue of sugar.

18 So, you know, where does sugar go?

19 Sugar goes to areas where there's in -- where there's
20 metabolic activity. So if something has a lot of metabolic
21 activity, we're gonna see it looking bright or, or intense
22 on the PET part of the study. Then with CAT Scan, we can,
23 we can take the computer and superimpose so we can say there
24 is abnormal metabolism and here's where it is located, and
25 that's a real powerful tool too. It's a lot of radiation.

William Woodruff - Direct examination
by Mr. McKinnon

1 It's expensive. So we tend to not do that first for those
2 reasons, but in a case like this where you really need the
3 information, it's powerful.

4 And, again, if you think about the things that are
5 metabolic -- any, you know, lots of things of metabolic
6 active. But most tumors are very metabolically active and
7 the idea is to say yeah, this is, is acting like a tumor.

8 Q Doctor, I think most folks who aren't doctors, they
9 hear metabolism and they think this person's got a fast
10 metabolism or a slow metabolism.

11 A Yes.

12 Q When you say metabolic activity, can you explain what
13 you mean?

14 A In other words, the cancer -- and, and you heard the
15 oncologist this morning talking about, you know, the rapid
16 turnover of cells and, you know, basically tumors are, are
17 doing that. They're -- you know, it's basically -- you
18 know, it's cellular growth out of control.

19 Well, that takes a lot of, of nutrition and a lot of,
20 of -- uses a lot of sugar to be honest. So that's what's
21 going on is. So we have sort of a, of a semiquantitative
22 way to measure that there's a lot going on there that's not
23 normal.

24 Q So am I -- is it fair to say that tumor cells burn more
25 energy than normal cells?

William Woodruff - Direct examination
by Mr. McKinnon

1 A As a general rule, that is correct---

2 Q And then---

3 A ---and that's what you're trying to -- you're trying,
4 trying to exploit that fact to get information you can use.

5 Q Got you.

6 And so that's what you're looking for in a PET Scan?

7 A Yes, sir.

8 Q Okay. And, doctor, what is this -- when was this PET
9 Scan done?

10 A It was done seven days after the CT. It was done on
11 the 18th of October of 2010.

12 Q Or eleven days after the October x-ray?

13 A Was it eleven?

14 Okay. Yes, eleven days after that first x-ray.

15 Q And, doctor, what is the, what is the impression of
16 that?

17 This is another radiologist?

18 A Yes.

19 Q What is the impression of, of that?

20 A Okay. Moderate level hypermetabolic activity, that's
21 sort of what we've been talking about that, you know,
22 abnormally active, you know, something corresponding to the
23 opacity in the right lobe. So the, the functional
24 abnormality and the anatomic abnormality match. That's sort
25 of what that's saying.

William Woodruff - Direct examination
by Mr. McKinnon

1 It, it is -- it says it's probably infectious.
2 However, primary can have this appearance. Now I'm gonna be
3 honest. I think this, again, looks more suspicious for
4 cancer than they did. Plus, again, we do know that the
5 answer is that there was a tumor there. But in all honesty,
6 I think that the amount of activity is dramatic and it looks
7 like again, I would have interpreted this as tumor till
8 proved otherwise.

9 Q Doctor, when this doctor says bronchoalveolar cell
10 carcinoma, that's a fancy word for what?

11 A Well, it's a, it's a primary lung cancer.

12 Q Cancer?

13 A Yeah.

14 Q And, doctor, I think you wanted to show us some of
15 these PET Scans.

16 A Yes.

17 Q Okay.

18 A This is gonna take just a minute to load cause this is
19 a big file.

20 Q Okay. If you can't get them, I don't want to make the
21 jury wait.

22 A Sorry.

23 Q Let's, let's just don't worry about it cause I don't
24 want to keep the jury waiting.

25 A You sure?

William Woodruff - Direct examination
by Mr. McKinnon

1 Q Yeah, we're good.

2 A But suffice it to say that, you know, when we talk
3 about, you know, this whole -- that whole wad of stuff shows
4 pretty intense metabolic activity. I mean to the point that
5 it reaches out and grabs you.

6 Q Have you looked at the actual PET Scan, doctor?

7 A Oh, I most certainly have.

8 Q And what did you see when you looked at that PET Scan?

9 A Basically what you saw on that CT, that whole area
10 shows increased activity in a lot of it and it's just -- and
11 the rest of it looks pretty normal. I mean -- but it's
12 right there. That whole thing is abnormal.

13 Q Okay. Doctor, after the PET Scan, are you aware of
14 were there any other procedures done to determine that Mr.
15 Farr had cancer?

16 A Yes, the day after this PET Scan, on the 19th of
17 October, the patient had a bronchoscopy. That's where
18 they---

19 Q What's a bronchoscopy?

20 A A bronchoscopy is something that is done generally by a
21 pulmonologist where they pass a tube that's called a
22 bronchoscope down into that windpipe and they look into the,
23 the different -- those bronchi, those breathing tubes, and
24 see are they open or are they obstructed, are there any
25 masses, is there inflammation, is there something there, and

William Woodruff - Direct examination
by Mr. McKinnon

1 then, I believe in this case, they, they did see abnormality
2 in that, in, in that right upper lobe of bronchus, breathing
3 tube, and they, they sampled it.

4 I don't know -- I think they did washings and some of
5 the stuff that you heard about this morning. They did, they
6 did attempt to obtain some kind of microscopic -- you know,
7 tissue to look under the microscope.

8 Q But did they actually see the tumor?

9 A They did not.

10 Q Okay.

11 A And---

12 Q Does that mean that he definitely doesn't have cancer?

13 A No, and go back to what I said a few minutes ago that
14 often times you will see inflammation surrounding the, the,
15 the tumor, and I think that that's what they saw, and that
16 they sampled that. And I'll tell you what makes me pretty
17 sure that that's correct is when Doctor Nguyen describes his
18 operative -- in his operative report, it said there was no
19 endobronchial lesion. In other words, the tumor, at that
20 time, he did not see growing in the bronchus, but there was
21 something that the pathologist saw to sample.

22 Now, I think what they were, were sampling was
23 inflammation surrounding tumor and I'm not a, I'm not a
24 pulmonologist. Is my understanding that just looking at it
25 you can't tell. That's why they sample it. But the bottom

William Woodruff - Direct examination
by Mr. McKinnon

1 line is it came back without a diagnosis of cancer on the,
2 on the 19th. That is correct.

3 Q Okay. And, doctor, do you recognize this report from
4 Doctor Cruz?

5 A Yes, I have seen that.

6 Q Okay.

7 A And this, this is Mr. Farr's first diagnosis of cancer.

8 Q Do you see what the date on the document is?

9 A Yes. Now that is the 26th. So that's seven days
10 later, on the 26th.

11 Q Right.

12 A And what happened on that day, obviously what
13 happened -- I mean Mr. Farr's doctors remained concerned
14 that there was a cancer in spite of that bronchoscopy being
15 non-diagnostic or negative for cancer. So what was done, a
16 radiologist actually passed a needle from the outside into
17 that wad of tissue, and, you know, a more invasive study,
18 but they felt it was necessary based on what we were seeing
19 on the CAT Scan and the PET Scan. And they were able to get
20 tissue and that tissue came back as positive for cancer.

21 Q And so, doctor, is that, what I'm pointing at here,
22 what lung BX means?

23 A BX stands -- is doctor shorthand for biopsy.

24 Q And that's what you were describing with a needle?

25 A Yes.

William Woodruff - Direct examination
by Mr. McKinnon

1 Q And, doctor, under interim history, what was the result
2 of that needle test?

3 A Okay. It says 2AT3NOM0 bronchoalveolar carcinoma.

4 Q Okay. So, doctor, this is November 1st, correct?

5 A Oh, this is -- this says October 26th.

6 Q Well, that was the actual date of the---

7 A Oh.

8 Q ---bronchoscope.

9 A That was the date -- no, that was the date of the
10 needle biopsy.

11 Q Well, assuming -- we'll use the later date to give the
12 benefit of the doubt.

13 So the day of the actual diagnosis of cancer would be
14 what?

15 A November 1.

16 Q Okay. And then the date of the October x-ray started
17 with this process is what?

18 A That was October 7th.

19 Q So how long did it take the -- all the doctors to go
20 from something's wrong on the x-ray to it's cancer?

21 A Just over three weeks.

22 Q Three weeks.

23 Okay. And this three weeks, if it -- a reasonable
24 radiologist had read the January x-ray, when would these
25 three weeks of test would of happened -- when would they

William Woodruff - Direct examination
by Mr. McKinnon

1 have happened?

2 A They would of -- this would of all been finished by the
3 end of January.

4 Q Okay. And by not reading that January x-ray properly,
5 all this stuff happened in October instead of January.

6 Is that---

7 A It appears so.

8 Q Okay. A nine month delay.

9 Okay. Let me see.

10 Doctor, have you looked at the operatory notes for
11 December 2nd for Doctor Nguyen where he cut out the cancer?

12 A I did look at that, yes, sir.

13 Q Okay. And what was your understanding of the size of
14 the cancer when it was cut out?

15 A It was approximately nine by eight and a half. I
16 forget the third dimension. But it was -- the biggest
17 dimension was about nine centimeters.

18 Q Okay. And when you first saw it, when you read it on
19 Doctor Wan's x-ray back in January, what is your best
20 estimate of the size?

21 A I had measured about two -- about 2.5 centimeters.

22 Q Okay. And so, in that length of time, it roughly more
23 than tripled in size?

24 Is that fair?

25 A That would be a fair statement, yes.

William Woodruff - Direct examination
by Mr. McKinnon

1 Q Okay. Doctor, doctor, are you familiar, as a
2 radiologist, with a mechanism spread of cancer called
3 aerogenous?

4 A Aerogenous.

5 Q Yes, sir.

6 A Not erogenous.

7 Q Aerogenous.

8 A Big difference.

9 Yes, I am familiar with that. This is discussed in, in
10 the radiology literature.

11 Q Okay. And that's -- can you explain what that spread
12 means?

13 A Yeah, as was mentioned this morning that, that
14 sometimes tumor cells will break off, and then those tumor
15 cells are floating around in these breathing tubes, and they
16 can certainly go out into smaller tubes and -- on the same
17 side. But if say you have a coughing spell, they can go
18 back up into that main, that trachea, that main tube, and
19 then they can fall wherever they want including falling to
20 the other side---

21 Q Based---

22 A ---and that has been documented.

23 Q Based on the radiology literature?

24 A That is in the, in the radiology literature and it is
25 something that is recognized as a phenomenon that does

William Woodruff - Direct examination
by Mr. McKinnon

1 occur.

2 (Witness returns to the stand.)

3 Q Okay. And, doctor, I'm basically done. I'm just gonna
4 try to sum up for the jury.

5 Is it your opinion, to a reasonable degree of medical
6 certainty, that Doctor Wan fell below the standard expected
7 of a doctor in South Carolina?

8 MR. WILLIFORD: Your Honor, I'm gonna object to the
9 leading.

10 THE COURT: All right. I'll -- you want to just
11 rephrase?

12 MR. MCKINNON: Sure.

13 Your Honor -- I'm sorry.

14 Doctor Woodruff, do you have an opinion about Doctor
15 Wan's reading of the x-ray?

16 A Okay. I do not believe -- okay. Again, I believe that
17 Doctor Wan, in providing a final interpretation of this
18 study, took on the standard of care expected of a
19 radiologist. I believe she failed to meet the standard of
20 care that I would expect for a radiologist or any physician
21 taking on the standard of a radiologist with respect to her
22 misinterpretation of this study.

23 Q And as a result, the cancer, instead of being caught in
24 January, was caught when?

25 A It was caught in October.

William Woodruff - Direct examination
by Mr. McKinnon

1 Q Okay. And, doctor, my last question.

2 Could Doctor Wan have sent this x-ray out to be read by
3 a radiologist like yourself?

4 A Oh, certainly. I mean I, I receive, or my practice, we
5 read for something like eight or ten offices in Central
6 North Carolina and I know that there are lots of
7 radiologists and this is common for practices to, to send,
8 you know, for, for practices to do that. And often a
9 practice will do what's called a preliminary read, and then
10 I, you know, they, they say do you agree or do you disagree.

11 But, again, my -- the radiologist read is the final
12 read. That's the read of record if you will. That's very
13 common and certainly could be done.

14 Q Okay. And your opinion you've offered today, doctor,
15 are those to a reasonable degree of medical certainty?

16 A Everything I said to a reasonable degree of medical
17 certainty, that is correct.

18 Q Thank you.

19 Nothing further, Your Honor.

20 THE COURT: Ladies and gentlemen, you want to stand and
21 stretch your legs?

22 (Jurors comply.)

23 MR. MCKINNON: Let me get my pen there, David.

24 Thank you, sir.

25 (Pause.)

William Woodruff - Cross-examination
by Mr. Williford

1 CROSS-EXAMINATION

2 BY MR. WILLIFORD:

3 Q Good afternoon, Doctor Woodruff.

4 A Good afternoon.

5 Q On the x-rays of January of 2010, we looked at the
6 front view, the PA view, and then the side-view, which is
7 the lateral view.

8 Correct?

9 A Yes, sir, we looked at both.

10 Q Okay. In your opinion, the -- what you called the, the
11 abnormality is, is more evident on the side-view and not the
12 front?

13 A It's on both. But I think it is easier, for me, it was
14 easier to see on the lateral view.

15 Q Okay. So, on the front view, if, if that is the only
16 one you had and I know you would have both.

17 A Right.

18 Q But if the front view was the only that we had, there's
19 no way to, to definitively say I think that's cancer?

20 A Well, now, I'm not gonna agree with that. I'm gonna
21 say that I think it would be, first of all, harder to
22 recognize. Having recognized it, I think one would be
23 obligate, would be obligated to take it to the next level
24 because there is asymmetrical -- a symmetry in the density
25 and that has to be explained if it was -- if it's

William Woodruff - Cross-examination
by Mr. Williford

1 recognized. But I mean I will be the first to say that if I
2 had only had that, I think that would be difficult to
3 recognize.

4 I mean, you know, in my case---

5 Q Sure.

6 A ---since I saw the lateral, I mean I'm, you know, I
7 knew to look there. And so I'm not -- you know, the fact is
8 one is obligated to look at both views. That's, that's
9 vitally important.

10 Q Sure.

11 But as far as the side and the front, the side to you
12 is more apparent?

13 A In this case, that is correct.

14 Q In this case.

15 A I do believe that to be so.

16 Q Okay.

17 A Yes, sir.

18 Q Now, Mr. McKinnon asked you about this aerogenous
19 spread of cancer or this airway spread.

20 You would agree that that would happen more in a
21 mucinous type of cancer where, where, you know---

22 A Now, I'm not a pathologist.

23 Q Okay.

24 A I don't honestly know as much about the specifics. I
25 know it happens, but I would have to defer the, the tumor

William Woodruff - Cross-examination
by Mr. Williford

1 type that's more common to a pathologist or an oncologist.
2 So really that's not in my domain. I mean I've read, but I
3 don't feel like I'm really qualified to take it to that
4 level.

5 Q Okay. So you're not qualified to talk about the
6 details of, of whether or not this breathing from one side
7 of the lung to the other theory occurs?

8 That's out of your field, correct?

9 A Well, I, I -- in my literature it says that it occurs.

10 Q Okay. No description---

11 A But beyond taking it to the level of which specific
12 cell type and so forth, I -- that is out of my domain.

13 Q Okay. Now, you talk about this breathing theory from
14 one side or the other.

15 That's, that's really just a theory though, is it not?

16 A Well---

17 Q It's not proven and accepted in the literature?

18 A It is accepted in the literature. Within the last year
19 an article has come -- a major article has appeared in my,
20 in my literature that says that it has been documented to
21 occur.

22 Q But it's a theory?

23 A No, I, I---

24 Q That actual article is a theory?

25 A Well, it sounded like -- I read that article and it

William Woodruff - Cross-examination
by Mr. Williford

1 sounded pretty convincing, but, again, I'm not a
2 pathologist. I'm not an oncologist. And beyond the fact
3 that it appeared in a peer review, a major peer review
4 journal in my, in my specialty, which I have a lot, you
5 know, that's as far as I can take it.

6 Q Okay. So just last year they came up with a theory,
7 and, and, as a radiologist, you would understand this, the
8 patterns that you would see from radiology would be a tree
9 and bud opacity and ground glass pattern?

10 A Well --.

11 Q Correct?

12 A I---

13 Q I mean that's what they would look at.

14 A Well, that -- it turns out it could look like anything.
15 But if you took all cancers, that seems to be the most
16 common pattern. But, again, I didn't read that it had to be
17 that pattern cause, ultimately, that is a pathologic
18 diagnosis, not a radiologic diagnosis. I mean I can not
19 look at an x-ray, and even if I saw tree and bud, I would
20 not -- I, I couldn't say oh, this is aerogenous for
21 positive, sure, that would need to be taken to another level
22 and I would not claim any further than that.

23 Q Correct.

24 Doctor, you have not authored any literature that
25 directly relates to this case.

William Woodruff - Cross-examination
by Mr. Williford

1 Correct?

2 A No, sir.

3 Q And you have not given any lectures or done any
4 presentations directly related to diagnosing lung cancer on
5 x-rays?

6 Is that true?

7 A Well, I have done local like -- you know, we have Tumor
8 Board in, in some of my hospitals too. But, but beyond just
9 like to a group of doctors in a specific case at Tumor
10 Board, no.

11 Q You have not done that.

12 Okay. And, and, again, I think you mentioned you're
13 not a pulmonologist. You're not a surgeon. You're not a
14 pathologist.

15 A That is correct.

16 Q Have you---

17 A I did one year of surgery, but that does not make me a
18 surgeon.

19 Q Okay. So you would defer to those specialties with
20 respect to the areas in which they practice and have
21 knowledge?

22 A With the one exception of the interpretation of the
23 chest x-ray, which I feel like that that was -- with that
24 caveat that we've already dealt with, I would agree with
25 what you just said.

William Woodruff - Cross-examination
by Mr. Williford

1 Q And like you mentioned, in terms of offering standard
2 of care opinions with respect to Doctor Wan, you feel like
3 you're qualified to give an opinion about the x-rays, but
4 not about the other clinical aspects of what Doctor Wan did?

5 A I would say that's a fair statement.

6 Q So, in other words, what she did, from a clinical
7 standpoint, you're not critical of?

8 A I, I have no basis for it and I'm not -- that's not in
9 my domain of expertise to comment upon.

10 Q Okay. You would agree, however, that it is appropriate
11 for a pulmonologist, such as Doctor Wan, to clinically
12 manage and treat a patient and also review x-rays as part of
13 that clinical treatment?

14 A I have no problem with that.

15 Q Okay. So it's okay for her to have Mr. Farr come in,
16 evaluate him, assess him, do a physical exam, do x-rays, and
17 come up with a clinical assessment and diagnosis?

18 A I, I have no problem with that at all, correct.

19 Q You're not of the opinion that Doctor Wan was reckless
20 or grossly negligent or intentional in a negative way
21 towards Mr. Farr?

22 A Oh no.

23 Q And you are not here to offer opinions on causation in
24 terms of any cancer progressing, progression of Mr. Farr's
25 lung cancer.

William Woodruff - Cross-examination
by Mr. Williford

1 True?

2 A I am not, no, sir.

3 Q Okay. And the only way to -- definitely to determine
4 the type of cancer one has is to have a pathology
5 determination of what that cancer is.

6 True?

7 A I believe that to be so, yes.

8 Q Okay. And you are not of the opinion that Mr. Farr's
9 second lung cancer, because you're not a pathologist, on his
10 left side was a metastasis?

11 In other words, you're not saying that the one on his
12 left side was a metastasis?

13 Is that correct?

14 A I can not comment on that. That is not in my domain of
15 expertise.

16 Q And you would have to agree, doctor, that if the left
17 lung cancer -- let me back up.

18 If the right lung cancer was fully resected, the one
19 that we've talked about was diagnosed in October, if it was
20 fully resected by Doctor Nguyen and the left lung cancer was
21 not a metastasis, then you would agree that whatever Doctor
22 Wan did or didn't do did not cause Mr. Farr's death?

23 A Honestly, as a radiologist, I'm really not able to
24 get -- again, that's, that's a clinical and a pathologic
25 judgment. So I'm really not gonna comment one way or the

William Woodruff - Cross-examination
by Mr. Williford

1 other. That's really not in my domain as a radiologist.

2 Q All right. Okay. Now, you agree, and I think you
3 mentioned this, when Doctor Wan interpreted the x-rays in
4 January of 2010 as hyperinflation consistent with COPD?

5 A Yes.

6 Q So she's correct in that?

7 A I, I agreed with that part of her interpretation.

8 Q Okay. Looking at the x-rays in January of 2010, in
9 your opinion, there's, there's something there, but you
10 can't determine whether it's cancer or even what type of
11 cancer it might be?

12 A I think we discussed that, but that is correct.

13 Q Okay. You would agree that CT Scans and PET Scans are,
14 are better, more definitive studies than x-rays typically?

15 A Typically.

16 Q Okay. Now, in terms of the cancer, in your opinion, in
17 January, overlies the hilum and is not part of the hilum.

18 Would that be fair to say?

19 A It's clearly separate from the hilum.

20 Q So the hilum is ultimately normal?

21 A On, on that x-ray, yes.

22 Q Now, I want to walk through those studies just very
23 briefly cause Mr. McKinnon touched on them and ask you a few
24 questions about them.

25 Now, right here, this is the x-ray from October 7th.

William Woodruff - Cross-examination
by Mr. Williford

1 This is the report and, again, it confirms that there's no
2 hilar or mediastinal adenopathy or mass or lesions that way.

3 Do you see that?

4 A Yes, I agree that there are no hilum or mediastinal
5 lesions --

6 Q Okay.

7 A -- that we can see on -- I mean -- now, now, strictly,
8 that's what his report says. Now I understand we don't have
9 that actual x-ray. But if I look at the, the Scout
10 Topograms from four days later, which we'll say four days is
11 not a lot of time, a lot of change -- time for change, I do
12 not see it four days later.

13 Q Okay. And under impression, and we've gone through
14 this a little bit, but confluent and patchy and streaky
15 radiopacities in the anterior segment of the right upper
16 lobe. While this may be chronic in nature earlier -- or
17 evolving pneumonitis can not be excluded.

18 A Yes.

19 Q Now, what they're saying right there, this radiologist,
20 and you're a radiologist, is based on this x-ray, most
21 likely it's a pneumonitis?

22 A Well, I---

23 Q At this point it's just -- if you had to weigh it, most
24 likely it's pneumonitis?

25 A Well, again, I've looked at it myself, and I mean --

William Woodruff - Cross-examination
by Mr. Williford

1 first of all, I'm not saying that I a hundred percent agree
2 with the way -- what he says here. But what I -- how I
3 interpret this, as a radiologist, is he's really not sure.
4 He's saying well, I don't have any old images. So I don't
5 know if it's acute or chronic, but, you know, I've got to
6 think about what are the bad things it can be.

7 The bad things are pneumonia. The bad things are
8 cancer and he's saying, you know, you got to explore -- we
9 got to deal with those two things, which is exactly what I
10 said as far as January was concerned. Your main
11 differential considerations are, unless you've got proof
12 that something is chronic, which he doesn't, which Doctor
13 Wan did not as far as that goes back in January, is, you
14 know, could be pneumonia, could be cancer, could be both.
15 And then -- and then he correctly says what needs to be done
16 to take it to the next step.

17 Q Okay. Well, let's, let's go over that real quick.
18 Earlier evolving pneu, pneumonitis can not be excluded. In
19 addition, the possibility, and, again, this is just a
20 possibility. Not a probability.

21 Correct?

22 A That's what he says.

23 Q Of an underlying occult pulmonary mass can not be -- he
24 doesn't say can not be excluded. He says can not be totally
25 excluded.

William Woodruff - Cross-examination
by Mr. Williford

1 Correct?

2 A Well, that's again, I---

3 Q That's his interpretation.

4 A Again, I think that he is -- I would, I would of come
5 down a little harder on this, and, again, just by -- and
6 I'm, and I'm -- and I've tried very hard -- cause I mean is
7 it -- you know, it's true. I know what January looked like
8 if he didn't. But, nonetheless, I see that big, I'm gonna
9 call it just for, you know, it's a wad of something, and
10 what things look like a wad of something. Cancers and
11 pneumonias and many times there's a cancer with pneumonia
12 around it. I see it -- I see two or three of these every
13 week -- every work week of my life.

14 And, you know, so he's saying totally. I would of left
15 out that totally word cause I think that implies a -- I mean
16 I think that was -- I wouldn't of used that, but the bottom
17 line is -- the bottom line is, he's saying my differential,
18 assuming that it's something that's not chronic, and, you
19 know, he has no basis for just -- he's just mentioning that
20 as a possibility since he doesn't have any old studies to
21 compare, pneumonia and cancer, and he takes it to the next
22 level, and I don't think -- I think anything else is, is
23 playing semantics to be honest with you.

24 Q Okay. Well, I'm just going through his report.

25 A Okay.

William Woodruff - Cross-examination
by Mr. Williford

1 Q And one other additional thing I was gonna ask you
2 about, occult.

3 Occult means hidden?

4 A Well, yeah, and, again, you can -- again, we talked
5 about sort of, again, pneumonias surrounding the mass can,
6 can hide the mass as a discrete entity. But you got to know
7 what things live where and it's -- and that, that doesn't
8 sway -- if I was reading that, it wouldn't sway me from
9 thinking about cancer as a major possibility one bit.

10 Q Okay.

11 A And that's what I'm trying to say.

12 Q Right.

13 And, and this is ten months later.

14 Correct?

15 About ten months?

16 A Nine or ten months later---

17 Q Okay.

18 A ---was from---

19 Q And---

20 A Okay.

21 Q And, and you mentioned that, that, since you've seen
22 the, the earlier one and then you saw this one, you kind of
23 have a kind of a hindsight bias at some level?

24 A Well, I mean I, I know the answer, but, but,
25 nonetheless, looking at this de novo, and I mean I've tried

William Woodruff - Cross-examination
by Mr. Williford

1 really hard to separate that, I would have been concerned
2 about cancer just as I think that this doctor was.

3 Q All right. But you would of been harder than that?

4 A I would of phrased it a little differently, but I think
5 our -- but, again, I would of, I would of made the same
6 ultimate recommendation.

7 Q All right.

8 A And his recommendation was followed up on. So, whoever
9 got that report, was -- felt sufficiently convinced of the,
10 of the concern to take it to the next level. So the bottom
11 line, I have no fault with the ultimate outcome of what was
12 done with this report.

13 Q All right. Here there's no -- this is a CT a few days
14 later---

15 A Yes.

16 Q ---and we talked about that. There's no significant
17 axillary and axillary is kind of up in here. There's---

18 A Armpit.

19 Q ---kind of the armpit area.

20 A Armpit.

21 Q Mediastinal, the middle area.

22 Correct?

23 A Correct.

24 Q And the hilar adenopathy.

25 Correct?

William Woodruff - Cross-examination
by Mr. Williford

1 A I, I did not see any adenopathy anywhere.

2 Q Okay. And atelectasis again is just---

3 A It's volume loss.

4 Q ---collapse or volume loss?

5 A Yes.

6 Q And then -- and just skipping down here. There's some
7 soft tissue in the right hilum and endobronchial lesion
8 would be a possibility, but bronchoscopy may be the best
9 study for further assessment.

10 So really what he's saying is well, you know,
11 they're -- again, this is a CT, CT Scan, a better study.
12 It's a possibility. I can't say probably, but let's do a
13 bronchoscopy to look in the lung.

14 That's, what's what you're saying?

15 A He's saying if -- I'm gonna, I'm gonna rephrase it.
16 He's saying I don't know what it is, but I'm concerned
17 enough to take it to an invasive level cause I consider a
18 bronchoscopy an invasive procedure. So he's putting -- he
19 is committing Mr. Farr to doing something more involved,
20 more invasive.

21 Q But based on the CT Scan, they could not diagnose it
22 specifically as cancer?

23 A He could not make that as a 100 percent diagnosis. I
24 will agree with that statement.

25 Q Okay. And then going to the PET Scan a week later,

William Woodruff - Cross-examination
by Mr. Williford

1 again, there's no hilar or mediastinal adenopathy or
2 activity in the lungs or otherwise clear, and then, on the
3 back, the second page impression, the hypermetabolic
4 activity just does not have the typical appearance of
5 metastatic disease and probably infectious or inflammatory
6 pneumonic, pneumonic infiltrate.

7 So, again, you know, he's looking at it and I, without
8 getting into the details of the SUV, an uptake of five---

9 A Yes, sir.

10 Q --and, you know, we went through that in your
11 deposition.

12 A Uh-huh. (Affirmative).

13 Q But he called it a moderate level hypermetabolic,
14 metabolic activity and then his diagnosis is probably
15 infectious or pneumonic infiltrate.

16 He's not coming down hard on cancer, is he?

17 A Well, he is not, and as we talked about in my second
18 deposition, that, first of all, an SUV of five -- by the
19 way, for the, for the juries -- SUV is called Standardized
20 Uptake Value. In other words, we take a normal structure
21 and call it a one, and then we say how much more metabolic
22 activity is in the lesion compared to normal uptake. And,
23 remember, I mean, you know, our regular body parts are doing
24 some metabolism. I mean, after all that's why we, that's
25 why we went to lunch, you know.

William Woodruff - Cross-examination
by Mr. Williford

1 So, so this says an SUV of five. It's five times more
2 metabolically active than normal tissue.

3 I mean, you know, you know, what's a lot?

4 I mean five, I would of called it, called it
5 moderate -- I mean those are -- now we're getting into sort
6 of these, these, you know, he calls it moderate. I would of
7 called it moderate to a little more than that, and---

8 Q Well, let me just---

9 A And that's just -- I mean I'm not, I'm not -- we're not
10 arguing -- I'm not arguing with him. But I'm just saying,
11 as to my eye, I would of come down as cancer more suspicious
12 than he did. Though I agree that I have seen pneumonias
13 with an SUV of five and I won't dispute that, and the bottom
14 line is that, is that something else more invasive needed to
15 be done and that's what happened.

16 So, you know, we can quibble over, you know, if he
17 thinks it's a little more likely to be pneumonia, I think
18 it's a little more likely to be cancer, that's not the
19 point. The point is that he is said we need to take it to
20 the next level, which is what happened, and that's
21 appropriate. So it got done right even the -- if we
22 disagree a little bit over the details of the reports.

23 Q Okay. And, and -- okay. So you would of come down
24 harder, not landed on moderate, and then---

25 A I, I would of come down---

William Woodruff - Cross-examination
by Mr. Williford

1 Q It's a---

2 A I wouldn't of come down as -- I wouldn't of said
3 probably pneumonia. I would of said that, that, that cancer
4 remains a concern. I would of said something like that.
5 And, again, the two, you know, as I had, had mentioned
6 earlier, the, you know, sometimes you have pneumonia and
7 cancer coexisting and which is what I think actually was the
8 case here based on what we talked about the, the negative
9 bronchoscopy one day later.

10 So, you know, I think that we're all in the same, you
11 know, sort of, you know, we're, we're in the same church,
12 maybe on adjacent pews, instead of the same pew. But the
13 bottom line is we're saying I think the same basic
14 information.

15 Q Well, he's coming down saying it's probably infection
16 or pneumonia.

17 A But -- and still--

18 Q Possibly it could be cancer, but let's go do a
19 bronchoscopy and look in the lung. That's what he's saying.

20 A And the bottom line is we need to take it to the next
21 level.

22 Q All right.

23 A Okay.

24 Q And he---

25 A On that we agree.

William Woodruff - Cross-examination
by Mr. Williford

1 Q And he did that and---

2 A He did that the next day.

3 Q I'd like to briefly go over that, the bronchoscopy, and
4 here it is --

5 A Yes, sir.

6 Q -- the next day and I'm just gonna focus on this one
7 part. It says procedure and detail. Examination of the
8 right upper lobe showed no endobronchial lesion for three
9 upper lobe orifices.

10 A Yes.

11 Q I think it was -- yeah.

12 And there was no narrowing, bleeding noted.

13 Examination of the right middle and lower lobes showed to be
14 clear and free of secretions, mass, or bleeding, and
15 ultimately there -- the bronchoscopy, the invasive inside
16 the lung operation, could not find the mass---

17 A It---

18 Q ---based on the bronchoscopy?

19 A The bronchoscopy did not show it, but one week later
20 there was cancer from a needle biopsy. It just shows that
21 there's no perfect test and there was a case of a, of an
22 imperfect test. It doesn't mean it was done wrong. I don't
23 fault -- I mean I have no -- I'm not a pulmonologist, but
24 just as a doctor in general, I do not fault the
25 pulmonologist for not getting the diagnosis. That happens

William Woodruff - Cross-examination
by Mr. Williford

1 sometimes.

2 But, fortunately, the patient -- the, the -- they --
3 his referring doctors did not stop. They went to the needle
4 biopsy and got the definitive answer a week later, which is
5 a trivial amount of time in my opinion.

6 Q And the PET Scan we've talked about.

7 That's the Rolls Royce of radiology studies.

8 Isn't that true?

9 A Well, it's certainly a, a---

10 Q Yes or, yes or no, doctor.

11 A Well, I mean that's one way to put it. I don't know,
12 you know, it depends on---

13 Q Right.

14 A I think it's a very sophisticated, very in, information
15 intense study.

16 Q Okay. You, you termed it the Rolls Royce in your
17 deposition. I'll be happy---

18 A Okay. Well then fine, I'll be happy---

19 Q I can pull it out.

20 A I think it -- it's expensive. That's for darn sure.
21 So, yeah, I would say that's fine.

22 THE COURT: All right. Gentlemen, try not to talk over
23 each other.

24 THE WITNESS: Yes, sir.

25 MR. WILLIFORD: Yes, sir.

William Woodruff - Cross-examination
by Mr. Williford

1 THE COURT: Thank you.

2 Q All right. Now, based on the, the PET Scan, October
3 18th PET Scan, the Rolls Royce, you're of the opinion that
4 the tumor had grown into the bronchus, one of the tubes that
5 feeds the lungs, and is obstructing the bronchus.

6 Correct?

7 Your, your review of that---

8 A I thought that it looked like it had. Now, this says
9 that it didn't and, again, I -- again, they're, they're --
10 there's no perfect test and I certainly could of been wrong
11 about that. But, to my eye, I was concerned that that had
12 happened based on that PET.

13 Q And you would of called it "tumor obstructing a right
14 upper lobe bronchus"?

15 A Correct.

16 Q Based on that PET Scan, you would of said there's a
17 mass in the, in the bronchus?

18 A That was -- I believe that the, the PET was indicating
19 that.

20 Q But it---

21 A It turned out not to be.

22 Q ---was not?

23 A And, again, there's no perfect test. We're not
24 claiming perfection.

25 Q Now, doctor, you've charged 315.00 an hour for your

William Woodruff - Cross-examination
by Mr. Williford

1 time reviewing the case or giving depositions?

2 A That, that's correct.

3 Q And I think your deposition was -- was it a thousand
4 dollars for the first three hours?

5 A Yeah.

6 Q And then 350 for any additional time?

7 A If, if it had gone that long. It did not.

8 Q Okay. And you're here -- I think it's \$3,500 you
9 mentioned?

10 A That is correct.

11 Q You've done expert witness work for over 20 years?

12 A Off and on for 30 years. Most of it has been in the
13 last ten.

14 Q And you've reviewed about 250 cases in your career?

15 A I would say that's a pretty good estimate, yes, sir.

16 Q And given about 45 to 50 depositions or maybe a little
17 more?

18 A It's closer to 60 I would think.

19 Q Sixty.

20 A I don't know the exact number, but that would be close.

21 Q Would it be fair to say that almost all of the cases in
22 which you have testified have been medical malpractice
23 cases?

24 A Most have. I've had a couple of workman's comp. I've
25 done one -- a criminal murder trial. But the majority have

William Woodruff - Cross-examination
by Mr. Williford

1 been some kind of medical malpractice or negligence cases.

2 Q And 31 out of 33 cases have been for the plaintiff.

3 Correct?

4 A Well, in terms of my -- no, it's not -- no, 31 of 33
5 of---

6 Q Well, in terms of depositions.

7 A No, I've got---

8 Q For medical malpractice cases.

9 A Well, I -- no, it's, it's been -- I've done more
10 defense than that number. Two of the last three depositions
11 I've done have been for the defense. I think that's
12 information since we've last met. But I -- but, but if you
13 ask me my total, you know, percentage of review, it's
14 probably somewhere between 70 and 75 percent plaintiff. The
15 rest defense.

16 Q Okay. Right here is just some research that we have,
17 testimonial, history for the plaintiff, 31, defendant, two
18 in these various states.

19 A Yeah.

20 Q Okay. And, again, that would be your name, correct?

21 A That -- yes, that is correct.

22 Q Okay.

23 A Now, honestly, I haven't broken it down in terms of
24 depositions. But if you ask me what I review in terms of
25 total, what's sent to me to review cause, obviously,

William Woodruff - Cross-examination
by Mr. Williford

1 everything that I'm sent to review doesn't turn into a
2 deposition or a trial.

3 Q Okay. And you're currently reviewing about five to six
4 cases against South Carolina doctors?

5 A It may be that many. Like I said four to five. It may
6 be six. I don't -- somewhere in that range.

7 Q You would agree that radiology or interpreting films
8 such as x-rays has some interpretive aspect to it?

9 A Oh, quite -- yes, of course.

10 Q Not everything is clear cut in radiology such as
11 reading x-rays?

12 A I would agree with that absolutely, yes.

13 Q You would agree that a physician may do their best to
14 be prudent in reading an x-ray, yet, in retrospect, have a
15 little bit clear prospective or understanding of what might
16 be on the films such as x-rays?

17 A Yes, I would agree with that.

18 Q You would agree that two physicians can look at an
19 x-ray and have a difference of opinion and both physicians
20 can be reasonable and prudent in their interpretations?

21 That can happen?

22 A It can happen.

23 Q You agree that a physician can misread or miss
24 something on a radiology study and not be negligent?

25 A I would agree with that.

William Woodruff - Cross-examination
by Mr. Williford

1 Q In fact, that's happened to you?

2 A Oh yes.

3 Q In fact, you missed an aneurysm on a study and got sued
4 for it and was not truthful in Court about it?

5 A What do you mean not truthful in Court?

6 Q Well, I have a -- public documents from North Carolina
7 right here. I've got the complaint, the answer, and request
8 to admit.

9 In testimony -- in fact, let's just walk through it.

10 MR. MCKINNON: Your Honor, we're gonna object.

11 THE COURT: All right. Lawyers want to approach?

12 (WHEREUPON, a bench conference was held out of the
13 hearing of the jury at this time.)

14 Q Doctor Woodruff, it's true that you got sued for
15 missing -- for allegedly missing an aneurysm on a patient.

16 Correct?

17 A In the -- endocranially, that is correct.

18 Q Okay. And isn't it true that your answer in that case
19 that was filed in the Guilford County Court claim that you
20 denied it?

21 A Denied missing it or I'm sorry?

22 Q Yes.

23 Isn't that true?

24 A Well, I -- no, I never denied missing it. I don't
25 remember anything of that nature at all. I mean whether or

William Woodruff - Cross-examination
by Mr. Williford

1 not that was a deviation of the standard of care was
2 debatable, but I did agree to settle the case. But I don't
3 ever remember saying that I missed it. I was asked did I
4 remember reading the case and I said I had no recollection
5 of ever looking at the case. But I never denied that, that
6 I did.

7 Q Okay. Well, let's, let's look at that real quick.
8 Won't take long.

9 MR. MCKINNON: Your Honor, I'm gonna object.

10 THE COURT: All right. Lawyers want to approach?

11 (WHEREUPON, a bench conference was held out of the
12 hearing of the jury at this time.)

13 THE COURT: Ladies and gentlemen, I'm gonna let you
14 take a short break. We've been at this for sometime. These
15 are what's called matters of law I have to take up with the
16 lawyers.

17 I'm gonna need to remind you not to have any
18 discussions among yourselves about anything involving the
19 case.

20 You may retire back to the jury deliberation room.

21 (WHEREUPON, the following takes place outside the
22 presence of the jury.)

23 THE COURT: Doctor, you can step down as well. I just
24 need to remind you that you're in the process of giving
25 testimony. So please don't have any discussion with anyone

William Woodruff - Cross-examination
by Mr. Williford

1 about the substance of your testimony. But you may step
2 down.

3 (WHEREUPON, a short recess was taken at this time.)

4 THE COURT: Doctor, come back around.

5 (Witness returns to the stand.)

6 THE COURT: Do y'all anticipate using the ELMO again
7 for this, this witness?

8 MR. MCKINNON: No, Your Honor.

9 THE COURT: Okay.

10 MR. DAVIS: I can turn it off.

11 THE COURT: All right. Anything before we bring the
12 jury back?

13 MR. DAVIS: Is it okay if we just turn it off?

14 THE COURT: Yeah.

15 Anything before we bring the jury back?

16 MR. WILLIFORD: No, Your Honor.

17 THE COURT: Okay. Let's bring the jury back.

18 THE BAILIFF: Yes, sir.

19 (WHEREUPON, the following takes place within the
20 presence of the jury.)

21 THE COURT: Yes, sir.

22 MR. WILLIFORD: Thank you, Your Honor.

23 CONTINUED CROSS-EXAMINATION

24 BY MR. WILLIFORD:

25 Q Doctor, I really only have just a couple more questions

William Woodruff - Cross-examination
by Mr. Williford

1 for you.

2 After the diagnosis of lung cancer and Doctor Nguyen
3 did surgery and then he was followed up for, you know,
4 another year and a half at least and he went through
5 treatment, he got better, and then he ultimately developed
6 lung cancer on the left side, you're gonna defer to those
7 physicians in terms of what happened after the diagnosis of
8 the cancer?

9 True?

10 A That is correct.

11 Q Okay. And if, doctor, if the right lung cancer that
12 allegedly Doctor Wan missed was not the cause of Mr. Farr's
13 death, then Doctor Wan did not cause Mr. Farr's death.

14 True?

15 A Well, that seems reasonable. Again, I'm not the
16 clinical specialist who addressed that issue, but---

17 Q Sure.

18 A ---I don't have any negative comments along those
19 lines.

20 Q All right. Thank you, doctor.

21 THE COURT: Any redirect limited to what he went into?

22 MR. MCKINNON: Very briefly, Your Honor.

23 THE COURT: Yes, sir.

24 REDIRECT EXAMINATION

25 BY MR. MCKINNON:

William Woodruff - Redirect examination
by Mr. McKinnon

1 Q Doctor Woodruff, I won't keep you up here much longer.
2 There's a couple of things I wanted to clear up.

3 At the very beginning of Mr. Williford's questioning he
4 asked you about what if you had looked at the front x-ray
5 only.

6 A Yes.

7 Q In other words, you looked at the front view and not
8 the side view.

9 A Yes.

10 Q And what -- do you remember what you said?

11 A But I -- I basically do -- I mean, in my opinion, it
12 was, it was, is abnormal. It's harder to recognize the
13 lesion than it is having had the, the benefit of the lateral
14 view, but I do believe that it is abnormal.

15 Q That is why you take two x-rays.

16 Is that correct, doctor?

17 A Again, you need, you need three dimensions -- you need
18 two views to see three dimensions. In this particular case,
19 this lesion is easier to see in the depth component compared
20 to the length and the width component. I mean the next, the
21 next one might be something else. But, in this particular
22 case, you do need it and then, again, that is -- that gives
23 you that extra dimension and that, in this case, I think was
24 quite crucial.

25 Q Would it be reasonable for a doctor to take the front

William Woodruff - Redirect examination
by Mr. McKinnon

1 view and the side view and look at the front view only?

2 A well, they're billing for two views. That would be
3 dishonest.

4 Q All right. And not meet the standard of care for---

5 A And not meet the standard of care.

6 Q Okay. Doctor, I know, at one point, they asked if you
7 had a clinical opinion on Doctor Wan's pulmonary care as a
8 pulmonologist and you're not a pulmonologist.

9 Right?

10 A I'm not a pulmonologist.

11 Q So as to what medicines she gave and what she told him
12 and the breathing treatments, none of that, none of that's
13 in your field?

14 Correct?

15 A That is not in my field.

16 Q But x-ray reading is your field --

17 A Yes.

18 Q -- right?

19 And did -- do you have an opinion on the reading of the
20 x-ray?

21 A Again -- well, first of all, again, I think she---

22 MR. WILLIFORD: Yeah, Your Honor, objection. Asked and
23 answered. This is not ground that we had -- new ground.
24 He's already been asking those questions in direct.

25 THE COURT: All right.

William Woodruff - Redirect examination
by Mr. McKinnon

1 MR. MCKINNON: Your Honor, they muddled the water by
2 asking him did he have opinions. I've got to explore what's
3 clinical and what's not.

4 THE COURT: All right. Go ahead and ask the question
5 and then we'll move on from the subject.

6 MR. MCKINNON: Okay.

7 A In my opinion, Doctor Wan deviated from the standard of
8 care in her interpretation of Mr. Farr's x-rays in January
9 of 2010.

10 Q Moving on to nine months later when another doctor, her
11 primary care doctor, in October orders that second chest
12 x-ray, and---

13 MR. WILLIFORD: Your Honor, the same. I think he's
14 going into a ground that he went on on direct.

15 THE COURT: Let me hear the question first.

16 Q Mr. Williford went through the, the CAT Scan and the
17 PET Scan and asked you did they definitely say for sure it's
18 cancer.

19 Does that matter?

20 MR. WILLIFORD: Your Honor, he is gone -- he actually
21 went through all those as well on direct.

22 THE COURT: Okay. Well, I'll, I'll allow it.

23 THE WITNESS: Am I to answer?

24 I'm sorry. I don't---

25 THE COURT: Yes, sir.

William Woodruff - Redirect examination
by Mr. McKinnon

1 A Oh, okay. The bottom line is they, they conveyed a
2 sufficient suspicion that warranted what was the correct
3 thing to do was an invasive procedure, that percutaneous
4 lung biopsy with a needle that got the diagnosis of cancer.
5 So that led to the correct thing being done in, I think, a
6 timely manner.

7 Q And we know, in fact, for sure that he did have cancer?

8 A We do know that.

9 MR. MCKINNON: Nothing further, Your Honor.

10 THE COURT: All right. Thank you, sir. You may step
11 down.

12 Plaintiff ready to call their next witness?

13 MR. MCKINNON: We are, Your Honor.

14 The Plaintiff calls Doctor Sau-Yin Wan.

15 THE COURT: Ma'am, just come around right up here and
16 let the Clerk of Court swear you in.

17 DOCTOR SAU-YIN WAN, being first
18 duly sworn, testified as follows:

19 CROSS-EXAMINATION

20 BY MR. MCKINNON:

21 Q Good afternoon, Doctor Wan.

22 A Good afternoon.

23 Q Doctor Wan, could you state your full name for the jury
24 please?

25 A Sau-Yin Wan.

Sau-Yin Wan - Cross-examination
by Mr. McKinnon

1 Q Okay. And, Doctor Wan, you are the defendant in this
2 case that we're suing, is that correct, one of the two?

3 A Yes.

4 Q Okay. And, Doctor Wan, as we sit here today, what is
5 your job currently?

6 A I'm a pulmonologist and an intensivist.

7 Q Okay. What -- and a pulmonologist, who do you work for
8 today?

9 A Upstate Lung and Critical Care.

10 Q Okay. And are you a partner or owner of the practice
11 or are you an employee?

12 A I'm an employee.

13 Q Okay. And on January 11th, 2010, the date the x-rays
14 we've been talking about were taken, what was your job?

15 A Sorry. Repeat that again.

16 Q Sure.

17 On January 11th, 2010, when the x-rays that we've been
18 talking about were taken, what was your job on that day?
19 who did you work for?

20 A The same job that I have right now.

21 Q The same job?

22 You were a pulmonologist at Upstate?

23 A Yes.

24 Q And when you ordered those x-rays and interpreted them,
25 were those part of your job duties at Upstate?

Sau-Yin Wan - Cross-examination
by Mr. McKinnon

1 A Yes.

2 Q Okay. Who is your -- well, who owns that doctor group?

3 A It, it's kind of complicated --

4 Q Okay.

5 A -- and most of them are partners --

6 Q Okay.

7 A -- meaning they all share the practice.

8 Q Okay.

9 A We, we elected, we elected Doctor Feldman as the CEO.

10 But every doctors have different role in the practice

11 because they are all partners, and I just chose not to be
12 one.

13 Q Okay. But when -- at your deposition I asked you who
14 owned the practice.

15 Do you remember what you told me?

16 A I assume Doctor Feldman.

17 Q You did.

18 A Yes, sir.

19 Q And so -- that's different.

20 It's different now?

21 A Well, it is still the same, but he's the CEO of the
22 practice, but they are all partners.

23 Q Okay. But Doctor Gregory Feldman, he's kind of your
24 boss?

25 A Sort of.

Sau-Yin Wan - Cross-examination
by Mr. McKinnon

1 Q Okay. Well, sort of, what does that mean?

2 A He, he always say that I, you know -- I want to explain
3 this because he's very nice person and he always say that,
4 you know, don't call me my boss. I'm your partner. But, on
5 paper, he's my, he's my boss because he employed me. But he
6 is very nice. He always say you are a partner regardless of
7 whether or not you, you earn money from this practice. You
8 are my partner. So, yes, I call him boss, but he say you're
9 my partner.

10 Q But he's the CEO of the practice?

11 A You're correct.

12 Q Okay. Doctor, I want to turn this gizmo back on here.
13 Let me get it.

14 Where's the power?

15 Doctor Wan, do you remember seeing William Farr?

16 A By my note, yes.

17 Q Okay. And just to make sure I understand what you're
18 telling me.

19 You're saying you don't have a memory of seeing him,
20 but you have medical records that, that---

21 A You're correct.

22 Q ---describe the visit?

23 Why did Mr. Farr come to see you?

24 A He was, he was -- as I recall, my notes that say he was
25 referred by Doctor Vidito --

Sau-Yin Wan - Cross-examination
by Mr. McKinnon

1 Q Okay.

2 A -- to have his lung checked.

3 Q Okay. What did you find?

4 I'm gonna -- now, if you want, I'm gonna put up --
5 well, let's do it this way.

6 Do you recognize this document?

7 Well, that's not really good. There we go.

8 Do you recognize that, doctor?

9 A I can't see really well from here. But I think it is
10 my note.

11 Q Okay. Doctor, you feel free to stand up and look if
12 you have -- I know that's a bad angle.

13 A Is it okay?

14 Q Sure.

15 THE COURT: Yes, ma'am, if you would, just -- you'll be
16 moving away from the microphone. So please speak up loud
17 enough so that both the court reporter and this very last
18 juror can hear you.

19 THE WITNESS: Okay.

20 THE COURT: Thank you.

21 (Witness comes down from the stand.)

22 MR. WILLIFORD: Your Honor, may I ask if you can, Mr.
23 McKinnon, put a copy of the, of the record in her hand?

24 MR. MCKINNON: I don't have a second copy here.

25 MR. WILLIFORD: I've got you.

Sau-Yin Wan - Cross-examination
by Mr. McKinnon

1 MR. MCKINNON: If you'd got one, David, I'll be more
2 than happy to do that.

3 MR. WILLIFORD: Did you get that out of the medical
4 records?

5 MR. MCKINNON: Not out of the, the, the exhibit set I
6 did not. I pulled it out of mine.

7 MR. WILLIFORD: Here we go, Doctor Wan.

8 Q That's fine. You can sit back down, doctor. That way
9 if the -- and you can go back to the microphone.

10 (Witness returns to the stand.)

11 Q Okay. And, doctor, is what you have in your hand the
12 same as what I've got up on the screen here?

13 A Yes.

14 Q Okay. So, doctor, what, what is this document?

15 A This is my notes from January 11th, 2010. It is a new
16 patient encounter meaning I've never met him before.

17 Q Okay. And this was January 11th?

18 A 2010.

19 Q Okay. And let me see.

20 Okay. Doctor---

21 THE COURT: Is there anyway you could focus that
22 better?

23 I'm sorry. I can't read it.

24 MR. MCKINNON: Your Honor, I am really sorry. Let me
25 zoom in.

Sau-Yin Wan - Cross-examination
by Mr. McKinnon

1 Is that better, Your Honor?

2 THE COURT: It's readable.

3 MR. MCKINNON: I mean I can zoom in a little more.

4 That's -- how's that?

5 Q Doctor Wan, under problems, what did you diagnosis as
6 Mr., Mr. Farr's possible problems or his problems that he
7 had?

8 A Dyspnea, COPD, nondependent tobacco use disorder, and
9 hypoxemia.

10 Q Okay. In layman's terms, tell -- can you tell the jury
11 what dyspnea is?

12 A Shortness of breath.

13 Q Okay. And what about COPD?

14 A Chronic Obstructive Pulmonary Disease.

15 Q Okay. And nondependent tobacco use, is that the fancy
16 way of saying he's a smoker?

17 A Yes.

18 Q Okay. And then the final.
19 what is hypoxemia?

20 A Low oxygen.

21 Q Okay. Do any of those diagnosis suggest that he might
22 possibly have cancer?

23 A No.

24 Q No.

25 Okay. Doctor, what is -- studies above that, what does

Sau-Yin Wan - Cross-examination
by Mr. McKinnon

1 studies mean?

2 Right here.

3 A Tests.

4 Q Okay. And what tests did this -- does it say that you
5 ordered?

6 A Pulmonary function test and chest x-ray.

7 Q Okay. What is a pulmonary function test?

8 A It is a test we ask the patients usually to blow into a
9 device and---

10 Q Okay.

11 A ---there's more sensitive test where they can sit in
12 the box. Basically we're looking at different lung volume
13 and see---

14 Q Okay.

15 A ---the -- how, how good the breathing volumes are and
16 capacity.

17 Q Okay. Is that a test for cancer?

18 A No.

19 Q Okay. And then what's below that?

20 A Chest x-ray.

21 Q Okay. And that, that is your -- is that -- firstly,
22 that's a summary of your read of the chest x-ray or what,
23 what do those notes mean?

24 A This will be my interpretations of the x-ray.

25 Q Okay. And what are your interpretations?

Sau-Yin Wan - Cross-examination
by Mr. McKinnon

1 A There is no nodules. There's hyperinflation. There's
2 pleural effusion. Oh, I'm sorry. There's no pleural
3 effusion and no cardiomegaly.

4 Q Only. So the only thing -- is it fair to say the only
5 thing you found worthy of note was hyperinflation?

6 A That's correct.

7 Q Okay. What is hyperinflation?

8 A That is -- you have too much air in your lung and the,
9 when you breath in, you don't breathe out, and, as a result
10 of that, they get trapped in the lung.

11 Q Okay. Does that mean you have cancer?

12 A No.

13 Q And not suspicious for cancer?

14 A No.

15 Q Okay.

16 A Can, can I add a note on this?

17 Q Sure.

18 A There is a reason why I put no nodules and no pleural
19 effusion and no cardiomegaly in this.

20 Q Okay. Sure.

21 A It is what we call a potential negative. So, in other
22 word, it is something that I look for and did not find.

23 Q Okay. So, doctor, just to make sure I'm understanding
24 you correctly, a nodule would be something that might be
25 cancer, a mass, or a density?

Sau-Yin Wan - Cross-examination
by Mr. McKinnon

1 Is that fair?

2 A That's fair.

3 Q Okay. And so what you're telling the jury is, when you
4 wrote nodule no, that you specifically looked on the x-ray
5 for a nodule and didn't see one?

6 A That's correct.

7 Q Okay. And you, you were -- looked for one.

8 why did you specifically look for a nodule?

9 A Because he's a very high risk of lung cancer or any
10 cancer if -- for that matter.

11 Q Okay. All right. But nothing in your notes suggest he
12 might have cancer, that he needs follow-up for cancer.

13 Correct?

14 A That's correct.

15 Q Okay. Doctor Wan, on the day you saw him, knowing
16 everything you know now, knowing that, you know, he died of
17 cancer, that they cut a tumor out in December, knowing with
18 all of that, do you believe he had cancer when he saw you on
19 January 11th?

20 A It is possible, but I did not see any evidence of it.

21 Q Okay. So you're -- you're, you're saying that maybe he
22 had cancer, but you didn't see it?

23 A That's correct.

24 Q Okay.

25 A Not based on, not based on all the assessment that I've

Sau-Yin Wan - Cross-examination
by Mr. McKinnon

1 done on him.

2 Q Okay. Do you find it believable that there was no
3 tumor on January and it -- and a 9-centimeter tumor in
4 December?

5 A Yes.

6 Q You do?

7 So that is what you believed happened?

8 A Yes.

9 Q So you -- there was no tumor in January?

10 A Well, I looked for it. There wasn't.

11 Q Okay. Doctor, I just -- I want to make sure cause the,
12 the language, I want to make sure you understand what I'm
13 asking.

14 A Yes.

15 Q I'm not asking if you saw a tumor.

16 I'm saying, knowing everything you know now, with all
17 the medical records, do you think there was a tumor there
18 even if you didn't see it?

19 A Well, I can not make an assumptions on something that I
20 know was -- did not exist. I'm, I'm not trying not to
21 answer your questions, but you're asking me to make an
22 assumptions. But I know that I looked for it. There's an
23 x-ray.

24 Q Right.

25 A There's an x-ray that says, you know, there wasn't

Sau-Yin Wan - Cross-examination
by Mr. McKinnon

1 anything.

2 Q Is it possible there's something there and you missed
3 it?

4 A Not from my notes.

5 Q The notes prove -- how, how do the notes prove you
6 didn't miss anything?

7 A Well, it is my opinion.

8 Q Okay.

9 A The notes is my opinion.

10 Q Okay. But, doctor, just -- is it possible you're
11 wrong?

12 Is that -- in the way you interpreted the x-ray?

13 A Well, you could say that, but I don't think so.

14 Q Okay. Well, that -- let's go ahead and look at the
15 x-ray, doctor.

16 Would you, would you like the lights out or the lights
17 on for that x-ray box?

18 A Lights off.

19 Q Lights off.

20 Okay. Doctor, I'm gonna lift up the box for you here
21 and you just tell me how you want to position it. The jury
22 needs to be able to see it too.

23 Where, where would you like it?

24 A Wherever they can see it.

25 Q Is this -- I mean this is -- you, you can stand up,

Sau-Yin Wan - Cross-examination
by Mr. McKinnon

1 doctor.

2 Is this, this good?

3 A Yes.

4 Q Okay. Doctor, here are the actual films. I'll give
5 those to you.

6 A Yes.

7 (Witness comes down from the stand.)

8 A You want me to put it up?

9 Q Please. Yeah.

10 THE COURT: All right. She stepped away from the
11 microphone. So be sure you speak up, doctor, so the court
12 reporter can hear you.

13 THE WITNESS: Yes, sir.

14 THE COURT: Thank you.

15 THE WITNESS: Can you see it?

16 Can you see it?

17 (WHEREUPON, the jurors nod affirmatively.)

18 Q Okay. Doctor, and just through -- the one on the left
19 is what we call the lateral or the side-view and the one on
20 the right is what we call the PA or the front view.

21 Is that correct?

22 A That's correct.

23 Q Okay. Doctor, as we sit here today, looking at this
24 x-ray, having heard everything in this case, other than
25 hyperinflation, having extra air in the lungs, is there

Sau-Yin Wan - Cross-examination
by Mr. McKinnon

1 anything abnormal on these x-rays?

2 A No, sir.

3 Q Nothing at all?

4 A No, sir.

5 Q Okay. Let's start with the front view.

6 Doctor, what is this I'm circling with my pen right
7 here?

8 what is this structure?

9 A Pulmonary artery.

10 Q That's the pulmonary artery. Okay.

11 A And there is the hilum come -- this structures here and
12 this structures here is the hilum.

13 Q Okay.

14 A So there are pulmonary artery that comes out from there
15 and there's the trachea that comes out of the area. But you
16 really can't see them for a fact. You can only see white.

17 So that is the hilum, but there's structures in there,
18 pulmonary artery, pulmonary vein, and the trachea are --
19 goes and branch into that like what Doctor Woodruff say that
20 it goes into the lung.

21 Q Okay. But, doctor, the trachea is up here, right?

22 A Well, trachea goes right down and then it goes into the
23 right and the left main bronchus --

24 Q Okay.

25 A -- and the -- all the structures will go into the, the,

Sau-Yin Wan - Cross-examination
by Mr. McKinnon

1 the line. So the right main bronchus and the left main
2 bronchus or airway, the airway goes into the same area to go
3 into the lung.

4 Q Okay. But there's clearly an abnormal -- there's
5 something here that's not on this side.

6 How do you explain that?

7 A Sir, I want to tell you this takes years of training,
8 and to really tell you that there's nothing wrong with this.
9 The pulmonary vein -- the pulmonary artery can look
10 different on both sides. In fact, I, I have a pictures of
11 it. I don't know if -- can I show it now or---

12 Q Not -- you'll have a chance when they call you as
13 their, as their witness.

14 A Okay.

15 Q You'll do that.

16 A So what it does is that, you know, your pulmonary
17 artery comes out like this when -- this is my pulmonary
18 artery and what it does is say when you come out this way,
19 the pulmonary artery go in front of your airway. And when
20 it goes out this way, the pulmonary artery goes and loop
21 around it like this. Kind of loop, loop around the trachea,
22 the breathing pipe, or the bronchus -- the left main
23 bronchus. I'm going to say that correct term there.

24 So it is known, it is, in radiology we teach you that,
25 you know, they -- you expect symmetrical. But they're not

Sau-Yin Wan - Cross-examination
by Mr. McKinnon

1 always and it is known that they can look the way that it
2 is.

3 Q So your testimony is the reason there's this thing on
4 this side and not over here is it's just his natural anatomy
5 looks weird?

6 A Well, there -- no, there is something here. There's
7 the left hilum there.

8 Q But, doctor, you would agree with me that there's a
9 much -- something is much denser here than over here, isn't
10 it?

11 A That's the nature of, like I just say---

12 Q Yes.

13 A ---pulmonary artery and the hilum coming out because of
14 a different structures of both sides. You can look like
15 this and this thinking not -- they don't have to be exactly
16 the same.

17 Q Can you trace the pulmonary artery?

18 My pen is retracted. So only -- can you just show me
19 the pulmonary artery right here?

20 A Well, again, like I say, you're not suppose to see them
21 because they are just white. I can, I can only tell you the
22 structures most likely come out from this because not all
23 pulmonary artery can be, can be seen in all x-ray.

24 Now, on the very nice x-ray, you can actually see a
25 v-shape. In this case, they don't have a v-shape.

Sau-Yin Wan - Cross-examination
by Mr. McKinnon

1 Now, this is not uncommon in somebody with COPD
2 because, what happen when you have COPD, you have pulmonary
3 hypertension or high pressures in the, in the pulmonary
4 artery from low oxygens. So they, they tend to be a little
5 bit bigger or more generous. So if you want to -- if you
6 can imagine what we see, that's why I want to refer you to
7 the normal structures, what you will see is that the
8 pulmonary artery will go up like this and then branch like
9 this, the right upper, the right upper and right lower, and
10 then the left upper and left lower will go like this. Like
11 a V.

12 Q Let's look at the side-view, doctor.

13 A Yes, sir.

14 Q What is this structure right here?

15 A Well, again, like I say, the way we look at chest x-ray
16 on the side-view, I want to illustrate a little bit more.
17 When we look at x-ray, you can look at only black and white
18 and density and how far they are.

19 Now, this structure right here -- can I have a pen---

20 Q Yeah. Please.

21 A ---to do that?

22 Okay. Now, if you, if you can imagine, I need to ask
23 you to imagine right now because I don't have anatomy
24 pictures to show you and I do have one, what you would
25 imagine is that your heart is coming right here, and then

Sau-Yin Wan - Cross-examination
by Mr. McKinnon

1 your pulmonary artery is gonna go out this way and then come
2 up -- trace around and go this way. So they will look at it
3 from the side. Now -- and then you have your aorta coming
4 out from here.

5 Now, as far as the certain structures and how you can
6 delineate it, like draw where it is, I can not do that
7 because x-ray is not geared for this to look at it or to
8 differentiate it in that regard.

9 Q Doctor, this is the rib cage right here, isn't it?

10 A That's correct, yes.

11 Q Okay. So this structure is right under the ribs, isn't
12 it?

13 A Well, the way you look at it is you want to have a
14 black space in-between here --

15 Q Right.

16 A -- and there is. So that's how we look at it and
17 determine if there's anything, you know, abnormal, abnormal
18 about this and there is a space here. So, you know, again,
19 like I say, I can not delineate or draw exactly where the
20 structure's are coming out because x-ray only tells you
21 black and white. It doesn't tell you -- it doesn't tell
22 you, you know, exactly the structures and what it is there
23 unlike the CAT scan, which can see it all.

24 Q Let me ask it this way, doctor.

25 A Yes, sir.

Sau-Yin Wan - Cross-examination
by Mr. McKinnon

1 Q This is spine, right?

2 This is the person's back?

3 A That's correct.

4 Q This is his rib cage?

5 A This -- no, that's---

6 Q These are the ribs right here?

7 A That's correct.

8 Q Okay. So this structure is right under the front of
9 his chest.

10 Right?

11 Isn't it?

12 I mean this -- these are his ribs. So this is just
13 behind his rib cage.

14 Right?

15 A I---

16 THE COURT: Mr. McKinnon, you're standing in front of
17 the jury.

18 MR. MCKINNON: I apologize, Your Honor. I'm very
19 sorry.

20 This -- these are the ribs.

21 This structure, I'm asking, is right behind the ribs,
22 isn't it?

23 A No, I would disagree with that. I don't know how you
24 can tell it. I, I truly don't.

25 Q Okay. This is, this is a side-view, correct?

Sau-Yin Wan - Cross-examination
by Mr. McKinnon

1 A You're correct.

2 Q And these are the ribs.

3 This is like the sternum here where the ribs, where the
4 ribs come from?

5 A Correct.

6 Q And so this is just behind it. I mean here's, here's
7 the spine. This is very far forward just under his -- isn't
8 it?

9 A I, I honestly can not tell you this is right on the
10 ribs because you just can't. I, again, like I say, you, you
11 not -- you're not able to because you are looking on the
12 side and the ribs is going like this.

13 Q Right.

14 We'll say the front of the rib cage right here like
15 where the sternum is.

16 Isn't that what we're looking at there?

17 A The sternum, you're correct.

18 Q Right.

19 Which is right, right in the middle of your chest under
20 the skin.

21 Right?

22 A May I use your pen again?

23 Q Please. Yeah.

24 A So you can see that there's sternum and then you can
25 see that there's ribs---

Sau-Yin Wan - Cross-examination
by Mr. McKinnon

1 Q Right.

2 A ---in-between and then there's lungs in-between.

3 Now, this is merely, when you're looking at the side,
4 like this if that makes sense. So if it comes out like here
5 and it comes out like here, there's no way I can tell you
6 where exactly this is.

7 Q Okay. Let me just ask it, doctor.

8 Your testimony is this, this far forward, this is the
9 pulmonary artery?

10 That's what you're saying?

11 A To my eyes this structure did not come out from the
12 sternum if that's what you're asking me. It looks to me
13 that this structures is, is close to the heart, coming out
14 of here, and then it twists around and going into this hilum
15 here or where it branch out, which is the structures that I
16 see here.

17 Q Well, what would you describe as the upper of the
18 lobe -- of the lung here, the upper lobe of the lung?

19 A It is normal.

20 Q No, no. Show -- where would the upper lobe be on the
21 x-ray?

22 A The upper lobe?

23 Q Yeah.

24 A You can not -- I can -- well, I can not draw a line
25 here.

Sau-Yin Wan - Cross-examination
by Mr. McKinnon

1 Q Yes.

2 A So usually, usually you want to look at the fissure,
3 but not every, not every x-ray you can find a fissure. So
4 consequently, if you go for any teaching, they will say draw
5 a line here and then draw a line there if that -- if I'm --
6 I'm hoping I don't obstruct your view. And anything above
7 this is upper lobe.

8 Q So, doctor -- so this structure here would be on the
9 bottom of the upper lobe?

10 Is that fair?

11 A Again, like I say, I -- this structures is within the
12 mediastinum.

13 Q But I -- but this -- if you're looking -- you drew the
14 line here.

15 This would be on the border of the upper lobe, right,
16 what you just showed me?

17 A It lies on the line.

18 Q Right.

19 Isn't that exactly where the tumor was found and they
20 cut it out was on the border of the upper and middle lobe?

21 A You mean in October?

22 Q No, in, in December when they cut it out.

23 Wasn't it---

24 A In December?

25 Q Wasn't it on the -- found on the border of the upper

Sau-Yin Wan - Cross-examination
by Mr. McKinnon

1 lobe?

2 A I think I recall that.

3 Q Okay. So, so this structure is exactly where the tumor
4 was found?

5 A Sir, I don't see a structures in there, and you're
6 telling me that ten months down the road that the structures
7 were, therefore, I, you know, it's there. I, you know, I
8 don't know how I can explain myself, and, you know, again,
9 this is a normal structure that connecting the heart and I
10 wish to show you pictures of it so that you know that I'm,
11 I'm talking from the bow. I'm not talking from my head.

12 Q But your, your testimony is that's a normal structure
13 that just happens to be in the same place the tumor was
14 found?

15 A Yes. I mean this, this, this structure right here can
16 be abnormally enhanced if you have pulmonary, I'm sorry,
17 hyperinflations or COPD and the -- again, this is nothing
18 abnormal considering the patient's situations and his
19 current conditions.

20 MR. MCKINNON: I don't have anything further, Your
21 Honor.

22 THE COURT: Okay.

23 MR. MCKINNON: I'm sorry, David. Let me grab my notes
24 and pad there.

25 MR. WILLIFORD: Sure.

Sau-Yin Wan - Cross-examination
by Mr. McKinnon

1 (Witness returns to the stand.)

2 MR. WILLIFORD: Your Honor, I wanted to let you know
3 that I plan to go through my full direct examination at this
4 point under the rules for this witness.

5 MR. MCKINNON: May we approach, Your Honor?

6 (WHEREUPON, a bench conference was held out of the
7 hearing of the jury at this time.)

8 THE COURT: Are you gonna use the x-ray machine?

9 MR. WILLIFORD: Yes, Your Honor. I will. I'm not
10 gonna do it quite yet though. I'm gonna wait just a few
11 minutes and we'll---

12 MR. MCKINNON: David, would you like me to take the box
13 down?

14 THE COURT: Yeah. Please.

15 MR. WILLIFORD: Do my best to keep this out of the way.
16 If this is in someone's way, somebody raise your hand or I
17 would ask Your Honor -- I don't want to speak to the jury
18 directly, but if that's in anyone's way let me know.

19 DIRECT EXAMINATION

20 BY MR. WILLIFORD:

21 Q Doctor Wan?

22 A Yes, sir.

23 Q I want to go through a little bit of your background --

24 A Yes.

25 Q -- real quick.

Sau-Yin Wan - Direct examination
by Mr. Williford

1 A Yes.

2 Q Tell the jury who you are and a little bit about your
3 family and where you grew up if you will.

4 A I am from Malaysia and---

5 Q Go ahead.

6 A Sorry. I'm from Malaysia and I'm really terribly
7 sorry. I just all of a sudden thought about my dad. Sorry.
8 I'm from Malaysia and I grew up there with my parents and
9 my---

10 Q It's okay.

11 A ---my sister -- two sisters and one brother. I have
12 always want to go to Medical School and my dad supported me,
13 and I did my medical school in Malaysia, part of it. It's a
14 training with training program where we go to a different --
15 may I have a minute, sir?

16 THE COURT: All right. Ladies and gentlemen, I'm gonna
17 ask, if you would, to retire back to the jury assembly room
18 and we will get you back just shortly. Do not have any
19 discussions among yourselves about anything involving the
20 case.

21 Ma'am, sit down please.

22 THE WITNESS: I'm sorry. I'm sorry, sir.

23 (WHEREUPON, the following takes place outside the
24 presence of the jury.)

25 THE WITNESS: I'm sorry. This is unexpected of me.

Sau-Yin Wan - Direct examination
by Mr. Williford

1 THE COURT: Ma'am.

2 All right. We're gonna step down.

3 You need to gain your composure, ma'am.

4 THE WITNESS: Yes, sir.

5 THE COURT: Okay. We'll come back.

6 THE WITNESS: Yes, sir.

7 (WHEREUPON, a short recess was taken at this time.)

8 THE COURT: All right. We'll go on the record.

9 All right. Counsel, you need to be sure the doctor
10 understands that a request has been made of the Court by the
11 defense that I actually charge the jury that their decision
12 can not be based on passion or sympathy. I can not allow
13 that to be shown to the jury.

14 In the event, based on what I've already seen, the
15 doctor's reaction, I'm concerned that you better not lay any
16 background information about the doctor that would elicit
17 that type of emotion. If the doctor feels and advised you
18 that she will not break down in tears as she has done, I
19 think it's proper for you to ask those questions. But
20 otherwise I fear that you can not go into those questions.

21 MR. WILLIFORD: Okay. Your Honor, may I ask a question
22 of -- that, that I was planning to ask her?

23 THE COURT: Not unless you get that assurance from your
24 client.

25 MR. WILLIFORD: Well, I didn't want to speak to her

Sau-Yin Wan - Direct examination
by Mr. Williford

1 during the break.

2 THE COURT: You can ask her on the record?

3 MR. WILLIFORD: Okay. Right now?

4 THE COURT: Uh-huh. (Affirmative).

5 CONTINUED DIRECT EXAMINATION

6 BY MR. WILLIFORD:

7 Q Doctor Wan, why were you just emotional?

8 THE COURT: Sir, you wanted to ask her about that
9 question -- well, how would she respond to it.

10 MR. WILLIFORD: Yes, sir.

11 THE COURT: Is she going to be able still to be
12 emotional when asking those types of questions?

13 Q Are you -- Doctor Wan, are you gonna be emotional if I
14 ask you about your dad?

15 A No.

16 Q Okay.

17 THE COURT: Okay. If it happens, the Court will have
18 to take more measures other than just dismiss the jury out
19 of the courtroom.

20 MR. WILLIFORD: I understand and I'm probably just
21 gonna move on.

22 THE COURT: That's your call.

23 MR. WILLIFORD: Okay.

24 THE COURT: All right.

25 MR. WILLIFORD: Thank you.

Sau-Yin Wan - Direct examination
by Mr. Williford

1 THE COURT: Anything else before we bring the jury in?

2 MR. WILLIFORD: No, Your Honor.

3 THE COURT: Okay. Bring the jury in.

4 (WHEREUPON, the following takes place within the
5 presence of the jury.)

6 THE COURT: All right.

7 CONTINUED DIRECT EXAMINATION

8 BY MR. WILLIFORD:

9 Q Doctor Wan, your dad passed away earlier this year.

10 Is that correct?

11 A That's correct.

12 Q Okay. I want, I want to talk about your training. You
13 were talking about Medical School and explain to the jury
14 what your training is---

15 A Yes.

16 Q ---and what, what is it like in Malaysia in terms of
17 your education.

18 A It is a very long training. Usually you start off in
19 high school. So we finish high school and go into Medical
20 School.

21 At that time, I had the -- my father would not allow me
22 to go anywhere else. He say I have to go to an English
23 speaking country to learn medicine. So he, he asked me to
24 explore the options, and, at that time, the only option that
25 I had was this training school, a Medical University in

Sau-Yin Wan - Direct examination
by Mr. Williford

1 Malaysia or it's now called IMU, International Medical
2 University, where they have training programs to two
3 different country or the many different country for that
4 matter. So, once we finish over there, we, we can go to
5 different university in Canada, in Australia, in New
6 Zealand, and in the United States.

7 So I finished my training there and then you got into
8 the school that you pick. It's a matching product where I
9 pick them and they pick me and then I went to Canada. I
10 going to Canada for three years. And after I finish Medical
11 school there, I, unfortunately, they would not allow me,
12 even though I was a graduate from Canada, they say that I'm
13 not Canadian. So I have to explore other options for
14 training and I have to come to United States by myself
15 with -- in Richmond, Virginia and then I have to go through
16 Miami for three more years of training. Then I landed in
17 South Carolina because of the job.

18 Q You mentioned you had to come to the United States.

19 Do you like the United States?

20 A Yes.

21 Q Unpack that a little bit in terms of your training.
22 You talk about going to Richmond and Miami and being in
23 Canada.

24 Break down for the jury, if you will, what kind of
25 training and how long at each place.

Sau-Yin Wan - Direct examination
by Mr. Williford

1 A Okay. I first landed in Richmond, Virginia and it is a
2 three years program. You have one year of internship and
3 then two years of what they call residency and some people
4 do it in -- at different places, and I did it in all one
5 place, at VCU, Virginia Commonwealth University. At that
6 time they call Medical College of Virginia, and then three
7 years when I finish internal medicine training, I choose to
8 specialize in pulmonary and critical care. That's another
9 three years.

10 Then you go through a matching program again, and I
11 match into University of Miami or Jacksonville Memorial
12 Hospital for training.

13 Q And you talked about the residencies.

14 What is a residency?

15 A It's, it's internal medicine training. Once you go
16 through your first year of internship, you show proficient
17 in, in supervising the intern and then you move on. But, at
18 the same time, you continue to receive training and learning
19 from different -- usually internal medicine doctors and that
20 includes all the subspecialties. So you want to build-up
21 your general knowledge of internal medicine.

22 You -- we go through different, different training and
23 different specialty from GI, gastroenterologies, pulmonary.
24 We do ICU and we do cardiology. We do infectious disease
25 and some people might choose to do one more over the other.

Sau-Yin Wan - Direct examination
by Mr. Williford

1 There's a core training that we have to go through in order
2 to be board eligible meaning you have to have core training
3 to, to go for exam. But then some people can do extra of
4 certain things and if they're interested in those areas.
5 But there's core training that we go through for medicine.

6 Q You mentioned internal medicine.

7 What is internal medicine?

8 A Internal medicine is where basically anything related
9 to internal organ medicine that, you know, relief -- related
10 to internal organ. So -- and there's area. We, we tend to
11 break them down into two different, different organs.
12 There's the cardiologist, the heart. The GI system,
13 gastroenterologist. The lung, pulmonary. And then kidney,
14 the nephrologist, and then you can also break it down by
15 system, which is infectious disease, and you can also --
16 endocrinology.

17 So it is conglomerate of, of a different specialty in
18 everything, everything about medicine.

19 Q Okay. And correct me if I'm wrong, the way I
20 understand it is you start out in internal medicine, which
21 is a general internal body organ, you know, focus, and then,
22 from there, you branch off into specialities that focus on
23 different organs.

24 A Yes.

25 Q What that be fair to say?

Sau-Yin Wan - Direct examination
by Mr. Williford

1 A Yes, sir.

2 Q Okay. Now, when you do an internal medicine residency,
3 how long is that residency?

4 A It's two years.

5 Q Two years.

6 A So I have one year of internship and then two years of
7 residency.

8 Q And when you start a residency, are you a medical
9 doctor at that point?

10 A I have an M.D.

11 Q M.D.

12 Okay. So what are you doing during, during your
13 residency, for example?

14 A We -- basically we have to learn the clearly the aspect
15 of it. You know, I, I personally think that going through
16 Medical School is just to learn the language of how to state
17 the term. You don't know anything really. You -- when you
18 go into residency, it's a different story. You are trying
19 to apply what you learn by really basically understanding
20 what the doctors are talking about.

21 So that's when we really learn how to take care of the
22 patients, how to recognize diseases, how to manage them, and
23 how to follow them.

24 Q So after your two years of internal medicine residency,
25 where did you go after that?

Sau-Yin Wan - Direct examination
by Mr. Williford

1 A Miami, University of Miami.

2 Q And what did you do there?

3 A I did a fellowship in combined pulmonary and critical
4 care. It's basically the lung and critical care is the
5 speciality where you basically, when you are very very sick,
6 extremely sick, you go into an ICU and it is a lot of
7 general medicine because people can be sick from a variety
8 of reason. But they combine both because a lot of patients
9 with critical care illness, they tend to have lung problems
10 and a lot of them tend to end up on what we call mechanical
11 ventilation, a ventilator.

12 So because you often see them when you're doing
13 pulmonary anyway, so, you could combine them and make a
14 three years program rather than doing a two years of just
15 critical care of two years of just pulmonary.

16 So I combined them both so that I can do both at the
17 same time, learn them both at the same time.

18 Q How long was that in Miami, how many years?

19 A Three years.

20 Q Three years.

21 So three additional years after the two years --

22 A Yes, sir.

23 Q -- internal medicine --

24 A Yes, sir.

25 Q -- residency?

Sau-Yin Wan - Direct examination
by Mr. Williford

1 And then all of that is after you've already become a
2 medical doctor?

3 A That's right.

4 Q And then where did go from Miami?

5 A Spartanburg, South Carolina.

6 Q Okay. And where, where did you work then and where did
7 you work now?

8 A Same place, Upstate Lung and Critical Care.

9 Q You are a specialist in---

10 A Pulmonary.

11 Q ---basically---

12 A Yes.

13 Q ---pulmonary critical care?

14 A And critical care.

15 Q So basically a lung specialist and someone who focuses
16 on difficult diseases?

17 A That's correct.

18 Q Did you award -- were you awarded any kind of honors or
19 any awards in, in your training?

20 A I was on the Dean's, Dean's List --

21 Q Okay.

22 A -- and I think I had a grant from the University of
23 Canada where I actually got to do a research in, in England.

24 Q Tell us a little bit about that.

25 A You know, it's so many years ago I can, can not

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by Mr. Williford

1 remember what the name of the grant was, but I worked in
2 University of Aberdeen with the -- one of the researcher in
3 the lab and just reviewing their chart and then writing the
4 report.

5 Q Does everybody get to go to England under grants?

6 A No.

7 Q Now, have you given any publications?

8 Have you ever been published or made presentations in
9 your career?

10 A I have post a, post presentations, yes.

11 Q Okay. I'm just looking at your CV, your resume, if you
12 will, and there's one that says Tuberculosis Masquerading as
13 a Chest Wall Mass.

14 A That's correct.

15 Q Okay. And, and you gave that presentation?

16 A Yes, I did.

17 Q I mentioned this in opening and I've, and I've seen it
18 on your CV, but it appears you speak four different
19 languages?

20 A That's correct.

21 Q Yeah.

22 And what are they?

23 A I speak English and I speak Mandarin. I actually grew
24 up speaking Mandarin. I speak Cantonese, which is a
25 dialogue off of Mandarin, and I speak Malay, which is our

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1 national language.

2 Q Okay. And, and where is Malaysia by the way?

3 A It is -- I always say do you know where Thailand is,
4 and if you know where Singapore is, it's right between those
5 two country.

6 Q Doctor Wan, are you board certified?

7 A Yes, sir.

8 Q Tell us about the board certification process.

9 What do you have to go through to get board certified?

10 A We have to go through the training first. So you
11 basically have to have the knowledge. You have to go
12 through the residency or the fellowship, depending on what
13 speciality you go through, and after you go through the
14 training, they basically determined that yes, you, you have
15 the -- enough clinical knowledge to now just take the exam,
16 and, once you take the exam and you pass the exam, you are
17 board certified.

18 Q In what are you board certified?

19 A I'm board certified in internal medicine, pulmonary,
20 and critical care.

21 Q You're triple board certified?

22 A Yes, sir.

23 Q Did you pass the board certifications on your first
24 attempt?

25 A Yes, sir.

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by Mr. Williford

1 Q All of them?

2 A Yes, sir.

3 Q Why did you decide to become a pulmonologist?

4 A I -- I'll be honest, I first decided that because I
5 liked critical care. I liked the fact that it is so
6 intense. It's a lot of procedures and you take care of the
7 patient. It's very rewarding. It's when you a sick
8 patients, this sick, then you take care of them and they get
9 better. It's very very rewarding.

10 But I think because, because that it -- it's better.
11 The care will be better for the patient if I do both
12 pulmonary and critical care, and, at that time, I feel like
13 I should get the training. I have time. I, I'm relatively
14 younger compared to the American grad because I came from
15 Malaysia. So I feel like I want adequate training as much
16 as I can, and, in fact, I wanted to do even more training in
17 sleep medicine because I, I want to learn everything before
18 I come and practice on my own, but that didn't work out
19 because the program stopped, stopped the fellowship.

20 But that's how I actually choose to become, to become a
21 pulmonary doctor and critical care doctor.

22 Q You say you have a lot of time to get some training.

23 Did you have any family here in Spartanburg?

24 A No.

25 Q Where -- what about your immediate family?

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by Mr. Williford

1 A I mean right now I do. I, I got married two, three
2 years ago. Two years ago.

3 Q Do you have any children?

4 A I have an 18-month old.

5 Q Son?

6 A Son.

7 Q And in terms of being a pulmonologist, what does a
8 pulmonologist do?

9 You mentioned procedures, but what, what else -- what
10 kind of procedures do you do and what does a pulmonologist
11 do day in and day out?

12 A We have -- we can -- we have a lot of different
13 practice and different doctor actually can choose different
14 things because, to begin with, we, we are triple board
15 certified. So you could tailor your practice to do one
16 focus or the other.

17 But when I was here and the -- at that time, I, I was
18 doing pulmonary in the, in the office. So I see patients in
19 the office. I also see patients in the hospital if they
20 have a lung issues. I also take care of the patients in the
21 intensive care unit if they're called, if they wanted to
22 help them with manage patient in ICU.

23 Q Do you do bronchoscopies?

24 A Yes, I do.

25 Q Okay. And the jury's heard a little bit about that,

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by Mr. Williford

1 but from a pulmonologist, they have not heard from a
2 pulmonologist yet.

3 Tell the jury what a bronchoscopy is.

4 A It's basically a fancy camera. It's a fancy camera
5 that is on the tube about the size of this, this cable, and
6 the, the -- this camera has suction tube in there. It also
7 has a, of course, the camera and it goes through the nose
8 usually. Some -- and the -- some people have to go through
9 the mouth if the nose have any problem. But, in general,
10 you go through the nose and you go through your voice box
11 and then it goes into your lung and you look around the
12 lung. And specifically you look at what we call the
13 bronchial tree, the windpipe.

14 Q Okay. And, periodically, are there biopsies done for
15 bronchoscopies for various reasons?

16 A Yes.

17 Q Okay. Now what about x-rays?

18 Do you look at and review x-rays?

19 A Yes, I, I look at every single x-ray that I taken,
20 every single x-ray that -- of my patients. Chest x-ray I
21 mean. Chest x-ray. I do look at all the other x-ray. But
22 I, I don't integrate other x-ray also of the chest because
23 I'm not an expert in those. But I do look at chest x-ray,
24 every single, every single one of them and integrate them
25 myself.

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1 Q In terms of training, do you receive training or
2 experience, along with your training, in reviewing x-rays?

3 A Yes, sir.

4 Q Explain to the jury how and why and how much.

5 A Well, we, we -- everybody in, in residency, internship
6 meaning internal medicine training, they have to go training
7 looking at x-ray, and, in particular, when we become a
8 pulmonary fellow, because this is our field. So we will
9 have to read the chest x-ray and what we will do is we will
10 usually go to the radiologist. Actually we will have a
11 rounding with the radiologist in the radiology room, and
12 then, and then we integrate them with the radiologist and
13 the -- and then we bring the, the information back to apply
14 on our patients.

15 Q How many chest x-rays, I'm talking about chest x-rays,
16 of the lung have you seen in your career?

17 A Thousands. Too many to count.

18 Q Do you always agree with radiologists in their
19 interpretation of chest x-rays?

20 A No, I, I don't always agree.

21 Q And why not?

22 A Well, again, you know, it takes years of training to
23 look at a chest x-ray, and, and chest x-ray is only, many
24 time, black and white, and you rely on the structures around
25 it to, to see what is next to it. You -- if there's

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1 increased density in one place, and you will feel like the
2 other place look less dense, in other word, you know.

3 So I always look at it myself, and I -- if -- and, in
4 fact, in my notes I often time will integrate the x-ray,
5 chest x-ray myself, and I will make a note of it that the
6 radiologist say so, but, to my eyes, I feel that there is
7 certain things there and I usually will write that in my
8 notes as well.

9 Q What about being a pulmonologist helps you, if, if at
10 all, in interpreting chest x-rays?

11 A Well, the biggest advantage that I have is I know
12 what's -- what going on with the patient.

13 Q Okay.

14 A So I don't just look at that chest x-ray and say this
15 are this, this, this, this, and that. I have the
16 information of what the patient came to me with. And so I
17 put them together and integrate the x-ray and then come to a
18 final conclusions of what we think the chest x-ray is, and
19 that's why I don't just look at the x-ray and tell you the
20 diagnosis. I basically summarize them according to every
21 information -- every -- all the information that I have and
22 then make the diagnosis.

23 Q Doctor Wan, do you treat patients with lung cancer?

24 A Yes, I do.

25 Q Do you treat patients who smoke?

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by Mr. Williford

1 A Yes, I do.

2 Q And what effects, as a pulmonologist, does smoking have
3 on a patient?

4 A It's affecting everything. It, it is a common -- well,
5 most people think, when they think of lung cancer, they
6 think about or, I'm sorry, when they think about smoking,
7 they think about lung cancer. But my experience with
8 smoking is that people who smoke, the extent of it is more.
9 It's more extensive. It's basically a systemic effect of
10 the smoke.

11 I see patients with cancer. I see patients with COPD,
12 and because nature of my job, I see a lot of patients with
13 heart disease. You know, again, they -- when you talk about
14 smoking, everyone just say well, lung cancer, lung cancer,
15 but that's not just that.

16 Cardiovascular disease, peripheral vascular disease, a
17 lot of patient lose their leg because they don't -- they,
18 they smoke. They get peripheral vascular disease, which is
19 a disease where you, you don't have blood flow to the very
20 extremities of your leg because there is atherosclerosis,
21 which is hardening of your blood -- of, of your blood
22 vessels, and, therefore, there's no blood to the extremities
23 and they lose -- they get ulcers, they lose their leg, and
24 they get really really sick, and, you know, I, I, I see it
25 as more systemic disease, more than people usually say oh,

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1 you get COPD, you get lung cancer. The extent of it is a
2 lot greater, a lot greater.

3 Q Doctor, what is secondary erythrocytosis?

4 A It is conditions where your, your hemoglobin or blood
5 cells count as high for -- because of other reason, and
6 usually, in this case, it's hypoxemia or low oxygen level.
7 Anything that drives your kidney to think that you don't
8 have enough oxygens, the kidney is going to stop producing
9 red blood cells to deliver more oxygen --

10 Q Right.

11 A -- to the area where they think is needed. So because
12 of the hormone that the kidney produce, the red blood cell
13 increased.

14 Q What affects can increased red blood cells, or I guess
15 erythrocytosis, what can that have on a patient?

16 A The most serious and the effect is actually what we
17 call hypercoagulable state where you, where, if you imagine,
18 you have a lot of red blood cells in your blood, it becomes
19 very thick. So it doesn't move very easily. So it get
20 clogged at places. So particularly stroke, you can get that
21 and clogged.

22 Q Doctor, as a pulmonologist, is it accepted, in your
23 field of medicine, that patients who might have lung cancer,
24 a papillary adenocarcinoma type, can spread by breathing
25 into the other lung through the airways and land in the

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1 other lung and turn into a different kind of cancer?

2 A No, I, I have never heard of it before, before this
3 case, and they -- I have reviewed some article that was --
4 that's submitted to, to us because, out of curiosity, I need
5 to know if there's something out there I didn't know.

6 But, I'll be honest with you, it is just a theory and I
7 don't think it's proven, and the -- I -- it's not, it's not
8 proven in, in clinical situations. It is just a theory of
9 cells attaching here and cells attaching there and,
10 therefore, it could land on the other side. But it's not
11 accepted clinical diagnosis.

12 Q Have you ever seen it?

13 A No.

14 Q Did that happen in this case?

15 A No.

16 Q Have you and do you help diagnose patients with lung
17 cancer after reviewing chest x-rays?

18 A Yes.

19 Q Would you hesitate to make the call that says I think
20 that's lung cancer after looking at x-rays?

21 A No.

22 Q Do you---

23 A I---

24 Q ---do that?

25 A I, in fact, I always look at the -- I always look at a

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1 chest x-ray or a CT Scan myself to see what's the next
2 action, and then I, again, type -- you know, incorporate
3 the, the patient's informations in determining what the next
4 step is, and if the clinical information suggests so, it
5 will go after it.

6 Q Doctor, I want to have you come down for the stand and
7 I want to go through your note, your office note, if you
8 will, and I have a blow-up. So we -- we'll try to have that
9 close to the jury and I just want to walk through it with
10 regard to Mr. Farr.

11 okay?

12 A (Witness comes down from the stand.)

13 Q Would you like a pen?

14 A Sure. Please. Thank you.

15 Q Sure.

16 Okay. Now, Doctor Wan, you went through this a little
17 bit with Mr. McKinnon, but I want to go through this a
18 little bit more. I want the jury to understand what, what's
19 going on here, and, what you, from your prospective, was
20 treating -- were treating Mr. Farr for.

21 So let's walk through it and explain to us how Mr. Farr
22 came to you.

23 A Okay. Most of the time the patient came to me with
24 complaint. But, in this case, he did not. He came to me
25 because Doctor Vidito -- the patient is a smoker. "My

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1 cancer doctor sent me to have my lung check." I quote it
2 because it's -- he told me that and---

3 Q Let me stop right there, doctor.

4 A Yes.

5 Q All right. Yesterday we heard testimony that Mr.

6 McKaughan wanted Mr. Farr, you know, her father, to, to come
7 to see a lung specialist because she was worried about his
8 breathing.

9 Is that what happened?

10 A Not from my note. In fact, he -- I specifically asked
11 him if he has any shortness of breath. Dyspnea on exertion
12 means shortness of breath when they walk because, often time
13 when they don't complain of shortness of breath, they, they
14 don't realize it when they don't walk. It's walking or it's
15 when you start having shortness of breath.

16 So when he denies it, I ask him well, if you're not
17 short or breath when you walk, do you get short of breath
18 and he say no, I don't. So I further elicit the symptoms
19 cause I want to see if, well, he's a smoker, I want to see
20 if he has any symptoms of COPD or chronic bronchitis or the
21 smoker cough in that regard.

22 Q All right. And so, when it says history of present
23 illness, this is the reason he came?

24 A Yes.

25 Q Would that be fair to say?

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1 A Yes.

2 Q All right. And then, and then what else do you do?

3 A I, I want to find out, again, a little bit more, you
4 know, when patient say that I don't -- if you are not short
5 of breath, well maybe he's not short of breath now. So I
6 ask him well, have you ever been admitted to the hospital
7 because of breathing problem, but, again, he, he say he does
8 not.

9 Well, some people, they don't even tell you I'm short
10 of breath and they say, they will say well, I use an
11 inhaler, but he said no, I don't use an inhaler, and I go
12 down further and I saw that he had a cancer in 1998 and that
13 is a significant, significant informations because anybody
14 who has a history of cancer is at risk of cancer and he
15 smoked.

16 So I went back and I asked. I asked him, you know, how
17 is his cancer doing, but he say that it -- well, it's
18 completed resected. I don't have any problems and Doctor
19 Vidito is following me and he's not -- she's not even
20 following me for this cancer that is completely cure. She
21 is following me because I have this secondary air cytosis.

22 Q The increased blood cells---

23 A Increased blood cells---

24 Q ---related to the smoking?

25 A ---in the hemoglobin.

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1 Q Okay. And then surgical history, family history,
2 social history, explain all that and, and why that's
3 important to your assessment as a pulmonologist.

4 A Well, again, all this thing, it's, it's going -- it's
5 gonna tie you to what he presents right now. So, we, we ask
6 him well, for example, if he has a family history of cancer,
7 how, how old was the family history of cancer or, in this
8 case, if you have a history of heart disease, if you have
9 family history of heart disease, it's relevant because you
10 are a smoker.

11 So all this is relevant in that, you know, if you have
12 a family history of it, well, you are at risk because your
13 genetic predisposition for it, and then subsequently I also
14 asked about the social history because, again, it's
15 important in how much he smoke, how much do you drink.

16 I, you know, I -- we, we routinely ask about what they
17 do, whether or not they're married, and all their social
18 history because we are trained to try to elicit signs that
19 the patient is not voluntarily -- I'm just gonna give you an
20 example of this. This does not apply to him. For example,
21 someone who uses drug and they will have a very poor
22 situation. It's less relevant in his case as far as his
23 care, but, in many patients, it's relevant as far as, you
24 know, where to even go.

25 Do they have oxygen?

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1 Who's gonna take care of them?

2 So this our important information for us.

3 Q And you don't know what kind of family history, social
4 history until you ask and take the time to ask those
5 question?

6 A That's correct.

7 Q Would that be fair to say?

8 Okay. And just backing up and I think it's clear, but
9 was this the first time you had seen Mr. Farr?

10 A That's correct.

11 Q Is this the only time you've seen Mr. Farr?

12 A That's correct.

13 Q All right. Now, allergies and current medications,
14 review of symptoms, walk through that and explain to us what
15 you did and what's important to you as a pulmonologist.

16 A Well, of -- obviously any allergies is important. If
17 I'm gonna give you any medications, I don't want him to
18 react to it. Medications is very important. I -- if I'm
19 gonna add any medications, I need to know if they've been
20 interactions between medications, and obviously I know -- I
21 want to know what medication he's on right now as well
22 because, you know, some medication can affect one organ
23 rather than the other.

24 And then we went on and go through review of systems.
25 Review of systems give us information we need to pick up

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1 things that, things that the patient may not think is
2 relevant, you know. I, I -- you know, when we get to this
3 part, I have an idea of, you know, what could be relative to
4 this patient, and I specifically ask well, let's say for,
5 for a smoker, do you suspect a heart disease, and you ask
6 whether they have chest pain.

7 well, the patient would not think that this is related,
8 but, you know, this is all the information I can get from
9 review of systems by knowing further if, you know, this
10 patient have any other diseases that would suggest by
11 reviewing, reviewing all the different organs, symptoms, and
12 different organs.

13 Q And, doctor, let me ask you a question about, you know,
14 he comes in, you know, sent by Doctor Vidito to have his
15 lung checked.

16 why don't we just go straight to the x-rays?

17 why do you do all this?

18 A I can -- again, everything -- we have to integrate
19 everything and look at him as a whole person and look at him
20 as a, as a whole. I can't just say well, go for an x-ray,
21 go for a CAT Scan, come back to me, and, you know, without
22 going through all this. I wouldn't know. I wouldn't know
23 what cause this x-ray or I wouldn't be able to really
24 correctly diagnose it.

25 You know, x-ray is just a picture, and pictures, it's

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1 an exam. It suggest and help me with making this diagnosis
2 and it's, it's funny you ask me because, in Medical School,
3 I was taught the old way. I, I had a very old professor
4 that say, you know, by the end of your history and physical,
5 if you don't know what's going on with your patient, you
6 wouldn't find out.

7 So, the story actually tell me a lot about the patient
8 rather than all this exam, and I understand, in this
9 technology and in this era, we have a lot of information and
10 we integrate -- we incorporate them in our history and
11 physical. But, you know, I -- there's a reason why, in this
12 era, we still go in there and ask the patients and examine
13 the patients and rather than just saying well, go to all
14 these tests and come back to me, and that's the reason why I
15 have to do all that.

16 Q All right. And you have here review of systems,
17 constitutional symptoms.

18 Explain what this is.

19 A Yes.

20 Q Just walk through it.

21 A And constitutional symptom are, very often, nonspecific
22 symptoms, fever, weight loss, I don't feel well, my stomach
23 hurt. You know, if I had a bad day, I come home, I had a --
24 you know, I just don't feel good. Symptoms like that and
25 it's, it's nonspecific and nonspecific to specific organs,

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1 you know, and you can put it to, to those.

2 And I, you know, often time we ask symptoms especially
3 in cancer patients, if they have lost weight. If they lost
4 a lot of weight you would have to be on alert.

5 Q Did Mr. Farr lose a lot of weight in your examination
6 of him?

7 A No.

8 Q Okay. Based on any prior reports from Doctor Vidito or
9 anything?

10 A No.

11 Q Okay. And then, complaints of fatigue, you have that
12 and then you have other things.

13 What, what were you doing there?

14 A Well, again, he say he's tired. So I have to say well,
15 if you have a bad day, you had a long day, you could be
16 tired.

17 Is there something else that come with the tiredness?

18 Is it -- does it come because you, you lost weight?

19 Is it because you lost your appetite, you didn't eat,
20 or is it because, you know, you didn't sleep or is it
21 because you have a flu?

22 So, you know, when something complain oh, I'm tired,
23 it's a very nonspecific complaint to me. So I need to
24 further elicit and ask well, if you're tired, why.

25 Is there something else you think it's causing the

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1 problem versus, you know, versus you're just tired because
2 you, you had, a long day?

3 Q All right. Let's go to the second page of your note,
4 and, you know, again I don't want to prolong it too much,
5 but you've got eyes, ears, you know, pulmonary, gastric.

6 Just kind of walk through what you're doing briefly
7 with that.

8 A Well, again, I, you know, I basically would go through
9 every system, you know. Your eyes, and your heart, and
10 your, your lung, and your GI. I, I, often -- really people
11 might think I ask irrelevant questions, but they are not
12 irrelevant to me because, you know, I need, I need those
13 informations.

14 But, in this case, what his complains of does not
15 correlate with what I have. So he did say that he had some
16 gas. He say that he have high blood pressure. He have some
17 swelling of the leg, and he has normal gate.

18 Those is irrelevant to my exam and my, my assessment.
19 But, you know, there are times where, where there will have
20 signs where, you know, it's suggested for one thing over the
21 other.

22 Q Let me ask you about this. It seems a little bit odd,
23 but the -- let's see. Denies bleeding gums, difficulty
24 swallowing, you know, those kind of things.

25 why, why are you checking that as a pulmonologist?

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1 A Again, this are all suggestions of what can be causing
2 it. Well, we ask about bleeding in the gum because if you
3 have hematological conditions, you could have bleeding and,
4 you know, they, they, they bleed easier than other people.
5 So this, you know, signs that suggests something else is
6 going on.

7 Difficulty swallowing, if -- cancer can cause
8 difficulty swallowing. You know, if you have any ear pain,
9 if you have hay fever, hay fever is a good -- is associated
10 with an asthma. And hoarseness, people will come to me and
11 say doctors, I, I lost my voice, and, you know, the next
12 thing they, they have cancer. I, I have seen it.

13 So, again, like, like I say, many things that you or
14 regular people don't think of as a sign. To me, I look at
15 them differently because of how I was trained. That's,
16 therefore, we ask them.

17 Q All right. Now, we got follow-up lines and then we
18 have exam.

19 Explain to me, you know, what you've done on your exam.

20 A Well, I -- actually the exam is suppose to give me a, a
21 visualization of this gentleman. I, I don't remember him,
22 what he looked like, but this exam will tell me that he
23 actually is a, a pretty good -- is in pretty good shape
24 because well, first, he is good height, good weight. He's
25 not overweight. His BMI is within normal limit. His pulse

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1 is normal. His saturation is a little bit low, 95 percent,
2 on room air, but not low enough to a point where he needs
3 oxygen and blood pressure looks great.

4 So just this one line give me a lot of information
5 about him and I say he's well developed. So he doesn't look
6 like he's somebody who is malnourished, somebody who hasn't
7 eaten or have problem with appetite or nutritions.

8 Then I go through every single part of it, you, you
9 know. I go through the head, go through the eyes, go
10 through the mouth, and I, I listen to the heart. I listen
11 to the lungs, check his stomach, check the legs, and, and I
12 focus more on the lung exam because he came in with symptoms
13 or he -- not symptoms, but he came because he wants to have
14 his lung check.

15 So I, I, you know, pay special attention to it because
16 I'm also a pulmonologist. So I make special notations that
17 he had actually decreased chest expressions. His lung, he
18 has what we call Barrel Chest when you have air trapping of
19 your lung. Your air gets trapped in there when you exhale.
20 Air doesn't come out. So when you get more and more air in
21 there, you become like this.

22 So you basically breathe like this and this symptoms he
23 doesn't feel it or this signs he doesn't feel it. But it's
24 what we call Barrel Chest, almost like a barrel where you do
25 this. And if you take a deep breath, try taking another

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1 breath, it's hard. So he has signs of COPD. He doesn't
2 have symptoms because he didn't complain to me before, but
3 he has signs of COPD.

4 Q So the way I understand it is he came in to have his --
5 had lung checked. He wasn't manifesting or didn't think he
6 had -- he didn't come in saying I do have COPD, but it's
7 something you picked up on your exam.

8 A That's correct. I, I, you know, because he didn't
9 complain or anything -- I'll be honest with you, some people
10 don't complain. Some people just don't complain. They say
11 well, I'm fine. I don't -- especially, you know, I -- my
12 doctor wants to send me for a lung check. I'm fine. I
13 don't have a symptom.

14 So if -- I rely on my exam to find out what he, he has.
15 There's a reason why his doctors sent to me. So, I, you
16 know, again I, I -- in fact, I put a lot of details on this
17 exam. I, I specifically say that there is no intercostal
18 restriction -- retraction or use of accessory muscle because
19 when we breathe very hard, we stretch our muscle.

20 (Witness demonstrates.)

21 A That's one to look at. Accessory muscle and it's
22 basically sucking in your chest.

23 So, I mean, again, by this exam, even though I don't
24 remember what he looked like, he was not one that is having
25 hard time breathing. He was one is -- he was not

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1 struggling. He was well nourished, well nourished. weight
2 is good, you know, except, you know, and his blood pressure
3 is good and he, he looked well there. His---

4 Q Is that -- I'm sorry.

5 A No, I think that's it.

6 Q Doctor Wan, if a patient -- well, let me ask this.

7 Can a patient present with signs or symptoms of, of
8 cancer?

9 A They could. They could.

10 Q And did anything in your physical exam make you think I
11 think he's got cancer?

12 A No.

13 Q Okay. All right and -- well, let me ask you this.

14 You mentioned that, you know, there's a reason that he,
15 he, he was sent by Doctor Vidito.

16 Does COPD and, and secondary erythrocytosis related to
17 smoking, do they, do they go together?

18 Do they not go together?

19 A They do. I believe Doctor Vidito wanted me to evaluate
20 him for COPD. Particularly low oxygen because that's a
21 cause of secondary air flow cytosis.

22 Q All right. And then this is essentially your, your
23 last note. There's one little line of Doctor Vidito. She
24 was cc'd on this.

25 This is essentially the last part of your note, and,

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1 and, again, explain -- you know, we'll get to the studies.
2 we'll get to the x-rays in just a minute, but, but let's,
3 let's kind of walk through again, in a little bit more
4 detail than you did with Mr. McKinnon in terms of what you
5 did and what your assessment was.

6 A Okay. After I did all this exam and listened to him,
7 listened to his story, I have some evidence that he has
8 COPD. He has Barrel Chest and he has decreased breath sound
9 on my exam, but I need more objective, more objective test.

10 So the most objective in the pulmonary -- COPD patient
11 is pulmonary function test. So what I do is I ask my
12 assistant, usually I ask them to do the test, and then I
13 integrate them. In this case I put it in my notes that he
14 has COPD, which is what we call obstructions on the flow
15 changes. I mention it as moderate based on the percentage
16 of how one is predicted.

17 So let's say a person has -- for your age. For your
18 age, for your height, for your gender, you're suppose to
19 have a hundred percent of your lung volume, but him,
20 compared to a person at his age, at his gender, and his
21 height, he only have 50 percent of what would be predicted
22 and that is considered a moderate COPD and---

23 Q And---

24 A Yes.

25 Q No, I'm sorry.

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1 And then chest x-ray.

2 CXR, is that for chest x-ray?

3 A Yes.

4 Q Okay. And let me ask you this.

5 A Yes, sir.

6 Q When, in your -- in Mr. Farr's visit, did a chest x-ray
7 occur?

8 A Can you rephrase it?

9 Q Sure.

10 When, in relation to your physical exam and everything
11 else that you did for Mr. Farr, were the chest x-rays
12 interpreted by you?

13 A After I did everything. So after.

14 Q And why?

15 A Well, again, I -- they have to be a reason. There
16 really have to be a reason to order a test. I can't just
17 say well, I want to order a CAT Scan or go for it. I only
18 order a chest. No, I need to have a reason for it.

19 So, in this case, he has -- I have the -- believe that
20 he has COPD. I have objective finding that he has COPD.
21 And, in this case, he has history of cancer. He continues
22 to smoke and I think I have reason belief that I should get
23 a chest x-ray even though there is no recommendation. The
24 recommendation is actually you don't need a chest x-ray for,
25 for a screening, cancer test, at that time, and it does say

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1 that, if your doctor feel that way, you could do a chest
2 x-ray. But you're not required to do so. I do feel
3 strongly that I, I should get one because -- well, I want to
4 look at his lung.

5 Q All right. So let me just back up.

6 I think I -- what I, what I hear saying is that, even
7 though Mr. Farr came to you, he didn't even need to get an
8 x-ray, but you felt like you, you probably should do it?

9 A Yes, sir.

10 Q Okay. All right. And then -- and what was your
11 interpretation of the chest x-ray?

12 A There is no nodules. There's hyperinflations
13 suggestive of COPD. There's no pleural effusion. There's
14 no cardiomegaly.

15 Q And what's a pleural effusion?

16 A It's a, a -- fluid in the space between the chest wall
17 and the lung.

18 Q Okay.

19 A And there's usually fluid in there, but various
20 conditions can -- has increased fluid in the area and causes
21 symptoms for it.

22 Q And what about cardiomegaly?

23 what's that?

24 A Enlarged size of your heart. Again, I, you know, they
25 are many -- smoker can have a lot of problem. So cardio --

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1 heart disease, in particular. It's, it's really high up
2 there. So you want to see if there's any signs that his
3 heart is enlarged and he has evidence to suggest he have
4 heart disease.

5 Q And why would a, an enlarged heart be a negative thing?

6 A It doesn't come well. It's a suggestion that, you
7 know, your heart is working too hard and it become bigger.
8 People might think that bigger is better, but not in this
9 case in the heart. If you have a big heart, it doesn't pump
10 very well.

11 Q And we're about to look at the x-rays, but in terms of
12 the chest x-ray, was it just completely normal?

13 A No, it was not. He, he has COPD. He has
14 hyperinflations of the lung.

15 Q Let's look at the x-rays. Actually let's do one other
16 thing before we do that. I want to -- you had talked about
17 anatomy when Mr. McKinnon asked you questions.

18 A Yes.

19 Q And you've got anatomy and you said it's, correct me if
20 I'm wrong, but I think you said it's kind of difficult to
21 explain on a chest x-ray cause you're not seeing the
22 anatomy.

23 A That's, that's right.

24 Q Okay. Explain to us what, what we're looking at here.

25 A well, this, this is a picture basically you're looking

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1 at the patient this way on the side, which is exactly how
2 you look at it on the chest x-ray. Now, bear in mind that
3 this pictures, this pictures you lift the lung up. So, in
4 other words, you know, you pull the lung up and only look at
5 the central or what we call the mediastinum. This other
6 structures you will see and this other structure that is
7 gonna be white on the chest x-ray.

8 So I mentioned there was heart, and this is actually
9 the left artery, which is a small piece of "heart" on top
10 of, of, of the heart there and look at this here.

11 Q What is that?

12 A The pulmonary trunk, which is the part where the
13 pulmonary artery come out. So it's what we call the trunk,
14 the big, big vessel. So once it goes here, it actually
15 loop -- come up on the left side that I just told.

16 Now, bear in mind this is, again, on this one side
17 only. This vessels, when it comes out like this, it goes to
18 the other side. So it, it goes like this and this arm moves
19 around that like because there is a trachea. So there's a
20 lot of structures.

21 You have another one?

22 Q Sure.

23 Let's look at that real quick.

24 A Okay.

25 Q Okay. You were talking about that.

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1 A Yes.

2 Q What are we looking at here?

3 A Well, I want to orientate you a little bit because
4 this -- we're looking, we're looking at the patient from the
5 back like this.

6 Q Is that what -- posterior view?

7 A Posterior view. So, essentially, you know, I -- the
8 reason why I want to show the back is because your heart is
9 occluding all the structures. So you won't be able to see
10 it clearly.

11 So if you look at this from the back, you know that
12 this is the left side and this is the right side. So the
13 heart is on this side.

14 What I'm trying to point out is that there's this
15 trachea here. That's your windpipe. This trachea goes into
16 your left main, left main bronchus, and then over here, this
17 doesn't show you the view, but it comes right here and come
18 to the right main bronchus. Like Doctor Woodruff say, it
19 branches out like a trees.

20 So once it gets here, it branches out to the right
21 upper lobe, right middle lobe, right lower lobe, and then it
22 branches further and further and further. Now, the, the
23 structures around here, you see right here the hilum.

24 So if you imagine your lung is right here, this is the
25 structure that's going into your lung. You see the -- you

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1 see your airway and you see your -- I -- pulmonary artery
2 and goes around here. I'm sorry. This way. This purple
3 line is the pulmonary artery. So it, it goes around. It
4 goes to the front on the right side. This is your right
5 side. So it goes to the front of your trachea. But on this
6 side, the pulmonary artery cross and go to the back and loop
7 around it.

8 So all this thing you expecting me to see on the black
9 and white film and I'm here to tell you well, there's not
10 possible to tell you exactly what it is. Well, there is --
11 CAT Scan you can tell. All this structures, this structure
12 right here, this structure right here, and, in fact, funny,
13 you know, you can see that actually one side is even higher
14 than the other. If you can tell it's go up here and go down
15 here and it's very common. In fact, that's what we consider
16 normal, one side higher than the other, and one side is
17 actually angle like this and the other one is angle like
18 that.

19 So they're not exactly like a tree. So, you know, the
20 right lung is more angled down this way.

21 Q Sure.

22 And, and just to clarify, so when you're talking about
23 these structures, you know, this is the patient's right
24 side?

25 A Yes, this is the right side.

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1 Q And this is the left. And just for this, this
2 illustration, for example, these are some of the dense
3 structures right here and you can -- can you see that
4 somewhat on the x-rays?

5 A You -- when you look at x-ray, you have to remember
6 this other structure that's right there.

7 Now, if there's any abnormalities that you think is
8 there, then you, you correlate with where they are. You
9 kind of think okay, I know that the x-ray comes here and
10 this is where the pulmonary artery is gonna go out. Okay.
11 If there's some abnormalities showing up on here, this is
12 differential. well, it could be. But, again, you can not
13 confirm it and, you know, because you can only see white
14 especially with so much structures.

15 Like Doctor Woodruff say, you know, the light is gonna
16 shoot through the gas or the air. But anything that's soft
17 tissues are solid like this, and needless to say, that's a
18 lot of structures around here that you have to shoot through
19 to, to look at it on the chest x-ray.

20 Q Is it pretty dense in this area?

21 A Yes, it -- you know, like I say, the heart is
22 completely dense. Now, some of it here, it -- one can be
23 denser than the other, but, you know, a lot of time they
24 are -- they're abnormal so because this structure is around
25 here and this structure around here.

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1 Now, you could sometimes, like I said, the V-shape I
2 was talking about because you have the air. You have the
3 air in your windpipe. Now if you have a good technique, you
4 could sometimes see that the air in here. Well, because
5 there's air, then you can contrast the white in-between so
6 then you can see the difference in there, and, you know,
7 there's air in here and, you know, you sometimes see this
8 V-shape, but not all the time.

9 Q And I just want to go back to this one image real quick
10 and then, then we'll look at the x-rays.

11 So on -- when Mr. McKinnon called you, he talked about
12 the pulmonary or you mentioned the pulmonary artery looking
13 at you.

14 Again, this is looking at the patient into the left
15 side?

16 A Yes. Correct.

17 Q What's going on right here?

18 What's going on right here?

19 A There is, you know, the heart and around it there
20 actually fat, fat around, and there's skin of the heart,
21 skin of the heart and, again, this is not structures that
22 you actually can see on the x-ray, and then, you know, it
23 wraps around this area here until the pulmonary artery comes
24 out, and, of course, the aorta, the big artery comes out
25 also behind it. So when it comes up and turn, that's why I

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1 say pulmonary artery is coming out looking at you.

2 Q It, it looks at you.

3 Is it more here, but it comes up from kind of up and to
4 the left of the heart right there?

5 A That's correct.

6 Q And, and the aorta comes down.

7 Are those dense structures where you can kind of see
8 them on the -- on an x-ray?

9 A Yes, all this structures -- that's what I'm trying to
10 tell here, everything in here is gonna be what we call dense
11 structures. Line is gonna be -- or air is gonna be black
12 or, again, this structures here, we are lifting up the lung
13 to see it. So now you put the lung down, well, the x-ray
14 will shoot through them. But it shoot through them and stop
15 right there.

16 So, in other words, if I look at it here, I would not
17 be able to tell you next door line, which is, in fact, this
18 now. Now this is on this side. I lift this lung up. Well
19 now I put this lung down. Not only do I put this lung down,
20 I'm putting this lung down as well when I shoot the x-rays.
21 So everything just goes to one plane. We do this and I take
22 an x-ray.

23 Shoot through it, but there's lung here, there's lung
24 here, and there's structure in the middle that's gonna be
25 white. And now you asking me well, I, I think it's whiter

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1 in this area. I think it's in the lung.

2 I don't think you can say that. I don't think you can
3 say that well, I think it's, it's white, I think it's in the
4 lung. I don't think you can say that.

5 Now, he's correct in that you can tell from the PA view
6 whether or not there's something in the lung, but there
7 isn't. There isn't.

8 So I mean if I see something abnormal, I go back to the
9 PA film which is the structure from this side. I look at it
10 and I say well, maybe there's something right there and then
11 I look at the, the other from this structure and I didn't
12 see anything. So, I, you know---

13 Q And you're talking about Mr. Farr?

14 A Or anybody.

15 Q Or anybody. Got it.

16 A Anybody say basically -- you want to correlate like he
17 say. You don't -- you look at one film, you're like well,
18 maybe it's there and you look at the other well, oh, it's
19 not there. Well, my conclusion that it's not there.

20 (Witness returns to the stand.)

21 Q All right. Thank you, doctor.

22 Now I want to walk through the x-rays, and if we could
23 have the lights down I'd appreciate it.

24 And, Doctor Wan, if you don't mind, I'm gonna have you
25 stand up again and, and look at these. But I want you to

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1 explain to the jury the process of doing an x-ray.

2 when, when an x-ray is done in your office, what
3 happens?

4 A Okay. I don't do them. I sent them to the technicians
5 to do them. The way x-rays obtained is we -- and we usually
6 do a PA film and the lateral because those are the best, the
7 best chest x-ray view that you can get because what the PA
8 film does -- in fact, I have this right here.

9 So imagine this is a plane -- a plate. what we call a
10 plate. So I will stand like this with my heart leaning
11 against the, the plate because that's a closest to the
12 plate. Whatever is closest to the plate is going to show it
13 up the better.

14 well, again, like I say, the heart, you can not see it.
15 It's white. But we hope that if you go the closest, you
16 gonna see the most of it and you also want them to inhale.
17 Hold your breath because that's when you have the most air
18 in your lungs. So you want to see the contrast.

19 Inhale, leans against it, hold your breath, then shoot
20 the pictures and the pictures go through here. You can tell
21 already it went through here, the lung, it went through, but
22 the heart, it didn't go through, and it turned out as a
23 white.

24 Same thing on the left side. so the left side, I'm
25 sitting this side against a -- the plate and I want to have

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1 my arms up because I don't want the arm -- your hands is
2 something that will become white. So I don't want it. So
3 your hand is suppose to be up. Your heart, on the left-hand
4 side, leans against it closest so you can see it and shoot
5 the light. Whatever goes through is gonna become black.
6 Whatever doesn't in there that's on there is white.

7 That's what essentially x-ray does.

8 (Witness returns to the stand.)

9 Q All right. Now, doctor, these chest x-rays were
10 performed and after you did your clinical evaluation you
11 looked at these.

12 Explain to the jury how you go about looking at x-rays
13 in general and in this case.

14 A In general, I look at the x-rays from the -- from
15 outside to inside.

16 May I stand here?

17 Q Sure. Absolutely.

18 A (Witness comes down from the stand.)

19 Usually we start with the PA film first because my
20 opinion is that PA, they give you the most structures, the
21 most informations, and we see a lot more PA films or AP
22 films in the hospitals as well. Again, it give me the most
23 informations.

24 I go from outside to inside first because, you know, we
25 were taught that way. You -- if you're not looking for it

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1 you're gonna miss it, and it's easy for me, as the lung
2 doctor, to just go in there and say well, look at the lung
3 and then I will forget all the other things. So I -- my
4 approach -- and we were taught that way on -- in the school
5 is that, you know what, put aside the biggest thing. Look
6 at the small things first.

7 So I go from outside to inside. So I go from the top.
8 I look at the, the clavicle and I look at the, the bone.
9 Well, you can look for any structure. The clavicles is the,
10 the bone because the distance between this clavicle to this
11 spine right here tells you how adequate this x-ray is.

12 X-ray is like taking pictures. Well, I don't know if
13 any of you -- anybody is a photographer, but if you take a
14 pictures, if the light is too bright or if it's rainy days
15 is, you know, and other factors can affect it. If I turn
16 this way, if I turn this way, you gonna get a different
17 pictures.

18 So -- and also if you use too much exposure, too less
19 exposure, things are gonna look different. So we look at
20 the structures and we comment on whether or not this film is
21 adequate. So the people have to stand exactly the front
22 like this, and they, you know, there's shooting any
23 rotations so they can not go from the side. If there's too
24 much rotations, things will become white. Things that are
25 usually black will look like white.

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1 So it's relevant in terms of integrating white or in
2 this case and as far as looking at them and you look at the,
3 the airway, the trachea, and the -- if this trachea goes to
4 one side it might suggest different pathologies such as
5 cancer, cancer could push this trachea to one side or if
6 your air on one side, it can draw to this other side.

7 Then you can look at the, the ribs. You can look at
8 the ribs and you can count them. You can count how many
9 ribs to determine whether or not a patient's taking a deep
10 breath, and I always actually go down to the bottom first.
11 Again, I go from outside to inside. So you can look at the
12 diaphragm and see if, you know, patient has elevation of the
13 diaphragm. Sometime it might suggest something underneath
14 his liver. Air bubble, usually you will see air bubble in
15 there, and if you see a density between this and this, that
16 could suggest perforations.

17 So this are things that you look for. Then only I go
18 into actual central part of this x-ray, which is your aorta
19 and this is your hilum, hilar.

20 Q I'm sorry.

21 What is this again?

22 A This is aortic arch where your aorta come up, your big
23 vessel, your big artery come up. It comes up this way and
24 it twist around. Now anytime you twist around it look like
25 it's looking at you kind of. You can see this round

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1 structure here. That's called aorta arch.

2 And then you have your left ventricle, your right
3 atrium, your hilar here, and you have look at your aorta,
4 pulmonary windows, which is right here, between your
5 pulmonary, pulmonary artery coming out here and your aorta.
6 Sometime, if you have a density right there, you -- it's a
7 suggestion of mediastinum lymph nodes or something there.

8 Then, after I finish everything, I look into the lung
9 or, in this case -- well, you can't see it really well.
10 Again, a lot of the structure you have to remember in your
11 mind. Well, this is what I'm looking at. In this case you
12 don't see it. There is a line, like I just told Mr.
13 McKinnon, that there is the -- there is the major fissure
14 and then there's the minor fissures.

15 Q And what is that?

16 What is a fissure?

17 A Fissure is the area -- it's a place where your lung is
18 divided into different lobes. So the way your lungs is, if
19 you imagine it like a piece of meat. Okay. You have a
20 piece of meat right here. You have a piece of meat right
21 here and then a good piece of meat right there on the right
22 side.

23 Now, they're all hanging there, but I have skin.
24 They're wrapped around the structures. But even though
25 they're three piece of, of the meat, but you can see the,

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1 you can see extra -- the surface, the skin around it.

2 So that's the, the skin where it goes into the area
3 in-between those, those tree branches or the three lobes of,
4 of the, of the, the lung. On the right side they're three
5 lobes and then on the left side there's two.

6 Q There's two lobes on the left side and three on the
7 right?

8 A That's correct.

9 Q Okay. All right. And you were explaining -- you, you
10 were starting to talk about and you start outside and you
11 start working within the lung and you, and you were talking
12 about the fissures.

13 What else do you evaluate as you're looking at this?

14 A Well, there are a lot of -- there are a lot -- there
15 are a lot of small little things that you can, you can look
16 at in this case and I, you know, I'll be honest with you, it
17 took me years of training to, to finally come up with this,
18 this explanation because my patient always ask me.

19 If you want to really look in the microscope, so even
20 though there's just two big black structures right here, now
21 you want to imagine your lung as many little grapes. So you
22 have many little grapes like this. They all, they all
23 bundle of grapes, bundle of grapes. All the inside of the
24 grapes is going to look dark because there's air inside.

25 Now, you have to look really really closely to know

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1 that there's skin. Every grapes has skin and that really is
2 what you're looking at.

3 Now, you can see all this line. If you look closely
4 here, closely here, closely here, closely here, it's all
5 because of all these grapes. If you have many, many, many,
6 many little grapes in-between, then you have a lot of air.
7 In generally, you look at the big pictures always all dark.
8 I mean you look at it really really closely, there should
9 be, there should be the skin, the skin of the grapes.

10 Now, if anything's abnormal within the, the grapes
11 itself, then it's gonna become dark. So if I fill out this
12 grape with fluid, if I filled it up with pus, if you have
13 any liquid, or if I fill it up with blood, anything that's
14 not air, is going to become dark.

15 Now, if it's a big area, it's gonna be bigger. If
16 it's, you know, small area, it might be less dense. Again,
17 we are comparing the density on this x-ray.

18 Q All right. And, you know, here's -- is this the heart
19 --

20 A That's correct.

21 Q -- going from a frontal view?

22 You mentioned in your note that there was no
23 cardiomegaly.

24 How do you know that?

25 A You, you can only measure cardiomegaly in a PA film

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1 because that's the most adequate film. But, in general, you
2 do this heart bottle like this and you fill it up. If it's
3 more than half, it's there, but, in this case, it's not.

4 Q And how do you know that?

5 How do you know that by looking at it in terms of
6 whether or not it's cardiomegaly?

7 A Well, again, you know, there's no, no specific
8 measurement about how big is big. You actually want to
9 compare it relatively to the size of it. So the relative
10 size of this heart shape compared to the, the cavity, chest
11 cavity.

12 So, if you do this, and then you compare to the chest
13 cavity, which is from here to here, so the midline is right
14 here, and you go here. As long as it doesn't cross the
15 midline, there's no cardiomegaly or big heart.

16 Q All right. Now, hyperinflation and COPD, how do you
17 look at this, as a pulmonologist, and decide wow, that
18 supports my clinical suspicion?

19 A Okay. If you actually have -- I will tell you this.

20 The classic teaching on the book is no, you can not see
21 COPD, emphysema on the, on the chest x-ray match. Most of
22 the time they're normal. But, in fact, if you have really
23 severe COPD or emphysema, you can see those holes in the
24 lung. Those hole, because it's not smaller than the grapes
25 anymore, you know, if you imagine smaller the grapes in

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1 there, it's not smaller than the grape anymore. It's a big
2 hole. So it's gonna be dark. A lot darker. So sometime
3 you see some emphysema changes on the chest x-ray on the PA
4 film.

5 Now, when I mentioned about the flattening of the
6 diaphragms, hyperinflations, I go to the lateral film
7 because your hyperinflation, it's determined by, if you draw
8 a line from the back to the front, and you, you measure this
9 here, if it's greater than 1.5 centimeters, it -- there is
10 hyperinflation.

11 So I see a lot of x-ray and many times I can even see
12 it on the, on the PA film because you can tell that it's,
13 it's flat. But the true diagnosis of hyperinflation is on
14 the lateral film. That's how you make it and you can also
15 measure here. If it's greater than 2.5-centimeter it's
16 hyperinflation.

17 Q And, doctor, you mentioned that it was important to you
18 to understand Mr. Farr's prior history, his social history,
19 his medical history, and you noted that he had a prior colon
20 cancer, and so he's at risk for lung cancer.

21 Would you be considering that when you're looking at
22 this film?

23 A Yes, I, I mean not only lung cancer or even metastatic
24 cancer. So I know that his cancer was resected. That's,
25 you know, and he's saying he's completely cure, but you can

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1 see metastatic cancer if you -- is asymptomatic or you can
2 see lung cancer in the lung field.

3 Q Now, you say metastatic cancer and you talk about colon
4 cancer.

5 What exactly do you mean by that?

6 A Well, colon cancer is -- can migrate or spread, spread
7 to the lung. So I mean there's certain features on the
8 chest x-ray that would suggest metastatic disease. In
9 particular, smaller nodule. So tiny, tiny little nodules in
10 there.

11 Q Was this chest x-ray, did it show metastatic cancer
12 from colon cancer?

13 A No.

14 Q Did it show metastatic cancer from any kind of cancer?

15 A No.

16 Q Okay. Now, Mr. McKinnon pointed to this area right
17 here on the, the PA film. I'm not a doctor. You're a
18 pulmonologist.

19 Tell me what that is.

20 A Again, like I say, this was where the, the hilum comes
21 out. Now, you could kind of make out like here going up and
22 then going down where your pulmonary artery branches out.
23 This is the hilum where you have all the structures.

24 So you have to remember the structures are the
25 pulmonary -- the trachea. I mean sorry. The main bronchus,

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1 right main bronchus, and then there is the pulmonary artery
2 around it. In fact, there's also pulmonary vein.
3 Everything in the line, it wraps around your windpipe. So
4 what it does is that -- even though you have trees, the
5 trees goes smaller and smaller and smaller. So you have a
6 big trunk and then the tress goes branches, branches,
7 branches, branches. But along these trees on the surface of
8 it wraps around all the structures.

9 It wraps around your vein. It wraps around your artery
10 and wraps around with the nerve. That's how our lungs
11 supply the nerve and the oxygens and all the, the -- to
12 return the, the blood flow to the heart. That's how our
13 lung supplied our blood flow back and forth between the
14 heart and lung.

15 Q And right here -- I know it's dark, but I think we can
16 make it work.

17 You were talking about, and this is looking from the
18 patient's back, and here it can often be a little bit
19 higher. In here it goes down a little bit lower. But it's
20 pretty dense in this area where it, where it splits out.

21 Right?

22 A That's right.

23 Q Is that what you're talking about right here?

24 A Yes, sir.

25 Q Okay. Now, what about the, the size view, the lateral

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1 view?

2 What are we looking at here?

3 Mr. McKinnon -- well, explain, you know, in -- when you
4 look at, at lateral view, what are you looking at?

5 Where are some of the structures?

6 A Well, again, we are looking at it. I, you know, again,
7 from outside to, to inside. So you basically look at the
8 back and make sure the spine goes down and it gives me
9 informations about how adequate the lungs are, and the
10 bottom of lung is gonna be darker because of the gravity and
11 you can look at the ribs. Actually you can look at the ribs
12 and you can look at the diaphragm like I just say, whether
13 or not the diaphragm is sharp, and you have poor effusion,
14 this area here is gonna be dark looking like there's fluid
15 in there. And then you look mainly at this area right here
16 and you can look at the heart. Well, again, you have, in
17 your mind, try to visualize what you are looking at.

18 So I'm trying to -- okay. In this case I say okay, I
19 have heart right here. I see that there's something coming
20 out here, the artery coming out here, and then it turns
21 around and this is where I say pulmonary artery looking at
22 you. So it's dense. It's dense around here.

23 So, I---

24 Q Go ahead.

25 A Well, again, I'm relying on this and I say okay, I

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1 think they look like that's the right, the right density for
2 the structure that's about right there. I don't see any
3 nodules in here and I certainly can not describe the nodules
4 that Doctor Woodruff see. I -- if I don't see if I can not
5 describe it.

6 I -- you know, he can say well, you know, there's right
7 here, maybe is this big, or is this big. I -- again, these
8 are suppose to be dense, and he say that well, it looks
9 denser to me. I disagree. I am trained. I am, I am -- I'm
10 trained to read this x-ray. I, I stand here.

11 I say you know what?

12 I really don't see that as more dense than, than not,
13 and he's saying that well, no, because I'm a radiologist.
14 It's more dense. I, I can not agree with it and that's why
15 I can not describe the structure that he was talking about
16 because I don't believe that it's denser.

17 Q Did -- doctor, did you read these x-rays after the
18 lawsuit was filed?

19 A Yes.

20 Q Well, I'm -- well, the first time you read these was
21 there a lawsuit?

22 A No.

23 Q Okay. So you didn't have the benefit of knowing that?

24 A No.

25 Q Okay. Knowing that, that there's some allegation.

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1 All right. Now, you were talking about right here, the
2 pulmonary artery coming out and does it come around here and
3 come out---

4 A Yes.

5 Q ---basically?

6 And is that what we're looking at here?

7 A Right.

8 Q You know, you, you -- from here, if you kind of cut the
9 heart in half and then you see it come out right here.

10 Is that what we're looking at here?

11 A That's right. And, again, like I say, there's
12 structures around here that is also dense. It's -- there
13 fat in there. There's the skin of the, of the heart that's
14 in there. There's this left oracle there.

15 Again, I, I am no way to tell you in this film at all
16 right here is the oracle, right here is this area is this.
17 But the area that's here correlate with the area right here
18 and that's how it comes out, and there are suppose to be --
19 they're suppose to be white.

20 Q Thank you.

21 THE COURT: Lawyers approach one moment.

22 (WHEREUPON, a bench conference was held out of the
23 hearing of the jury at this time.)

24 THE COURT: All right. Ladies and gentlemen, we're at
25 a point to where we are going to take the evening break.

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1 I need to remind you that you can not do any type of
2 independent research or investigation in this case. I know
3 the lawyers have used some terms and -- that maybe you don't
4 understand.

5 Again, do not pull Webster's Dictionary or a medical
6 dictionary off the shelf. Allow them the opportunity to be
7 able to educate you as, as to those terms.

8 Do not do any type of independent research or
9 investigation into any of the other issues or the parties or
10 the lawyers or the Court.

11 Thank you for your time though today. You've been very
12 attentive. I'm gonna let you retire now. But I will ask, if
13 you would, to please return back to the jury deliberation
14 room by 9:30 in the morning. We'll resume the taking of the
15 testimony, which you may go with the bailiff.

16 Thank you very much.

17 (WHEREUPON, the following takes place outside the
18 presence of the jury.)

19 THE COURT: Doctor, I need to remind you that you're in
20 the process of giving testimony. And so, over the evening
21 break and tomorrow morning, you can't have any discussions
22 with anyone about the substance of your testimony.

23 You understand that?

24 THE WITNESS: Yes, sir.

25 THE COURT: All right. Thank you, ma'am. You may step

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1 down. Be careful with the step when you're stepping down.

2 You may step down.

3 THE WITNESS: Thank you, sir.

4 THE COURT: You welcome.

5 All right. Lawyers approach a moment.

6 (WHEREUPON, a bench conference was held at this time.)

7 THE COURT: All right. Well, I will see y'all at 9:30.

8 MR. DAVIS: Yes, sir.

9

10 (WHEREUPON, Court was in recess for the evening.)

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2

3 THE COURT: Anything before we resume the testimony?

4 MR. MCKINNON: Not from the Plaintiff, Your Honor.

5 MR. WILLIFORD: Not from the defense, Your Honor.

6 THE COURT: Doctor, if you would, just come back
7 around.

8 (Witness complies.)

9 THE COURT: I just need to remind you that you remain
10 under oath.

11 Do you understand that?

12 THE WITNESS: Yes, sir.

13 THE COURT: Okay. Just have a seat in the chair.

14 THE WITNESS: Sir, may I have a cup of water there?

15 THE COURT: Uh-huh. (Affirmative).

16 Usually they keep it right behind you.

17 THE WITNESS: I see. Thank you.

18 THE COURT: Uh-huh. (Affirmative).

19 All right. Let's bring the jury in.

20 (WHEREUPON, the following takes place within the
21 presence of the jury.)

22 THE COURT: Yes, sir.

23 CONTINUED DIRECT EXAMINATION

24 BY MR. WILLIFORD:

25 Q Doctor Wan, yesterday we, we just wrapped up looking at

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1 the x-rays of Mr. Farr.

2 Do you recall that?

3 A Yes, sir.

4 Q Okay. And what I wanted to do, and we, we ran out of
5 time yesterday, but now look at a few x-rays, you know,
6 that, that we found off, off Google like Doctor Woodruff did
7 and Mr. McKinnon went through --

8 A Yes, sir.

9 Q -- and I want you to explain to the jury what we're
10 looking at.

11 okay?

12 A okay.

13 Q And, and you have a laser pointer right here.

14 A okay.

15 Q And you'll probably have to point it up here, and if
16 you want, it'd be good if you get, get you down off the
17 stand --

18 A okay.

19 Q -- and we'll look at this.

20 okay. Now, Doctor Wan, please feel free to come down
21 --

22 A (Witness comes down from the stand.)

23 Q -- and I want to point to a few things and -- well,
24 tell the jury what we're looking at.

25 what, what are we looking at?

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1 A Well, again, I'm not going to go through the, the same
2 thing we did yesterday, but---

3 Q Sure.

4 A ---this is obviously a lateral view, left lateral view
5 of a chest x-ray. It really fairly adequate x-ray.

6 Again, we see spine, ribs around here, trachea columns.
7 We can see air columns in there. Good dark space here.

8 Like I say, if you come down here, it has to be
9 progressively darker because you're more lung around here.
10 Again, you look at the space right here and it's dark, and
11 you can look at the heart right here.

12 Now, this strickeness (phonetic) that you see right
13 here, again, as I mentioned yesterday before, that this is a
14 normal structure that comes out from the lung that improves
15 the pulmonary artery and then aorta to come right behind
16 here and the order in here in this x-ray you don't see very
17 well.

18 Now, this area right here is where you will see what I
19 called the pulmonary artery coming out. So it trips around,
20 it comes out, and look at it -- you this way. And looking
21 at this, and you can look at the diaphragm as well, this is
22 the, the left diaphragm because, if you lost the other -- at
23 the, at the -- where you have heart sitting on the left side
24 and then you have right the diaphragm where, where your --
25 your heart's not sitting on it. That's why you can see

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1 clearly at the front. This is actually a normal left
2 lateral view of the chest x-ray.

3 Q Sure.

4 And this area right here, it's kind of protruding out a
5 little bit right here, but you're saying that's normal?

6 A Correct. It is normal.

7 Q Okay. Normal structures?

8 A Normal structures.

9 Q Okay. And, in fact, this is that image and it's a
10 normal x-ray.

11 Correct?

12 A That's correct.

13 Q And what about this one?

14 A Now, if you, if you look at this x-ray here, if it goes
15 progressively down. The same thing. I'm just gonna point
16 to the obvious.

17 Q Sure.

18 A That I believe this patient again has hyperinflations
19 of the lung and COPD, and this area right here is suppose to
20 be dark, but, you know, I think that his hand may be in the
21 way.

22 Again, there's the heart right here, and then there is
23 the -- where you suppose to have a hilum where the pulmonary
24 artery comes out, and you have the air columns right here,
25 and, again, this, this structure right here is not abnormal.

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1 Q And when Doctor Woodruff was here yesterday, he was
2 talking about, on the other x-rays, that the -- that this
3 area right here kind of above -- like if here's the heart,
4 this area right here, that, that's abnormal on Mr. Farr's.

5 But, in your opinion, that was normal and this was
6 normal as well?

7 A In terms of, in terms of when it comes to COPD patient
8 is not, is not uncommon.

9 Q Got you.

10 Sure enough, that's normal, correct?

11 A Yes.

12 Q And then what do we see here?

13 A Now, this is clearly abnormal you see right here. Now
14 that's what I would call a mass. Clearly defined right
15 here.

16 Now, again, on this side, because you have the heart, I
17 can not tell you exactly how big this will go in. Now, this
18 is when the lateral view will really help you and you can
19 see right here. It -- there's definitely something on the
20 right hilum up there and I would call this a mass.

21 Q And what about this?

22 A Again, this is clearly abnormal and I would be very
23 concerned right here. The heart is somewhat generous. But
24 you can see, not only here, there is a big infiltrate. Now
25 you can see -- look at the trachea right here. Yesterday I

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1 was talking about the trachea.

2 When you have something right here, the trachea gets
3 pulled to the other side. You worry. Because if you have a
4 tumor, it, it gets bigger and it -- tumor is very hard. It
5 can get very hard. So what it does is it pulls and you see
6 that the air columns, right here, the trachea, usually it
7 goes straight, but it doesn't. It goes -- it actually goes
8 to the side and get pushed to the other side.

9 Now yesterday we were talking about the fissure. This
10 x-ray actually shows nicely the fissure is right here. Now
11 that's when you're gonna tell that yes, this is actually the
12 right upper lobes and there's a mass in the right upper lobe
13 close to the hilum region, medial aspect, and this is a mass
14 and this needs to be worked up.

15 Q And what about this?

16 A Now, I brought up this x-ray actually because I found
17 this x-ray I think on the -- on a COPD radiology tutorial
18 because, you know, I, I already mentioned that even the
19 circumstances of Mr. Farr, the chest x-ray was not abnormal.

20 Now, you know, you can look at this and say well, look,
21 I see a dense, dense, density right here, and I see it right
22 here, and there's a density, and I see it right here, and
23 there's a density, but this patient actually has COPD. He
24 does not have any mass. Does not have any infiltrates in
25 this case.

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1 Q And when you say COPD with these dense or white areas,
2 how can you determine that that's COPD looking at this x-ray
3 with those white areas?

4 What is it about the patient that might manifest that?

5 A Well, you know, I mentioned about the hyperinflations.
6 I didn't go into detail again. But this x-ray, at the
7 bottom, you see here, the, the -- it's cut off right now.
8 Exactly.

9 So, right here, again, she has, he has, he or she has a
10 flattening of the diaphragm. You should see a really nice
11 tube size around here and, here again, there is
12 hyperinflations of the lungs where you can see the space
13 here. It's bigger and, in general, you can look at the
14 epidiameter. This is when I talk about the Barrel Chest
15 when somebody has -- breathe like this and their chest
16 becomes like a barrel because you can see somewhat like
17 here. That's how we describe somebody who has
18 hyperinflations and COPD of the lung.

19 Q And what about pulmonary edema?

20 You mentioned that yesterday.

21 Is there some manner of that going on?

22 A In this x-ray?

23 Q Yes.

24 A No.

25 Q All right. Now, this---

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1 A It -- may I add?

2 Q Sure.

3 A This, this x-ray, you know, it's, it's not -- x-ray --
4 lateral side x-ray does not look at the lung very well
5 because of the, the big structures here. Now, it's -- for
6 me to comment on really pulmonary edema, ideally I should
7 have a PA film to look at it.

8 Q Frontal true?

9 A The frontal view of it, the other x-ray.

10 Q Now, right here, you know, you've got that area that's,
11 you know, as a layman, I'm looking at this as maybe a heart,
12 and then you've got this area kind of sticking out and this
13 kind of coming out close to the chest wall, and you're
14 saying that's normal?

15 A You're correct.

16 Q Okay.

17 A And this is not what I'm saying. This is what the
18 Internet and -- this, this came from University of
19 Massachusetts, you know, where we learn all the x-ray.

20 Q And this is that same film, the frontal view, and
21 you've got -- well, doctor, explain.

22 A Well, he, he, again, has hyperinflations and COPD where
23 you can see the lung is kind of -- the heart is kind of
24 stretched. Usually you will see the lung -- a very nice
25 shape sitting on the diaphragm. But because of his

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1 hyperinflations, the lung is kind of -- the heart is
2 stretched into more like a bottle looking.

3 Now, right here is generous. But, again, like I say,
4 you know, in COPD patient, this is not uncommon. This is a
5 normal variance for a COPD patient. I can say that -- I
6 can, can comment and say that this abnormal because well, he
7 has abnormality, which is hyperinflation, and -- but, you
8 know, this structures right here is more prominent of the
9 hilum and pulmonary artery. But those are not uncommon in
10 patient with COPD especially if they have pulmonary
11 hypertensions. That's one -- the driving force of the
12 prominence of this area where your pulmonary artery becomes
13 bigger because there's low oxygens in the area.

14 Now, on this frontal view I don't see any pulmonary
15 edema.

16 Q Okay. And then kind of on the right side of this
17 patient, this is a little bit more dense on this side than
18 that side.

19 would that be fair to say?

20 A You're correct.

21 Q And it's normal -- would it -- well, would it be normal
22 in terms of a mass?

23 A No, I don't see any mass in here.

24 Q Okay. Almost done.

25 And, and this was the -- this is the article that you

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1 got those from?

2 A That's correct. This is where the x-ray came from.

3 Q Okay. All right. Doctor, let me go back to your note
4 now.

5 A (Witness returns to the stand.)

6 MR. MCKINNON: David, can you leave up that number one
7 there?

8 Leave up the x-ray, the one that's normal?

9 MR. WILLIFORD: Yes, sir.

10 MR. MCKINNON: Thanks.

11 Q Okay. Now, Doctor Wan, I want to go to your note, and
12 if you wouldn't mind coming down again?

13 A (Witness comes down from the stand.)

14 Q And what we were doing is we were going through your
15 note, your evaluation of the patient, and the physical exam,
16 your assessment, and the clinical history, the different
17 things that you were doing, and then, after you did all
18 that, you did the x-rays. You went through that and now
19 we're here.

20 You know, you've talked about the studies, the
21 pulmonary function test you did, the chest x-ray, and now
22 we're here at, at the problem list in all caps.

23 Explain to the jury what your diagnosis is and why you
24 came up with these diagnoses for Mr. Farr.

25 A Okay. First of all, the dyspnea is something that my

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1 technicians actually put in in order to perform a pulmonary
2 function test because, you know, we are required to give a
3 diagnosis for, for what we do, and my technicians have been
4 instructed to put that, and then we will, you know, go ahead
5 and put the, the subsequent diagnosis down after we do the
6 proper evaluations.

7 Now, my evaluation of this gentleman I -- this is not
8 in a sequence of significance. In fact, usually I would put
9 the sequence of significance.

10 In this case, truthfully, COPD is his main problem, but
11 I want to address the main issue that he came to me was
12 because of secondary erythrocytosis.

13 Number one, this is actually Mr. Farr who was -- who --
14 how old is he?

15 Seventy?

16 Mr. Farr is 67-year old man who came to me because
17 Doctor Vidito is concerned about secondary erythrocytosis
18 and, and he wanted me -- she wanted me to evaluate for
19 causes of hypoxemia and he does. He does have hypoxemia and
20 I did mention that and is non, non-oxygen dependent
21 because -- to obtain oxygens, you need to have the oxygens
22 saturation less than 89 percent.

23 So it's not just while a patient is low oxygens. It
24 makes sense to give oxygen now. We are -- you know, the
25 assessment is that oxygen has to be lower enough to -- in

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1 order to give oxygen mainly because we have study to prove
2 that patient who have just a little bit low oxygen, but not
3 very low oxygen, does not benefit from it. So I, I
4 mentioned it, non-oxygen dependent, and then next he, he has
5 COPD.

6 He has moderate, moderate COPD on, you know, by my
7 assessment that he's asymptomatic COPD patient. The
8 treatment for COPD is, you know, depending on the symptoms.
9 As I say, I asked him before if you have any symptoms.

10 No.

11 If you have been in the hospital?

12 No.

13 Any times you have any COPD as a patient and you've
14 been hospitalized in the past, you should have some sort of
15 medications, but he has denies it and he not use any
16 inhaler.

17 At this point in time, based on his symptoms, there's
18 really no indication to even give him an inhaler, and I
19 don't believe that he would use it anyway because, you know,
20 the inhaler that I would give is, is as needed basis and he
21 already say I don't get short of breath. When I walk, I
22 don't get short of breath. So basically there's no
23 indication from him to use the inhaler.

24 Q Now -- oh, I'm sorry. Go ahead.

25 Well, let me ask this question.

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by Mr. Williford

1 In terms of COPD, he didn't come in complaining of
2 that, but you found it on your exam?

3 Is that fair to say?

4 A That is correct because -- well, he want to have his
5 lung check. So I need to -- he say he wasn't having lung --
6 so anything that's pertaining to the lung, it's, you know, I
7 need to make the diagnosis. He didn't come to me with that,
8 but I, I want to build a case to this man that, even though
9 you don't feel any symptoms, you, you need to quit, quit
10 smoking.

11 So that leads to my third assessment of his tobacco use
12 disorder. In fact, I spent -- I put capitalized smoking
13 cessations because, truthfully, if I'm gonna make a
14 difference in this man's or this patient's health down the
15 road, there is the number one things I could prevent.

16 Now, by my assessment, I want to say there's no
17 indications at, at this point that he has any cancer.

18 Am I concerned?

19 Yes.

20 He not only is at risk of having cancer, he's at risk
21 of developing symptoms from COPD because he already have
22 signs and he has already have objective findings of COPD.
23 But he is one of those lucky person who, at that point,
24 still doesn't have symptoms, and maybe, like I say, he is
25 just use to it. A lot of people that live with COPD, and

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1 they got use to being short of breath, they don't realize
2 oh, I'm short of breath. But, according to him, he's not
3 symptomatic.

4 However, he already have signs, Barrel Chest,
5 hyperinflation, moderate COPD. So, at this point in time,
6 the most important things that I can recommend that will
7 change his outcome is smoking cessation. Not only from the
8 COPD standpoint, from cancer standpoint. I'm not only
9 concerned about him developing lung cancer, he's at risk of
10 developing any cancer that's related to smoking. Recurrent
11 colon cancer, head or neck cancer, esophageal cancer. I, I
12 see a lot of them and it's very important for him to stop
13 smoking.

14 I, again, want to emphasize I'm not prejudiced against
15 him, but it is my job. It is my job, as a physician, to
16 tell him you need to stop smoking because, right now, you
17 tell me well, my job is to just tell you to stop smoking
18 because you're not having any symptoms. I don't have to
19 treat you for the symptoms, but hey, if I can change you by
20 asking you to stop smoking, I potentially can prevent a lot
21 of complications down the road and that, in this case, is
22 what I call the primary preventions.

23 If I can not treat, I need to prevent. Therefore, it
24 becomes the most important thing in my visit to tell him
25 well, you need to stop smoking because I am concerned. I am

Sau-Yin Wan - Direct examination
by Mr. Williford

1 concerned that you have so many medical problems that will
2 get worse, and it's not a matter of whether it will. It's a
3 question of when, when this is gonna become a symptoms, when
4 this gonna become a problem.

5 Q Okay. And is that why you put an exclamation mark as
6 well and not just capitalized?

7 A That's right.

8 Q Okay. Now, were you ahead of the game in terms of
9 diagnosing COPD for him based on your evaluation and your
10 interaction with him?

11 A Yes. Again, he didn't have any -- he didn't have any
12 symptoms and he -- I wanted to find him something. Somebody
13 have to have incentive to stop smoking.

14 Everybody knows smoking is bad. But if you come to me,
15 I tell you well, you have moderate COPD and this are things
16 that I find. Well, I, I hope that I give him enough reason
17 because, if he doesn't feel anything, he's not gonna take
18 medication.

19 Anybody who have high blood pressure is gonna not take
20 the medication because you don't feel it.

21 But does it cause problem?

22 Yes.

23 So I am trying to bring up the, the things that he can
24 see that will motivate him to stop smoking because, you
25 know, if you don't feel it, hey, I go on smoking another

Sau-Yin Wan - Direct examination
by Mr. Williford

1 time and it will still, you know, it's still not gonna be
2 different, but that's not the case. You don't feel it. I
3 see it. I see it in here clearly that it has affected you.

4 Q Okay. And then what did you do?

5 Your note was smoking cessation with an exclamation
6 mark.

7 what did you do for him?

8 Did you -- explain to the jury about that.

9 A Well, I, I gave him a prescription of Chantix, but he,
10 he declined it. He say he wanted to try without, without
11 medication first.

12 He is -- when it come to smoking cessation, he, he's at
13 a phase where we call that he's not ready. You know, the
14 number one people who need smoking cessation is the mind.
15 You need to stop -- you need to say well, I need to -- I
16 want to stop smoking, but, you know, he, he didn't want to
17 and he didn't want any help with it either. He didn't feel
18 like there's any need.

19 Q And what is Chantix more specifically?

20 A Chantix is actually a pretty new medications that bind
21 you to our receptors to help decrease your urge for, for
22 smoking.

23 Q All right. And, doctor, in your assessment, and then
24 coming up with your plan, did you fail to gather
25 information, whether it be through your exam, physical exam

Sau-Yin Wan - Direct examination
by Mr. Williford

1 or interactions with him or interview with him or the way
2 you went about looking at the x-ray, did you fail to gather
3 information to come up with your plan and your diagnosis?

4 A No, I -- if you have asked me to do this again, I think
5 I did a thorough exam on him and it's -- in his case, it's
6 not the easiest case because he doesn't have symptoms and it
7 involved me trying to elicit those signs, and I clearly
8 have -- I clearly have found it. I clearly have pointed it
9 out, out to him and I, unfortunately, I don't believe
10 there's anything else I can do to best help him in this
11 case.

12 Q Based on your note, looking at the x-rays, your exam of
13 him, everything you did for him, your interactions with him,
14 did the standard of care require you to order a CT Scan?

15 A No, in fact, there is a recommendation not to order CT
16 Scan for screening of lung cancer because -- at that point.
17 This was 2011. Now, 2013, we have a different
18 recommendation.

19 2011, you know, there was recommendation not to obtain
20 a CT of the chest to do cancer screening because we believe,
21 for one thing, the, the x-ray that you expose the patient to
22 is too much, and the secondly, you do pick out a lot of
23 small things. So you can pick out a small little nodule
24 that probably is not gonna be any significance and, you
25 know, right now, in this era, if you have a .5-centimeters

Sau-Yin Wan - Direct examination
by Mr. Williford

1 small little nodule, you are committed to two years or CT
2 check. That means that my job is to screen you for two
3 years to make sure this is small little nodules does not
4 turn into a cancer.

5 So, you know, because of that you -- because of the
6 high exposures and the x-ray, the x-ray and, at that, the
7 recommendation is not to get CT of the chest to screen for,
8 screen for cancer, and, of course, in my case I already
9 looked for the x-ray and I did not see any cancer. So
10 there's really no reason for me to even pursue more study at
11 that time.

12 Q If you felt like a CT Scan was warranted, would you
13 have done so?

14 A Of course.

15 Q Doctor Wan, did you have the benefit of having ten
16 months go by to then look at other films, other x-rays or CT
17 Scans, at the time that you evaluated him in January?

18 A No.

19 Q Right here, disposition, what does that mean?

20 A Plan for future.

21 Q Okay. And what was your plan for Mr. Farr?

22 A I wanted him to come back to the office in six months.

23 Q And why did you want to do that?

24 A I want to see if he quit smoking. He say that he -- he
25 say he wanted to try without medications. So that would be

Sau-Yin Wan - Direct examination
by Mr. Williford

1 my number one agenda in there.

2 well, I wanted to see also whether or not he develop
3 any symptom because he obviously has COPD. Now, he develop
4 any symptoms, any change in the review of systems like I
5 just did before, those are red flags and, again, I'm looking
6 for, you know, red flags to do further study---

7 Q And the---

8 A ---or other investigations.

9 Q And, and if he came in and he had an indication, would
10 you have done another x-ray at that point?

11 A That's correct.

12 Q Okay. If you had done another x-ray at six months,
13 which would of been June or July of 2010, would you have
14 compared them to the ones in January?

15 A Yes.

16 Q Okay. Did you have that opportunity to evaluate him
17 and compare any x-rays?

18 A No.

19 Q All right. Thank you, doctor.

20 A (Witness returns to the stand.)

21 Q Doctor, does the word recurrence mean metastatic?

22 A No.

23 Q Why not?

24 A Well, you can have, you can have a recurrence of a
25 cancer, but it might not necessarily be from one place to

Sau-Yin Wan - Direct examination
by Mr. Williford

1 the other. You have to have evidence of tissues to really
2 prove that it's, it's coming from the same place. And so,
3 no, even if you have -- you could have recurrence of a
4 cancer without having a spread of a cancer.

5 Q Based on your exam, your review of the records, your
6 review of the x-ray at the time and even subsequently, did
7 Mr. Farr have lung cancer identifiable on that visit with
8 you, whether it be through x-rays or by your exam?

9 A No, he doesn't or he did not.

10 Q If Mr. Farr had lung cancer at some level, a small
11 level or whatever, was it detectable?

12 A Not by eyes. Not by the investigation I've done.

13 Q Did you fall below the standard of care in evaluating
14 Mr. Farr?

15 A No.

16 Q Did you breach the standard of care in evaluating Mr.
17 Farr?

18 A No.

19 Q Did you breach the standard of care in the way you went
20 about reviewing that x-ray?

21 A No.

22 Q Did you negligently read and interpret the
23 January 11th, 2010, x-ray that you did?

24 A No.

25 Q Did Mr. Farr die of metastatic lung cancer from his

Sau-Yin Wan - Direct examination
by Mr. Williford

1 right lung cancer?

2 A No.

3 Q why not?

4 A well, his right lung cancer was completely resected as
5 far as I can tell from all the medical records that I see
6 and no, he did not.

7 Q Did you cause Mr. Farr to die?

8 A No.

9 MR. WILLIFORD: Give me one moment.

10 (Pause.)

11 MR. WILLIFORD: That's all I have, Doctor Wan. Please
12 answer any questions Mr. McKinnon has.

13 THE COURT: Yes, sir.

14 MR. MCKINNON: David, if you'd just fire that back up
15 for that x-ray please.

16 RECROSS-EXAMINATION

17 BY MR. MCKINNON:

18 Q Morning, Doctor Wan.

19 A Good morning.

20 Q Doctor Wan, you spent a lot of time with these blowups
21 of your charts.

22 A Yes.

23 Q Is there anything on these charts at all that proves
24 whether or not you misread that x-ray?

25 A Can you repeat that question again?

Sau-Yin Wan - Recross-examination
by Mr. McKinnon

1 Q Sure.

2 I mean you spent a ton of time going through these big
3 blowups of the chart in this case and Mr. Farr's records.

4 Is anything on any of those charts prove whether or not
5 you misread that x-ray?

6 A Well, I did mention that there was no mass in there.

7 Q Right.

8 But the, the x-ray is what we're here about.

9 Right?

10 A That's correct.

11 Q And so all of this stuff is not the x-ray.

12 Right?

13 A Well, my, my, my notes has interpretation of the x-ray.

14 Not just that preliminary report that you have. And that's

15 part of my interpretations and there's no mass in there as

16 contrast to what Doctor Woodruff would have indicated.

17 Q Well, let me give you a for example, doctor.

18 You spent a long time talking about COPD.

19 Does whether Mr. Farr have COPD or not, does that prove

20 whether or not there's cancer on the x-ray?

21 A No.

22 Q Okay. You talked about Mr. Farr's allergies and his

23 inhaler where you were giving him an inhaler.

24 Does that have anything to do with whether or not

25 there's a mass on that x-ray?

Sau-Yin Wan - Recross-examination
by Mr. McKinnon

1 A well, sir, it is part of my job to do a detailed
2 examinations, and, again I, I can not say that it's
3 irrelevant, but it is important informations to me.

4 Q Doctor Wan---

5 A Okay.

6 Q ---I understand, but the issue in this case is the
7 x-ray.

8 Right?

9 A Okay. Yes.

10 Q Okay. So, Doctor Wan, did you -- here -- actually let
11 me get the x-ray up too so we can see the difference.

12 Doctor Wan, you may want to come around. I don't want
13 to put this in front of your face.

14 A (Witness comes down from the stand.)

15 Q Let's see. Doctor Wan, this up here is what you put up
16 as a normal x-ray.

17 Correct?

18 A That's correct.

19 Q Okay. And if you look at this area above the heart,
20 these densities right here are about the same, right?

21 They're about the same brightness?

22 I mean this, this looks to me like this. It's all kind
23 of the same level of brightness, the same density of tissue.

24 Is that correct?

25 A No.

Sau-Yin Wan - Recross-examination
by Mr. McKinnon

1 Q You can --.

2 A See, right here, this is density and then you have a
3 little lucency and then you come right here, and then you
4 come right here. There's, you know, a little lucency right
5 here as well. White, black a little, white.

6 Q Okay. Doctor, I understand.

7 But this -- I mean, again, I'm not a doctor.

8 But this right here is the heart.

9 Right?

10 A That's correct.

11 Q Above the heart, this tissue here, it all kind of
12 look -- it's the same density, isn't it?

13 A You can see right here there's a little dark and then
14 there's a little white here and -- I, I don't want to go
15 into an argument about which one is darker and black.

16 Q Okay.

17 A I, I -- I'm not trying to argue or anything, but, you
18 know, it's -- right now we're talking about wow, this is
19 darker and this is whiter. I hate to say this. I mean this
20 is like an art now. You, you ask me well, this is darker
21 and I say well, no, I don't think this is completely the
22 same, and, and, you know, I will tell you this.

23 When I first received the training, you ask me to point
24 out x-ray, I would tell you oh, gosh, I don't know, I don't
25 know that I could ever read an x-ray. But the day comes.

Sau-Yin Wan - Recross-examination
by Mr. McKinnon

1 The day comes when you read enough x-ray you're like, oh,
2 yeah, actually I can read it. So I'm not trying to, you
3 know, change everybody and say well, this is darker and not.
4 I can -- you know, I don't want to keep arguing with you,
5 sir.

6 Q Okay. Well, doctor, I just -- this is the critical
7 issue in the case. So we need---

8 A Yes.

9 Q ---to talk a little more.

10 A Yes.

11 Q This is the heart.

12 Correct?

13 A Yes.

14 Q Okay. Right here.

15 This is not the heart.

16 Is that correct?

17 A That's correct. You have the heart right here, and
18 then this area right here is where you expect, you know, on
19 top of the heart in-between this area there will be the
20 pulmonary artery coming down and also there will be
21 pericardial in this area right here, and you have the left
22 oracle around this area right here.

23 Q Okay.

24 A That's correct.

25 Q Doctor, now, again, I'm a layman, but, to my eyes, this

Sau-Yin Wan - Recross-examination
by Mr. McKinnon

1 area right here is much lighter than the rest up here. This
2 here is different than the rest of this tissue up here.

3 Isn't that the case?

4 A That's the case.

5 Q Okay. And I'm looking on the normal x-ray.

6 That is not the same as that---

7 A Well---

8 Q ---isn't it?

9 It's different?

10 A You're correct, sir, and, you know, that's the reason
11 why I brought up several different chest x-ray and let you
12 know that you could see different density in, in those
13 patients in the area and they are not abnormal---

14 Q Right.

15 A ---in the, in the case, and, in this case especially,
16 this patient has COPD. He has hyperinflation. This area
17 here is white.

18 I don't have the exact same x-ray that I can find to
19 show it to you and the -- but I was trying to help point out
20 that well, you look at different x-ray, they are all normal,
21 but you -- truthfully, all this x-ray, they have different
22 density in the area. But this are not considered abnormal
23 especially in the face of COPD.

24 Q Okay. And, doctor, you testified, did you not, that
25 this bright area right here was the pulmonary artery?

Sau-Yin Wan - Recross-examination
by Mr. McKinnon

1 A It is where you're suppose to see where the pulmonary
2 artery comes out and also the left oracle and also the
3 pericardium where it should come out.

4 Q Okay. Everyone has that anatomy.

5 Right?

6 A That's correct.

7 Q So this person up here on the screen, he has a
8 pulmonary artery and a pericardial and the things just
9 mentioned?

10 A Yes.

11 Q But it does not look like that, does it?

12 A Well, you are not suppose to be able to see those
13 structures. As I mentioned before, when you look at the
14 x-ray, you have to keep in your mind this are the structure
15 that is in the area.

16 Now, if something's abnormal in the area, then you, you
17 have to have an idea oh, okay, this is where the structures
18 is and this will be where the abnormalities will be. So
19 you're not suppose to see them. In other word, you're not
20 suppose to see them.

21 Now, when you see abnormalities or intensity, then you,
22 you have to think well, is it abnormal. well, the
23 structure's right here. Is pulmonary artery. This is the,
24 the heart right here.

25 Now, it is gonna be abnormal, what would it be?

Sau-Yin Wan - Recross-examination
by Mr. McKinnon

1 Now, in his case, there's a density right there, but he
2 has pulmonary hypertension. Oh, I'm sorry. Not pulmonary
3 hypertension. He has COPD.

4 So, in this case, it's not abnormal for him because the
5 structures relaying in the area comes out like this and
6 that's where I would expect it to be.

7 But in the normal chest -- in the normal x-ray you're
8 not able to, to delineate. I, I would not, I would not be
9 able to tell you look right here, this is where it is in
10 contrast to the -- in contrast to the trachea.

11 See, like I say, you want to look at something. You
12 need to compare.

13 Now, right here, why do I know that this is trachea?
14 That's just line.

15 Well, it's trachea because there's air in there.
16 There's air in there. That's where I'm suppose to see the
17 trachea and you can only see it when there's air in there.
18 So, now, if the air is not in there, you're not gonna be
19 able to see the structure.

20 Now, is the trachea there?

21 Yes, it is. But because there's air in the trachea,
22 air in the trachea right here, therefore I'm able to
23 identify right here.

24 Now, I will tell you that somewhere around there
25 there's esophagus and I know that is right behind the

Sau-Yin Wan - Recross-examination
by Mr. McKinnon

1 trachea.

2 Can I see it?

3 No, not in this case.

4 So I will tell you that well, there is also other
5 structures right here. But I'm not able to see it.

6 Now, I will tell you though also around this area
7 there's lymph nodes in there. well, I'm not gonna claim
8 that I can see the lymph nodes. But I can tell you there is
9 lymph node in there. I have to keep in my mind well,
10 something -- if this showing up right here, it might be the
11 lymph nodes.

12 So what I'm trying to say is that, you know, this are
13 structures that you keep in mind that, when you look at the
14 x-ray, it's there. But this not -- this is not the
15 structures you are able to see on the x-ray unless there's
16 something else next to it or something else changes.

17 Q Doctor, what -- I'm trying to get us out of here. So
18 let me just try some yes/no questions if that's okay.

19 Did you testify that this structure was the pulmonary
20 artery?

21 A I testified that this is where the pulmonary artery
22 will come out.

23 Now, you -- Mr. Woodruff, Mr. Woodruff insisted that
24 there's a structure right there. I, I, I not only disagree
25 with him on my x-ray, I also disagree with his

Sau-Yin Wan - Recross-examination
by Mr. McKinnon

1 interpretation of the subsequent x-ray to say that there is
2 tumor looking at you, and I -- he disagree with our
3 radiologist in the subsequent test he just gave and say that
4 well, even though they say inflammation, I think they could
5 have said it -- I think that there's a tumor right there.

6 Well, I tell you I disagree with that. So now he
7 disagree with me, disagree with our radiologist, and come to
8 me and say well, there's something right here, do you not
9 see it.

10 Sir, I -- with all due respect, I can tell you that
11 this is what I exact will see it. But the abnormalities
12 that he is seeing and he's saying that there's a tumor
13 looking at you, and you want me to describe the structures
14 that I can not see. I just can't.

15 What I can tell you that is, that in my mind, when I'm
16 looking at it, this is where the pulmonary artery is gonna
17 come out and this is where the left, the left oracle is
18 gonna be, the pericardium is gonna be, and the structures
19 right here, if you feel more dense, if you feels abnormally
20 more dense, that it will be where it is. But I can not
21 point out the nodules and the mass that he talked about. I
22 can not.

23 Q Doctor, let's try it one more time.

24 Did you testify, yes or no, this was the pulmonary
25 artery right there?

Sau-Yin Wan - Recross-examination
by Mr. McKinnon

1 A This is where the pulmonary artery will be.

2 Q Okay. And on this gentleman, this is a normal x-ray
3 where he has a pulmonary artery there too, right, or he'd be
4 dead?

5 A He does.

6 Q Right.

7 And this, this area here of whiteness, which means a
8 density, more tissue, looks different than that normal
9 x-ray.

10 Is that correct?

11 Yes or no?

12 A If you compared about, yes.

13 Q Okay. And your testimony is still there is nothing
14 abnormal about this x-rays -- there's, there's no mass on
15 it?

16 A There's no mass on it. This structure right here, in,
17 in the context of COPD, it's very confident that I can tell
18 you it's pulmonary artery.

19 Q Okay. Take this down, doctor, and you can -- we can
20 shut that off. Yeah.

21 A (Witness returns to the stand.)

22 Q Okay. A couple of quick minor other points, doctor.

23 You mentioned yesterday that you did not believe that
24 it's possible for tumors to spread from the lung -- one lung
25 to another via the airways.

Sau-Yin Wan - Recross-examination
by Mr. McKinnon

1 Is that correct?

2 A That's correct.

3 Q Okay. I'm gonna put -- this is a medical textbook from
4 Cambridge---

5 MR. WILLIFORD: Your Honor, I object.

6 THE COURT: Y'all want to approach?

7 MR. WILLIFORD: May we approach?

8 THE COURT: Yeah.

9 (WHEREUPON, a bench conference was held out of the
10 hearing of the jury at this time.)

11 Q Doctor, I'm gonna hand you this textbook.

12 Doctor, what is the title of that textbook?

13 A Lung and Mediastinum Cytohistology.

14 Q Okay. And what is cytohistology?

15 Can you explain that?

16 A It's related to looking at a cell under the microscope.

17 Q Okay. And who published that textbook?

18 A Ali and Yang---

19 Q Okay.

20 A ---Cambridge Medicine.

21 Q Right.

22 And so that would be Cambridge University, England?

23 A Yes.

24 Q Okay. Is that, in your opinion, is that an
25 authoritative source?

Sau-Yin Wan - Recross-examination
by Mr. McKinnon

1 A No.

2 Q Cambridge University publishes bad science?

3 A No, I -- I'm not, I'm not sure if this authoritative
4 in, in pathology. It's not something that I'm aware of.

5 Q Okay. But I -- but can you flip to the authored page
6 of the textbook?

7 MR. WILLIFORD: . Your Honor, objection. She -- he's not
8 established foundation.

9 THE COURT: All right. I'm gonna -- he's proceeding
10 properly so far.

11 Q Doctor, can you tell me who the authors of the --
12 editors of the textbook are?

13 A Where is it?

14 Q It's right at the very beginning.

15 A Ali and Yang.

16 Q And they're the editors of the textbook?

17 A Yes.

18 Q And where does it say Doctor Ali works?

19 A John Hopkin.

20 Q Is that a well regarded Medical School?

21 A Yes.

22 Q Okay. And what about Doctor Yang?

23 A Weill Medical College, Cornell University.

24 Q Is Cornell University a well regarded medical college?

25 A Yes.

Sau-Yin Wan - Recross-examination
by Mr. McKinnon

1 Q Would you agree with me that they -- that is an
2 authoritative -- they are authoritative in their field?

3 A It's -- I, I really don't know if they are, sir. I, I
4 mean they write the book.

5 Q Do you have any reason to believe they're not
6 authoritative?

7 MR. WILLIFORD: Objection, Your Honor. I mean it's---

8 A I don't---

9 THE COURT: She can answer is she knows.

10 A I don't have any opinion of this because, you know
11 what, I have never used this book before. I have never used
12 this book in pulmonary medicine. So I can not -- I'm not
13 here to comment on a few that someone else uses. I mean
14 maybe a pathologist can tell you they use this book. But I,
15 I, I don't use this book. So I don't, I don't have any
16 opinion about this book.

17 Q Are you familiar with the Cambridge University in, in
18 England?

19 A I heard of it.

20 Q You've heard of it.

21 A Yes.

22 Q Glad you've heard of it.

23 Okay. Are you familiar with it's a Medical School?

24 A Yes.

25 Q Does it have a good reputation?

Sau-Yin Wan - Recross-examination
by Mr. McKinnon

1 A Yes.

2 Q Does it -- scholarship produces -- it is reliable?

3 A You would, you would---

4 MR. WILLIFORD: Your Honor, I mean---

5 THE COURT: I'm gonna allow her to answer.

6 Q Is the scholarship to Cambridge University Medical
7 School produces reliable?

8 A You would hope so.

9 Q Okay. And that textbook is produced by the Cambridge
10 University Medical School.

11 Correct?

12 A Look, I don't mean to be -- I don't, I don't want to
13 comment on any of the expert witness and -- but Doctor,
14 Doctor Barry Singer came from John Hopkins and Harvard and
15 he failed his board. So, I, I -- I'm not trying to say that
16 it's not, but you will hope so. You will hope that
17 everybody who comes from this universities are, are good.

18 I didn't come from this University.

19 Do I think that I, I'm -- I'm not competent?

20 No.

21 I, you know, I think I'm equally well trained compared
22 to this University. You have a good name tacked to it and I
23 understand that. But you will hope that all your care from
24 there is good. But I'm not here to give that opinion right
25 here.

Sau-Yin Wan - Recross-examination
by Mr. McKinnon

1 Q Doctor, is there any reason that's not -- I mean have
2 you used Cambridge textbooks before?

3 A It's been so long since I used a book because right now
4 we go on-line to Internet. I don't, I don't know where
5 those publisher came from.

6 Q Do you have any reason to believe that the Cambridge
7 research textbooks aren't reliable?

8 A No.

9 Q Okay. Do you have any reason to doubt doctors, the
10 doctors who wrote that book that are professors at John
11 Hopkins and Cornell?

12 You have any reason to doubt their reliability?

13 A No.

14 Q Is that a peer reviewed textbook?

15 A I don't know if it is.

16 Q You can look.

17 A Well, it looks to me that they have different authors
18 from different university.

19 Q And each, each chapter is authored by an expert in that
20 field?

21 A I would assume so.

22 Q Okay. Doctor, would you flip to I believe it's Page
23 122?

24 MR. WILLIFORD: Your Honor, may we approach?

25 THE COURT: Yes.

Sau-Yin Wan - Recross-examination
by Mr. McKinnon

1 (WHEREUPON, a bench conference was held out of the
2 hearing of the jury at this time.)

3 MR. MCKINNON: Doctor, may I borrow that for the judge?

4 (WHEREUPON, a bench conference was held out of the
5 hearing of the jury at this time.)

6 THE COURT: All right. Ladies and gentlemen, I need
7 for you to please retire back to the jury deliberation room.
8 Do not have any discussions among yourselves about anything
9 involving the case.

10 (WHEREUPON, the following takes place outside the
11 presence of the jury.)

12 THE COURT: Lawyers approach a moment.

13 Lawyers approach a moment.

14 (WHEREUPON, a bench conference was held at this time.)

15 THE COURT: All right. Doctor, if you would, I need to
16 remind you that you are under oath and still in the process
17 of giving testimony.

18 THE WITNESS: Yes, Your Honor.

19 THE COURT: I'm gonna let you step down though.

20 Okay. You can't have any discussions with anyone about
21 the substance of your testimony.

22 THE WITNESS: Okay.

23 THE COURT: And, if you would, doctor, I'm gonna ask
24 you, if you would, to wait outside the courtroom.

25 THE WITNESS: Okay.

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by Mr. McKinnon

1 THE COURT: Thank you.

2 (WHEREUPON, the following takes place outside the
3 presence of the witness.)

4 THE COURT: All right. Hang on.

5 (Pause.)

6 THE COURT: All right. Let's see. This is your
7 objection. So you can go.

8 MR. WILLIFORD: Yes, Your Honor. Thank you, Your
9 Honor.

10 We object to Mr. McKinnon's use of the textbook and the
11 one he just produced.

12 Bill, do you mind reading the title of it?

13 MR. MCKINNON: Yes, of course. It's Lung and
14 Mediastinum Cytohistology. Edited by Doctor Ali and Yang.

15 MR. WILLIFORD: And what year is that?

16 MR. MCKINNON: 2012.

17 MR. WILLIFORD: Okay. Your Honor, that textbook was
18 utilized on cross-examination initially to, to attempt to
19 get Doctor Wan to agree that it is authoritative and
20 reliable. She definitively said it was not authoritative.
21 She does not use it in her practice. She would not -- she
22 hasn't looked at it -- textbooks in years cause that's not
23 what, what they do as clinicians, and, and her care was in
24 2011 -- 2010 and this book came out in 2012.

25 It's not really even relevant in that regard. In terms

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1 of her care at that time, it's not relevant and the fact
2 that Mr. McKinnon did not establish it per Evidence Rule
3 803(18), it's not reliable and authoritative. He is not
4 established that.

5 Now, I understand he's got an expert who may do that
6 this morning, but not with Doctor Wan. He is not
7 established that with Doctor Wan.

8 And so, he should not be allowed to cross-examine her
9 on something she has not or anyone else so far in this trial
10 has admitted that that's authoritative and reliable, and
11 that's clearly what the rule is. And if it's not
12 authoritative and reliable, it's hearsay and, therefore, not
13 allowable on cross-examination at this point.

14 MR. MCKINNON: Your Honor, just a couple of things.

15 The, the fact that that textbook is in 2012 is totally
16 irrelevant. Her testimony was she's never heard of the
17 theory. This is a causation argument, Your Honor. Has
18 nothing to do with the standard of care in 2010 so that the
19 age of the textbook is not relevant.

20 Your Honor, under the Learned Treatise Exception,
21 first, the expert has conceded that it's -- Cambridge is
22 reliable. The authors are from John Hopkins Hospital and
23 Cornell. They're reliable. She's not conceded the textbook
24 is reliable cause she's never heard of it. But she has
25 admitted the authors in the publishing house are reliable.

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1 And I think, Your Honor, the rule has a safety valve
2 for experts who are being difficult like this. The third
3 option is judicial notice, Your Honor, that it says it can
4 be established by testimony, admission of the witness, or
5 other expert testimony, or by judicial notice.

6 This is a standard of set histology textbook published
7 by Cambridge University in England, authored by immanent
8 professors in America. It's clearly an authoritative text,
9 and just by her being difficult, she should not be allowed
10 to.

11 THE COURT: I'm sorry. I didn't mean to cut you off.

12 MR. MCKINNON: No, no, that's fine, Your Honor. I'm
13 happy to pass you the textbook if Your Honor wants to see
14 it.

15 MR. WILLIFORD: Your Honor, may I?

16 (The Court nods affirmatively.)

17 MR. WILLIFORD: Clearly she did not see it as
18 authoritative and Mr. McKinnon, when he asked questions
19 about, you know, is it reliable, she didn't say it was
20 reliable. He said do you have any evidence to, to provide
21 to me here that it's not reliable and that's a whole
22 different story.

23 I mean she's not coming in to bring evidence to rebut a
24 textbook that she doesn't even consider authoritative
25 anyway. So his questions were misleading in that regard.

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1 She did not say it's reliable. Clearly when asked
2 specifically about a textbook that's not reliable, it's not
3 even in her field.

4 It's pathology and they have a pathology expert who
5 will testify I believe next in the case. And if, and if he,
6 you know, says it's authoritative and reliable, I think the
7 rules allow that. But not with Doctor Wan.

8 Thank you, Your Honor.

9 THE COURT: Thank you.

10 MR. MCKINNON: And, Your Honor, if may just say one
11 further thing, Your Honor.

12 The rule Mr. Williford's citing is the hearsay rule,
13 Your Honor. I'm not asking to admit this treatise into
14 evidence at this point. I can cross-examine her on anything
15 that I want, Your Honor, and the rule he's citing is about
16 admitting into evidence, Your Honor.

17 MR. WILLIFORD: Your Honor, and just directly on that
18 point, it says if it, if admitted, the statements may be
19 read into evidence, but may not be received as exhibits.

20 We are, we are not contesting -- we're not saying that
21 it shouldn't be admitted into evidence. We are
22 contesting -- we are trying to abide by the rule that says
23 it can't even be read if it's not relied upon as
24 authoritative and it has not been for the record here in
25 Court.

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1 THE COURT: Okay. All right. I'm going to allow him
2 to cross-examine her on this. I have -- I feel like that
3 the way that State versus Council was intended is that
4 this -- is they allow Courts to be gatekeepers to unreliable
5 medicine. Sometimes I would just call it junk medicine.
6 And I am -- I feel confident that, while the doctor, this
7 particular doctor, can dispute her acceptance of the fact
8 that this particular Plaintiff's cancer was not metastasized
9 from the other lung, which that means she can dispute that
10 continually, you know, I disagree with that.

11 I feel like that he can ask her about this science.
12 She brought it up in her direct testimony. You elicited
13 from her the fact that it did not, you know, that that
14 doesn't occur. So I think that that has become an issue
15 with this particular witness and I would take judicial
16 notice of the -- I feel like this is a reliable textbook.

17 So I'm, I'm gonna allow him to do it.

18 MR. MCKINNON: Thank you, Your Honor.

19 THE COURT: How much longer do you have?

20 You said---

21 MR. MCKINNON: Five minutes.

22 THE COURT: Five minutes?

23 MR. MCKINNON: Yes. Yes, sir.

24 THE COURT: Okay. Cause we're gonna need to take a
25 morning break.

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1 MR. MCKINNON: Extraordinarily short, Your Honor.

2 THE COURT: Okay. All right. Let's try to get
3 finished with this particular witness.

4 You want to bring the witness back in?

5 (WHEREUPON, the following takes place within the
6 presence of the witness.)

7 THE COURT: Ma'am, just come right back up here to the
8 stand if you would.

9 (Witness returns to the stand.)

10 THE COURT: All right. Will you see if, if the jury is
11 ready?

12 Will you see if the jury is ready?

13 THE BAILIFF: Yes, sir.

14 MR. DAVIS: Before they come in, Your Honor, would it
15 be appropriate, and I'm just asking for advice, for the
16 Court to announce in front of our client the ruling so that
17 she understands what's going on about your taking judicial
18 notice?

19 THE COURT: Yeah, I'm just -- he is going to -- the
20 counsel for the Plaintiff is going to be allowed to pursue
21 the line of questions that he had -- was pursuing when the
22 objection was made.

23 THE WITNESS: Okay.

24 THE COURT: Okay.

25 MR. DAVIS: Thank you very much, Your Honor.

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1 (WHEREUPON, the following takes place within the
2 presence of the jury.)

3 THE COURT: Yes, sir.

4 MR. MCKINNON: Thank you, Your Honor.

5 CONTINUED RECROSS-EXAMINATION

6 BY MR. MCKINNON:

7 Q Doctor Wan, I'm gonna hand you the textbook again.

8 A Okay.

9 Q Cytohistology.

10 Just would you mind refreshing the jury's memory of
11 what's cytohistology is.

12 A It is the study of the cells under the microscope.

13 Q Okay. If you turn to Page 122 of that textbook?

14 A (Witness complies.)

15 Q What is the chapter at Page 122 entitled?

16 A Adenocarcinoma.

17 Q Okay. And adenocarcinomas are the particular type of
18 lung cancer that Mr. Farr has.

19 Correct?

20 A That's correct.

21 Q Okay. Doesn't that textbook say that aerogenous,
22 through the airways, dissemination occurs in lung tumors
23 with lepidic growth?

24 A That's what it say right here.

25 Q Okay. Doesn't it also say that it forms lesions in the

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1 contralateral meaning the other lung?

2 A That's what it say right here.

3 Q Okay. So that textbook says that lung cancer like Mr.
4 Farr had can spread through the airways to the other lung?

5 A No.

6 Q It doesn't?

7 Okay.

8 A It say that this aerogenous dissemination occurred in
9 the tumor with lepidic growth.

10 Q Right.

11 Didn't---

12 A Mr. Farr had the different cancer I think.

13 Q Weren't the three types of cells in his tumor
14 papillary, acinar, and lepidic?

15 A On the right side it was papillary.

16 Q But there were three types of cells in both left and
17 right tumors, papillary, acinar, and lepidic, weren't there?

18 A That's correct.

19 Q So doesn't that textbook say that cancers with lepidic
20 growth can spread through the airways from the one lung to
21 another?

22 A That's what it says here.

23 Q Okay. Thank you, doctor.

24 Doctor, you were here yesterday, right, when you --
25 when Doctor Singer testified?

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1 A Yes.

2 Q And you heard Doctor Singer say that a 2.5 centimeter
3 tumor is -- Mr. Farr likely would of survived that?

4 A I recall -- vaguely recall it.

5 Q Okay. And you heard him say that he believed the tumor
6 spread from the right lung to the left lung?

7 A Yes.

8 Q Okay. And that, that 9-centimeter tumor was spread was
9 not survivable.

10 Did he say that?

11 A I don't remember.

12 Q Okay. If those things are true and you missed that
13 x-ray, aren't you responsible?

14 A He -- repeat that question again.

15 Q Sure.

16 If that cancer grew from 2-centimeters to 9-centimeters
17 and spread to the other lung after you missed that x-ray, if
18 you did, aren't you responsible?

19 A I'm sorry. I'm getting a little confused now. Try
20 again. Three things to---

21 Q Sure.

22 If the two and a half centimeter tumor in January grew
23 to 9-centimeters and spread to the other lung after you
24 missed it on an x-ray, aren't you responsible?

25 A So you want me to assume that I missed it on the x-ray

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1 and you want me to assume that it's a 2.4 centimeters tumor,
2 then you want me to assume that it grow, then you want me to
3 assume that it went to the left lung?

4 Q Absolutely, as Doctor Singer testified yesterday.

5 A Based on assumptions, possible.

6 MR. MCKINNON: Okay. Nothing further, Your Honor.

7 THE COURT: All right. Thank you, doctor. You may
8 step down.

9 All right. Ladies and gentlemen, I know that you just
10 came back into the courtroom after we took up a matter of
11 law. But I have not allowed the -- everybody else to have a
12 morning break. So I've got you -- I'm gonna send you back
13 to the jury deliberation room. So please indulge me.

14 Again, do not have any discussion among yourselves
15 about anything involving the case and we'll get you back
16 just shortly.

17 (WHEREUPON, the following takes place outside the
18 presence of the jury.)

19 THE COURT: All right. We're gonna step down a few
20 minutes.

21 (WHEREUPON, a short recess was taken at this time.)

22 MR. MCKINNON: Your Honor, I believe the Defendant has
23 something that they would like to put on the record.

24 THE COURT: Okay.

25 well, yes, sir.

1 MR. WILLIFORD: Your Honor, I certainly don't want to
2 put something on the record after, after your ruling. So I
3 will certainly decline that.

4 THE COURT: Thank you.

5 MR. WILLIFORD: Okay.

6 THE COURT: All right. Plaintiff's ready to call their
7 next witness?

8 MR. MCKINNON: We are, Your Honor.

9 THE COURT: All right. And is this your last witness?

10 MR. MCKINNON: It is indeed, Your Honor.

11 THE COURT: Okay. Let's bring the jury back.

12 (WHEREUPON, the following takes place within the
13 presence of the jury.)

14 THE COURT: The lawyers and Mr. Darwin want to
15 approach?

16 MR. WILLIFORD: Sure.

17 (WHEREUPON, a bench conference was held at this time.)

18 THE COURT: Plaintiff ready to call your next witness?

19 MR. MCKINNON: Your Honor, the Plaintiff calls Doctor
20 Willard Milby.

21 THE COURT: Sir, just come right up here and let the
22 Clerk of Court swear you in.

23 DOCTOR WILLARD MILBY, being first
24 duly sworn, testified as follows:

25 THE COURT: Sir, just have a seat in the red chair and

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1 pull the red chair up to the microphone if you would.

2 (Witness complies.)

3 DIRECT EXAMINATION

4 BY MR. MCKINNON:

5 Q Good morning, Doctor Milby.

6 A Good morning.

7 Q Would you mind stating your name for the jury?

8 A Willard P. Milby.

9 Q Okay. And, doctor, what is your profession?

10 A Pathologist.

11 Q Can you tell the jury what a pathologist is?

12 A Yes.

13 Basically we do several things. Primarily I look at
14 tissues. Like if you go have a biopsy say of your skin or
15 breast biopsy or they take out your colon or something, I'm
16 the doctor that looks at that and makes a determination as
17 to what it is. We also do autopsies and, lastly, we also do
18 clinical pathology, which has to do with the laboratory and
19 the laboratory testing. We're there to make sure that
20 the -- we get, you know, good accurate results. We're there
21 to consult with the physicians if they need advice on what's
22 in the order.

23 Q Doctor Milby, let's go back and talk about your
24 education and training a little bit.

25 A Okay.

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1 Q Where did you go to college?

2 A I went to the University of Richmond for undergraduate
3 and then to the VCU School of Medicine for my Medical
4 School. Did my residency training at VCU Medical Center in
5 pathology. I'm boarded in anatomic and clinical pathology
6 and finished that up in 1988. And since then, I joined a
7 group called Commonwealth Laboratory Consultants. We're
8 based in Central Virginia. We have 13 pathologists. We
9 have three pathology assistants. We cover nine different
10 hospitals, all community hospitals.

11 I'm primarily based at Chippenham Medical Center, which
12 is located in Richmond. It's a 407 bed hospital. It does
13 just general type surgeries. I'm also the president of our
14 group. I'm also the medical director for John Randolph
15 Medical Center which is in Hopewell. It's a smaller
16 hospital with about a hundred to 120 beds.

17 Q Okay. Doctor, and can you explain to the jury the
18 difference between anatomic and clinical pathology?

19 A Anatomic pathology would pertain to the tissue
20 diagnoses where you look at, again, what's removed from a
21 patient, and clinical pathology pertains to the laboratory
22 testing.

23 Q And, doctor, you're board certified in both fields?

24 A Correct.

25 MR. MCKINNON: Okay. I move that Doctor Milby be

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1 certified as an expert, Your Honor.

2 MR. DAVIS: No objection.

3 THE COURT: In what area?

4 MR. MCKINNON: Oh, pathology, Your Honor, anatomic and
5 clinical pathology, Your Honor.

6 MR. DAVIS: No objection.

7 THE COURT: Thank you.

8 Q Did you---

9 THE COURT: All right. Hang on a second. I'm writing
10 in my notes. Sorry.

11 Ladies and gentlemen, normally a person can not give
12 opinion testimony. Normally, when a person testifies, they
13 must testify as to what they either saw, heard, or sensed by
14 smell or something of that nature. However, there is an
15 exception when someone is qualified because of education or
16 experience. They are permitted to give their opinion in
17 certain areas if the Court qualifies them in that way. This
18 witness will be qualified in the areas of clinical and
19 analytical---

20 MR. MCKINNON: Anatomic.

21 THE COURT: Anatomical, sorry, pathology to give
22 opinion testimony in those areas.

23 Now, that does not mean that you must accept the
24 opinion. But it is evidence for you to use in anyway that
25 you see fit.

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1 Yes, sir.

2 MR. MCKINNON: Thank you, Your Honor.

3 CONTINUED DIRECT EXAMINATION

4 BY MR. MCKINNON:

5 Q Now, I'm not a pathologist myself, Doctor Milby. So
6 I've got to pay you to be here.

7 So tell me how much am I paying you to be here at this
8 trial to help me out.

9 A Normally, for review of the medical records and review
10 of slides and things like that, I usually charge \$500 an
11 hour. For this particular trip, I just do a flat rate of
12 \$2,500 a day.

13 Q Thank you.

14 Doctor Milby, in your practice working at the hospital,
15 how many lung cancers would you say you've diagnosed and
16 dealt with?

17 A At our facility we have four different thoracic
18 surgeons. So we see between two and three lung cancers per
19 week, and out of that, I probably see one to two. And so
20 that's, you know, over my 28-years, that adds up to several
21 thousand lung cancers.

22 Q Primarily -- and roughly a hundred a year that you
23 personally look at?

24 A Correct.

25 Q Okay. We have brought you in, Doctor Milby, as I'm

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1 sure you know, because the defense has raised the issue of
2 whether this is spread from the right lung to the left lung.
3 What we call a metastasis.

4 So let's start out with do you have an opinion as to
5 whether the 9-centimeter tumor in the right lung, where it
6 spread to the left lung?

7 A Yes, it is my belief that the tumor from the right did
8 metastasize to the left.

9 Q And, very briefly, can you tell the jury what the basis
10 for that opinion is?

11 A Well, when I go and review the slides, I look at the
12 slides from 2010 and then I looked at the slides from 2012,
13 and when you look at it, it has one of the types of cancer
14 we call adenocarcinoma.

15 Now, we can subclassify the adenocarcinoma to different
16 sub-types and, in 2010, there were three different subtypes.
17 There was an acinar pattern, a lepidic pattern, and a
18 papillar pattern, and when I go to look at the slides from
19 2012 I see these exact same patterns. So, when I see the
20 tissue under the microscope, I look at it -- look and they
21 look exactly the same. It's my belief that it metastasized
22 from the right to the left.

23 In addition, it's -- when you look at metastasis in
24 primary tumors, when a patient has a primary tumor, it's
25 much more likely that he has metastasis in the -- in the new

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1 secondary tumor. In my estimation, probably -- out of a
2 hundred tumors that were, say, a new tumor in the lung, he
3 already has a tumor in there. It's another tumor. Probably
4 95 to 99 percent of the time that's gonna be a metastasis
5 and not new tumor.

6 Q And just make sure I understand, doctor.

7 You said that if a patient has a tumor like in the
8 right lung, and whenever he gets a tumor in the left lung---

9 A Right.

10 Q ---95 to 99 percent of the time it's a spread or a
11 metastasis?

12 A Correct.

13 Q And not a new cancer in the other lung?

14 A Correct.

15 Q Doctor, you used a few words and I, as a lawyer, I'm
16 not sure I know.

17 So can you first explain, when you say you looked at a
18 slide, what do you mean---

19 A Okay.

20 Q ---when you say you looked at slides?

21 A When they take the tissue out of a patient, we go -- we
22 process it and it goes into the formula and we fix it. It's
23 called fixation. It goes from the machine that processes
24 it. It goes through various alcohols and reagents and
25 eventually it's embedded in Paraffin and that way we can cut

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1 very very thin sections of the tissue itself and we cut
2 these very thin sections, we put them on glass slides, and
3 then they're stained with a hematoxylin eosin which stains
4 the DNA and the cytoplasm. So that gives them a little bit
5 of -- a color differentiation we look at under the
6 microscope.

7 So that's what a slide is. It's prepared from the, the
8 tissue itself and that's what we look at under the
9 microscope.

10 Q So is it fair to say you're looking at a very thin
11 slice from the tumor itself when comparing the two tumors?

12 A Yes, these are extremely thin. They're usually about
13 four microns. So they're very very thin.

14 Q If you're trying to compare it, two different tumors,
15 and decide whether they're a metastasis, whether they're the
16 same tumor or not, is looking at the slides the best way to
17 do that?

18 A Yes.

19 Q Okay. Before we get to the path reports, we -- as the
20 defense is talked about, the first tumor in the right lung
21 they say it's an adenocarcinoma with a prime, you know, with
22 one type and the adenocarcinoma with a different type on the
23 other side.

24 A Correct.

25 Q Does that mean they're not -- it's not -- one's not a

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1 spread from the other?

2 A No.

3 Q Okay. Doctor, if you don't mind, I'm gonna -- we'll
4 start with the pathology reports. Hopefully that's gonna
5 clear up.

6 A Can I adjust it?

7 I can't really see.

8 Q Yes, please, doctor.

9 A (Witness comes down from the stand.)

10 Q And, doctor, if you want, we have a pointer I can give
11 you.

12 A I think I have a laser pointer.

13 Q Okay. So, doctor, let me -- I'll zoom in a little bit
14 and make this as good as I can.

15 Okay. Doctor, what are we looking at right here?

16 A Okay. This is the, the -- what the pathologist
17 dictated as his final diagnosis after looking at the slides.

18 Q And which tumor are we looking at, doctor?

19 A Now this one is from 2010.

20 Q So this is the 9-centimeter tumor that was removed from
21 Mr. Farr's left -- right lung in 2010?

22 A Correct.

23 Q Okay.

24 A So actually they're several specimens here and they're
25 labeled A, B, C, D.

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1 Now, the first one is just a lymph node that they took
2 out. Again, another lymph node. Another lymph node.

3 These are various locations. Like a 4L is on the left
4 side, and the seven, again -- I'm sorry. It's not left.
5 It's just 4L and then seven and another 4R. Then the --
6 what he did, the surgeon took out the upper and the middle
7 lobes. He took out two, two lobes from the right of the
8 lower lobe in.

9 This specimen was received in tact. The tumor site is
10 at the junction of the right and -- right upper and right
11 middle lobe. So it's involving two segments of lung.

12 All right. This is the type of tumor it is. It's
13 adenocarcinoma with papillary features. Generally, in lung
14 pathology, they're three types of lung cancers we see.
15 There's small cell carcinoma, there's squamous cell
16 carcinoma, and then there's adenocarcinoma.

17 Now, they subclassify this to a degree. This was the
18 primary pattern they're seeing when they're looking at it
19 under the microscope. So it's adenocarcinoma with papillary
20 features.

21 Then you look at the grade of the tumor. This is a
22 Grade 2. We grade these 1, 2, and 3. One would be called
23 well differentiated carcinoma, two would be a moderately
24 differentiated, and a three would be a poorly differentiated
25 carcinoma. And what we're looking at there is it's one, it

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1 resembles the normal tissue. Two, to a lesser degree. And
2 if it's a three, it really doesn't look like normal lung.

3 Okay. And then this is the tumor size. It was
4 9-centimeters. You see it's 9-centimeters dimension. It
5 has multiple foci. It's not a single focus within the lung.

6 The visceral pleura is the outside lining of your lung,
7 and here, this is negative. So there's no tumor involving
8 the pleura of the lung, which, again, the outside of your
9 lung. That's pleura.

10 All right. Tumor extension is confined to the lung.
11 When they look at that under the microscope in grossly, all
12 these are the margins. You have the bronchial margins,
13 which is the tube where the airway moves -- where the air
14 moves through. So that's negative. You have a vascular
15 margin where you have the artery and vein. So that's
16 negative. You have a parenchymal margin, which is the lung
17 issue around the arteries and the bronchus. So that's
18 negative. Chest wall, he didn't take any chest wall. And
19 there's no other attached tissues.

20 The pathologist didn't see any lymph vascular invasion,
21 which means going into the lymphatics or into the vessels.
22 And sometimes they do have -- sometimes these patients get
23 treated prior to surgery, but this one was not. So that's
24 not present.

25 Then we look at the lymph nodes. He took out 13 lymph

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1 nodes and all of them were negative. So zero out of 13
2 lymph nodes.

3 Q Doctor, before we leave that page, if I can ask you
4 just a couple questions?

5 A Okay.

6 Q The fact that it says adenocarcinoma with papillary
7 features, does that mean that's the only cell type in that
8 tumor?

9 A No, that's a primary type in that tumor.

10 Q Okay. So there could be other cell types as well?

11 A They could be, yes.

12 Q Okay. Does this report mean that there was no spread
13 of a tumor?

14 A No.

15 Q Because are there spreads that would not show up on a
16 pathology report?

17 A Correct.

18 Q Okay. Doctor, this is not -- it's not much longer.
19 This is the second page of that report.

20 A Again, these are just additional lymph nodes. They're
21 accounted in that total count of 13 and these are negative
22 as well.

23 Now, going back up here, it was originally staged as
24 PT3PN0. Now the staging system works likes this.

25 T stands for tumor size. N stands for nodal status

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1 like how many nodes are positive. Like you have five out of
2 thirteen. But here we have zero out of thirteen. So there
3 is -- so that's an N0. And then there's an M, which stands
4 for metastasis, but path just doesn't have knowledge of
5 that.

6 So, originally, this is stage PT3. The T staging works
7 like this for lung cancer. If it's less than 3-centimeters,
8 it's a T1. Between the three and 7-centimeters is a T2. If
9 it's above 7-centimeters, it's a T3. So since this was
10 you -- they staged as a T3. However, there's some other
11 factors to come into play in the staging system.

12 When you start looking at T3 and T4 tumors, they start
13 counting if it invades adjacent structures, and, in this
14 case, it involves both the upper and middle lobe of the
15 lung. And since it belongs -- it does involve both the
16 upper and the middle lobe, that moves it up to T4. So the
17 correct stage for this is a T4, which is been changed here.

18 Q And, basically, doctor, is it fair to say, in layman's
19 terms, the higher the T number the worse the tumor is?

20 A Correct.

21 Q Okay. And is T4 the worst?

22 A Yes.

23 Q Okay. So this -- after, you know, in December when
24 this was cut out, it really was staged as the worst possible
25 tumor?

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1 A Correct.

2 Q Okay. Doctor, I want to show you another report on the
3 same tumor.

4 Doctor, do you know where this report is from?

5 A This is from the Medical University of South Carolina.

6 Q So where Mrs. Farr went and took her dad to get a
7 second opinion?

8 A Right.

9 Q Okay.

10 A So you can see here these are outside slides. So what,
11 what happens here, the same slide, 2010, they were sent to
12 the Medical University of South Carolina. Their Department
13 of Pathology reviewed the slides and went through the same
14 process and, and I've looked at this. And it shows the
15 exact same diagnosis that was rendered earlier on the first
16 report. Nothing's changed here. The only thing was
17 noted -- I think it's on the second page maybe.

18 Q But, doctor, so this is a report on the same tumor---

19 A The same, the same tumor.

20 Q Second opinion?

21 A Second opinion.

22 Q All right.

23 A So the second page here -- the only difference was that
24 they noted -- they were talking about -- let's see. They're
25 talking about the staging here. Since it involved both the

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1 upper and middle lobe, the stage had been changed from a
2 three to a four and that's what was done. I saw that on the
3 previous report.

4 Q So the only, the only thing they corrected was the
5 changing it from a T3 tumor---

6 A Yeah, right here.

7 Q ---to the worst, T4?

8 A Right. Since -- it's the AGCC staging manual describes
9 a PT4 lesion.

10 Q Okay. All right. And, doctor, again, does this
11 pathology report mean the tumor didn't spread?

12 A No.

13 Q Okay. All right. Okay. Doctor Milby, the last one
14 I'm gonna show you is this 2012 report.

15 A Okay. This is in 2012. The surgeon did two wedge
16 resections of a left upper lobe. So we're on the left side
17 now. This is the upper lobe. Did one wedge there, a wedge
18 here.

19 And a wedge resection is basically sort of imagine if
20 you had a head of lettuce and you cut a wedge that way,
21 wedge that way, same type of principle. That's what a wedge
22 biopsy is and down here is the synopsis report.

23 Again, it just shows where the specimen is coming from
24 the left upper lung, it's a wedge resection. There's two
25 pieces, but we see here A and B. Okay. B and B. It's

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1 invasive adenocarcinoma, which means that it -- the tumor
2 cells invade the supporting structures that they're on.

3 This one is better differentiated. It's well
4 differentiated, a Grade 1 tumor. The tumor size is
5 3.5 centimeters. What they're doing is aggregate. They're
6 adding what's positive here and what's positive here. So
7 they're coming up with 3.5 centimeters.

8 Again, the tumor totality is multiple focal. See
9 comment. I'll show you that in a second. There is, in this
10 case, there is invasion of visceral pleura, which, again, is
11 the outside lining of the lung. It's -- tumor there is
12 present there.

13 So the tumor extension does involve the lung -- the
14 pleura. The parenchymal margin appears positive. So that
15 would be at the edge of that wedge. There's tumor still
16 there. So the patient has residual tumor left in them.

17 They didn't take any lymph nodes. So there's no lymph
18 nodes or actually -- I'm sorry. This is no lymph --
19 vascular invasion within the tissue that's present here.
20 Again, there's no evidence of treatment effect. He didn't
21 take any lymph nodes and then there's additional pathology
22 that the lung shows emphysema, emphysemic changes.

23 Q Okay. And, doctor, this is the report from the left
24 lung in 2012, the second tumor, about two months before Mr.
25 Farr died?

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1 A Right. And then -- what they're seeing here, notice it
2 says well differentiated. Again, it's adenocarcinoma
3 lepidic predominate with acinar pattern. The same thing for
4 the second one here.

5 So these are subclassifications of adenocarcinoma. So
6 the predominate pattern here is lepidic and acinar.

7 Q But both this tumor and the 2010 tumor were
8 adenocarcinomas, the same type of cancer?

9 A Correct.

10 Q Okay. And, Doctor Milby, you -- this was about two
11 months before Mr. Farr's death.

12 When they cut this out, did they get all the cancer?

13 A No, cause they left -- these margins were positive.

14 Q Okay. And when it says invasive adenocarcinoma, that
15 means the tumor is already spreading into the surrounding
16 tissue?

17 A Correct.

18 Q Okay. Can you tell the jury what it means when it says
19 tumor extension right here, invades visceral pleura?

20 What does that mean?

21 A Right.

22 That would be the outer surfaces of the lungs. So the
23 tumor's inside the lung itself. But it grows out onto the
24 surface of the lung.

25 Q And then below that there's a really difficult word,

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1 parenchymal.

2 Can you tell the jury what is, what is a parenchyma?

3 A That's the lung tissue itself. That's where they,
4 that's where they -- air, you know, the oxygen and carbon
5 dioxide exchange each other. So that's the, the, the --
6 like I said, that's where that happens.

7 Q So does that, does that mean the cancer is spreading
8 past the edge of the lung?

9 A Well, it's spreading to the -- onto the surface of the
10 lung.

11 Q Okay. So what this means, although he -- the
12 pathologist, the surgeon cut a sample out, there was still
13 cancer in---

14 A Yeah.

15 Q ---in the lung?

16 A There's still -- right, in the parenchyma itself, the
17 lung tissue is still positive.

18 Q Okay. And this is roughly two months before his death?

19 A Yeah.

20 Q Okay. Okay. Doctor Milby, if you want to sit down on
21 the -- back on the seat for a second we'll -- I'll turn this
22 off for a minute or I'll just take this off of it.

23 A (Witness returns to the stand.)

24 Q Oh, doctor, I'm sorry. I really apologize. I, I
25 don't -- there's a second page of that report. I don't

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1 think it's anything particularly key, but I don't want
2 anyone to think I'm not showing you something.

3 So this is, again, this is the 2012 report for the
4 second tumor and it says Page 2.

5 A (Witness comes down from the stand.)

6 Okay. This is actually -- first they did a frozen
7 section which showed the adenocarcinoma. That's where they
8 take the tissue. We -- they, they send it over to the
9 laboratory. We freeze it minus 20-degrees and make a real
10 thin section of it. We do a little quick stain and then we
11 look under the microscope. In this case, it showed the
12 adenocarcinoma, and, in this gross, it's just a description
13 of what the pathologist was seeing. So these are the
14 descriptions of the tissue itself. This would be the A and
15 B.

16 Q Anything else that's relevant there, doctor?

17 A I don't think so.

18 Q Okay. Thank you.

19 A (Witness returns to the stand.)

20 Q And, doctor, it is your definite opinion, to a
21 reasonable degree of medical certainty, that the tumor in
22 the right lung spread to the left lung?

23 A Correct.

24 Q Okay. The defense lawyer, my colleague, Mr. Williford,
25 in his opening, made a big deal about the mechanism, how it

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1 spread from one lung to the other.

2 Do you think that's a big issue in this case?

3 A No, I mean it's -- irregardless of how it spread, the
4 fact is, when I look at it under the microscope, it looks
5 exactly the same. So it's there.

6 Q Okay. But that having been said, do you have an
7 opinion as to how the cancer spread from the right lung to
8 the left lung?

9 A I do. Basically there's four different types of spread
10 of cancer. There's direct extension, which it grows
11 directly into something. There's what we call hematogenous
12 spread, which spreads to the blood vessels. There's
13 lymphatic spread, where it goes to the lymph glands, and
14 then there's another type that pertains just to lung cancer,
15 and it's called aerogenous spread, endobronchial spread,
16 aerogenic spread, and what happens there is these tumor
17 cells, they break off from the main tumor and they become
18 aerosolized and they can be spread, just through normal
19 breathing, to other parts of the lung. They're very small.
20 They implant in more normal tissue and start growing.

21 Q Doctor, is it possible, in the lymphatic spread, for a
22 tumor to spread through a lymph node, but lodge somewhere
23 else?

24 MR. DAVIS: Objection to the question about
25 possibilities. This is an expert.

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1 THE COURT: All right.

2 MR. DAVIS: We object.

3 THE COURT: All right. I'm gonna allow it.

4 A Can you repeat the question?

5 Q Sure.

6 Is it possible for a tumor to spread through the
7 lymphatic system but pass a -- skip a node and go somewhere
8 else?

9 A Yes.

10 Q Okay. But your opinion, in this case, is it spread
11 through the airways?

12 A Correct.

13 Q And that's to a reasonable degree of medical certainty?

14 A Yes.

15 Q Doctor, tell us what you do base that on.

16 A Well, I think you -- there are references in pathology
17 that speak to this type of aerogenic spread.

18 Q Okay.

19 A And I mean, as a resident, that was something we
20 learned that it's rather unique to this bronchoalveolar or
21 adenocarcinoma in situs. That was one of the unique
22 features of it is that's how it spread.

23 Q And you were taught that when you were in pathology
24 training?

25 A Correct.

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1 Q Okay. Doctor, let's, for the jury, let's talk about a
2 few of those references.

3 Do you have your Dail Hammar's textbook?

4 A No, it's on the first bench.

5 Q It's on the first bench.

6 A The blue one.

7 Q This is a monster.

8 A Well, that's a small -- this is a two volume thing.

9 Q Uh-huh. (Affirmative).

10 A The, the first volume's twice as thick as this.

11 Q I'm glad I'm a lawyer. That sucker is big.

12 So, doctor, just tell the jury briefly what is that
13 book.

14 A This book is devoted to pulmonary pathology. In other
15 words, it's just devoted to lung pathology. That's all
16 these pathologist deal with is just looking at lung and so
17 it's a, you know, it's very specialized and they
18 concentrate, like I say, just on lung pathology. You've got
19 all your different body parts. But there's about 1,500
20 pages, if you combine the other one, just devoted to lung
21 pathology.

22 Q Doctor, is that an authoritative text?

23 A Yes.

24 Q Okay. And, doctor, would you tell me, is there a
25 reference to aerogenous spread through the airways of lung

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1 tumors in there?

2 A There is.

3 Q Can you turn to that page?

4 A (Witness complies.)

5 Okay. Count that -- it's on Page 6 -- I mean it's on
6 Page 757.

7 Q And what does it say, doctor?

8 A It says in contrast, bronchoalveolar carcinomas can
9 spread aerogenously, and despite their extensive and often
10 bilateral spread, avoid the lymphatic pathways and regional
11 nodes.

12 Q And what does bilateral spread mean, doctor?

13 A Bilateral means to both lungs.

14 Q So what that's saying is tumors can spread through the
15 airways, the kind of cancer Mr. Farr had, one tumor from the
16 lung to the other?

17 A Correct.

18 Q And avoiding the lymph system?

19 A Yes.

20 Q Okay. Doctor, I'm gonna show you another book. It's
21 not the one you found, but my nurse found.

22 Do you recognize that textbook?

23 A Yes.

24 Q Okay. Doctor, can you tell the jury what the name of
25 that textbook is?

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1 A The name of it is Lung and Mediastinum Cytohistology.

2 MR. DAVIS: Your Honor, we object. This has never been
3 disclosed or produced, mentioned, by Plaintiff counsel thus
4 till today.

5 THE COURT: The book?

6 MR. DAVIS: Right. Never, never heard of it before
7 today.

8 MR. MCKINNON: This -- Your Honor, can we go up, have a
9 conference?

10 THE COURT: All right.

11 (WHEREUPON, a bench conference was held out of the
12 hearing of the jury at this time.)

13 THE COURT: All right. Ladies and gentlemen, this is
14 one of those times that I've got to take up a matter of law
15 with the attorneys outside of your presence. So I apologize
16 that I have to ask you to return back to the jury
17 deliberation room, but we'll get you back just shortly.

18 (WHEREUPON, the following takes place outside the
19 presence of the jury.)

20 THE COURT: Yes, sir, Mr. Davis, you want to or---

21 MR. WILLIFORD: I think I'm gonna, Your Honor.

22 MR. DAVIS: May I let Mr. Williford?

23 THE COURT: Oh, is he gonna do it?

24 MR. DAVIS: If that please the Court.

25 THE COURT: Okay.

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1 MR. WILLIFORD: Thank you, Your Honor.

2 The book that Mr. McKinnon was about to introduce to
3 Doctor Milby on direct examination was never ever named or
4 produced in anyway whatsoever after defense's
5 interrogatories early on in the case, supplemental
6 interrogatories, or request for production, and in a letter
7 that I sent on July 13th, 2015, and I just want to read it
8 for, for the record:

9 It says Dear Bill, hope you are doing well.

10 In preparing for trial I noticed in Doctor Milby's
11 deposition testimony, Page 29 Line 1 through Page 30 Line 7,
12 that, upon my request, Doctor Milby agreed to produce
13 information supportive of his theory of metastasis in the
14 above referenced matter. In other words, he said he would
15 produce textbooks, journals, or other literature to support
16 his endobronchial or aerogenic spread theory of metastasis
17 with respect to lung adenocarcinoma.

18 In short, I am asking you for production of such
19 articles or materials. Thanks in advance. I very much
20 appreciate it.

21 Let me know if you have any questions, Bill, and do not
22 hesitate to contact me for any other reason.

23 I also sent emails on -- emails were exchanged
24 March 12th, 2015, and also July 13th, 2015. That emails
25 that I have and I can produce to the Court, if necessary,

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1 asking for the exact same thing, and never has Plaintiff's
2 counsel produced or named that textbook in anyway whatsoever
3 until trial.

4 He has not abided by interrogatories, request for
5 production, other requests has not emanated from Doctor
6 Milby in anyway, and, in fact, my understanding is Mr.
7 McKinnon's nurse found it last week, and he never disclosed
8 it when he disclosed a few other things. And so, for that
9 reason, he should not be allowed to use it at trial. It
10 prejudices the defense. We have not had the opportunity to
11 look at it and evaluate it and, you know, despite all of our
12 efforts to fairly and adequately ask for that kind of
13 information.

14 So we would ask Your Honor to exclude the use of that
15 at trial.

16 MR. MCKINNON: Your Honor, after Doctor Milby's
17 deposition they asked for some texts supporting his theory.
18 I emailed them in March, that was four months before Mr.
19 Williford even wrote that letter, I sent them the names of
20 four different textbooks that Doctor Milby gave me.
21 Further, Your Honor, in response to Mr. Williford's letter,
22 I sent eight more articles that supported that theory, but
23 never, Your Honor, did Doctor Milby say he was gonna give
24 them every possible document supporting it.

25 Your Honor, the interrogatories and request to produce,

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1 I objected to them. They are not entitled to know what I'm
2 gonna use at trial, and if they feel differently, they can
3 file a motion to compel. They are not -- this is -- I am
4 entitled to bring stuff to trial, Your Honor, and this is
5 not Doctor Milby's. He didn't know about it. I showed it
6 to him for the first time yesterday, but I am entitled to
7 bring authoritative treatise into trial, and they did ask
8 that in interrogatories, and they did ask that in requests
9 to produce, and I properly served objections, which they did
10 not respond to, and I am under no obligation to produce
11 those textbooks.

12 MR. WILLIFORD: And one last thing. The email with
13 textbooks that were named by Mr. McKinnon in response to our
14 inquiry about Doctor Milby's textbooks and other literature,
15 the four textbooks are Pathologic Basis of Disease by
16 Robbins and Cotran, Practical Pulmonology and Pathology by
17 Leslie and Wick, Pulmonology Pathology by Zander and Farver,
18 and Dail and Hammar's Pulmonology Pathology.

19 He listed those and, and then he subsequently provided,
20 on two of those books, updated editions of those or specific
21 editions he may reference, and then he produced some other
22 articles. But never was that book that is the subject of
23 this motion ever named, produced, or noticed to us in anyway
24 whatsoever, and it's just -- prejudices the Defendants and
25 certainly Plaintiff has other things he may point to. But

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1 certainly not that one.

2 MR. MCKINNON: It's trial -- Your Honor, it's trial
3 strategy. I made a proper objection. I do not believe
4 they're entitled to it. But they can not force me to
5 disclose every single thing I bring to trial, they're not
6 entitled to that, and if they thought they were, they should
7 of filed a motion to compel, Your Honor.

8 THE COURT: All right. Let me ask a couple questions.
9 I'm not one that's real big on trial by -- doing trials by
10 surprise, but if the rules were complied with, then the
11 rules were complied with. But I am not a big fan of
12 surprises during trial, and I know I do not like to be
13 surprised during a trial.

14 well, this is the same book that I just looked at a
15 while ago.

16 MR. MCKINNON: It is, Your Honor.

17 THE COURT: And I looked at it on Monday when we
18 addressed an argument from defense counsel then to have
19 it -- to exclude this theory.

20 MR. MCKINNON: Yes, that's correct, Your Honor, along
21 with -- we have eight other articles and two other
22 textbooks.

23 THE COURT: I wish you've of made that argument on
24 Monday.

25 MR. WILLIFORD: Well, Your Honor, it wasn't utilized

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1 until today at all. I mean we don't know when he's gonna
2 use it.

3 THE COURT: well, I know, but they -- anyway.

4 what are you gonna use this book for that, that you
5 don't already have with this other book?

6 MR. MCKINNON: well, I mean fair enough, Your Honor.
7 As long -- I mean if they're not gonna try to get to -- I am
8 worried they're gonna renew their motion to limit this
9 testimony, and so I'm trying to put in as much as possible.
10 If they're not gonna renew that motion, I will, I will leave
11 it alone, Your Honor.

12 THE COURT: well, I don't understand.

13 well I, I'm not gonna ask him now what motions he's
14 gonna ask -- do in advance.

15 MR. MCKINNON: I mean a Council motion, Your Honor,
16 just to limit the testimony on aerogenous spreading.

17 THE COURT: well, we've already addressed the Council
18 motion.

19 MR. MCKINNON: So that one -- if that's not gonna be --
20 come up---

21 THE COURT: well, I'm sure they'll take it on appeal
22 if -- in the event if the trial goes south for the defense.
23 But I think we've already made that record.

24 MR. DAVIS: Right.

25 MR. MCKINNON: Okay. If that's the case, Your Honor, I

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1 can do without it.

2 MR. DAVIS: Well, Your Honor, I, I agree, for the
3 record, that we've already addressed that. I don't
4 anticipate making any other motions other than for directed
5 verdict at the close of each stage of the case as I'm
6 required by -- I'm not gonna renew that.

7 THE COURT: All right. Well, I tell you what, you want
8 to proffer the book and just say therefore, it's a part of
9 the record, but it's not part of the record that goes to the
10 jury?

11 MR. MCKINNON: That will be fine, Your Honor.

12 THE COURT: Okay.

13 MR. DAVIS: Just to be sure, is -- this is kind of new
14 to me with this book.

15 Is this a book that the judge is taking judicial notice
16 of, that it's authoritative?

17 THE COURT: Prior---

18 MR. DAVIS: Excuse me?

19 THE COURT: As part of the prior ruling, I did based
20 upon the testimony that was elicited based upon my review of
21 the book --

22 MR. DAVIS: Okay.

23 THE COURT: -- and based upon the fact that the defense
24 elicited from the witness that testified an opinion as to
25 that particular theory. That was that this book was being

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1 used to impeach.

2 MR. DAVIS: Well, you know, in all fairness to the
3 Court and to my friend, Mr. McKinnon, my understanding is if
4 the Court is taking judicial notice of the book as
5 authoritative, he doesn't even have to say it's
6 authoritative and he can -- he can use it as he wants to.
7 So I'm gonna withdraw my objection.

8 THE COURT: But I only was gonna allow it for purposes
9 of---

10 MR. DAVIS: Yeah.

11 THE COURT: ---that cross-examination.

12 MR. DAVIS: I, I -- well I, I -- I think once -- I
13 think the rule is, my understanding, and this may come up
14 later with this witness and other witnesses, our experts, my
15 understanding is that once it has been determined, either by
16 judicial determination as you have done, or by another
17 expert, that a text is authoritative and is, therefore,
18 allowed to be used both in direct and cross-examination,
19 once it's been determined this is authoritative by the Court
20 in this case or another expert, it can be used for direct
21 examination or cross-examination with any other expert cause
22 it's -- I mean it can already be used.

23 So I'm -- that's my understanding. I'm just trying to
24 be fair to everybody here. So I mean -- I guess what I'm
25 saying is---

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1 THE COURT: Well, do you not want me---

2 MR. DAVIS: ---I'm withdrawing my objection.

3 THE COURT: Do you want me to now let that book into
4 evidence?

5 MR. DAVIS: Well, it's not gonna be in evidence. But I
6 mean if, if Mr. McKinnon, as he is proposing to do, I'm just
7 thinking through the things in, in light to be most fair to
8 everybody here and the Court and everybody else, my
9 understanding is once it's been determined, as the Court
10 has, that it's authoritative, then he can ask any other
11 expert, any of my experts, his own experts, about that book
12 and what it says. It doesn't put it into evidence and he
13 can read from it like he's done.

14 I just -- I'm just, I'm just trying to be fair to
15 everybody. I think, I think my objection is probably -- it
16 wasn't timely disclosed, but, you know, I think the judge is
17 already ruled it's, it's fair game, it's authoritative, and
18 I think he's properly entitled to---

19 THE COURT: So are you arguing with your co-counsel?

20 MR. DAVIS: Yeah, kind of. So --.

21 MR. MCKINNON: Your Honor, may I---

22 MR. DAVIS: I'm gonna supercede that and I, and I --
23 we're not saying it wasn't disclosed. It wasn't. And, and
24 we don't like trial by surprise either. But I think this
25 issue has, has already been determined by a Court. The

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1 Court is, is ruled that it's taken judicial notice it's
2 authoritative, and I think now we can use that book with our
3 experts, Mr. McKinnon can use them against our experts. I
4 think it's fair game.

5 THE COURT: All right.

6 MR. DAVIS: I just think that's what the rule says.

7 MR. MCKINNON: Are you withdrawing your objection to it
8 totally?

9 MR. DAVIS: Yeah, I'm withdrawing the objection.

10 MR. MCKINNON: To any use at all at trial?

11 MR. DAVIS: Well, under the rule, I think you can have
12 your expert refer to it. I think you can use it on
13 cross-examination. I think we can use it on direct and
14 cross-examination of other experts.

15 MR. MCKINNON: Are you making an objection to it being
16 an authoritative text?

17 MR. DAVIS: Well, I think the -- I'm not gonna argue
18 with the Judge's ruling if that's what you're asking me to
19 do.

20 MR. MCKINNON: It seems like, Ashby, you're trying to
21 protect an appeal issue. This is what it sounds like to me.

22 MR. DAVIS: I'm not waiving any appeal issue. The
23 Judge has ruled that this is authoritative. He's taking
24 judicial notice under the exception to the hearsay rule.
25 I'm not arguing with his ruling. I think that, consistent

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1 with his ruling, I think it's fair game for you and me to be
2 able to use this text for direct and cross-examination of
3 any expert cause it's, it's -- it doesn't come into
4 evidence. The book doesn't come into evidence to, you know,
5 just -- but you can ask him about it. I can ask him about
6 it.

7 MR. MCKINNON: Sure.

8 MR. DAVIS: I can ask my experts about it and you can
9 ask yours.

10 MR. MCKINNON: My concern is, Ashby, you're encouraging
11 me to use it. Well then you're gonna file an appeal saying
12 it shouldn't of been used.

13 MR. DAVIS: No, I'm not gonna do that.

14 MR. MCKINNON: Okay. So there's no, there's no---

15 MR. DAVIS: I'm not gonna do that.

16 MR. MCKINNON: There's no appeal issue here on this
17 book?

18 MR. DAVIS: No, not on this book.

19 MR. MCKINNON: Okay. Great.

20 MR. DAVIS: No.

21 MR. MCKINNON: As long -- if -- Your Honor, if there's
22 no appeal issue as to that book, we're good.

23 THE COURT: Mr. Williford, are -- you agree with your
24 partner to withdraw your objection?

25 MR. WILLIFORD: While I don't always agree with him for

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1 sure, I will defer to him on this one.

2 THE COURT: Okay. All right. Then let's bring the
3 jury back.

4 MR. MCKINNON: Your Honor, just really quickly, I, I've
5 said I was willing to stop using it.

6 Is that what you would like me to do or would you
7 like -- am I allowed to ask him about it now?

8 I will -- whatever Your Honor wants.

9 THE COURT: No, y'all proceed. Apparently I have no
10 issue -- I have no dog in this fight at this point in time.

11 MR. MCKINNON: Okay.

12 THE COURT: So I mean---

13 MR. MCKINNON: No, no issues.

14 THE COURT: Y'all do what y'all see fit. Y'all make
15 the decisions.

16 (WHEREUPON, the following takes place within the
17 presence of the jury.)

18 THE COURT: Yes, sir.

19 MR. MCKINNON: Thank you, Your Honor.

20 CONTINUED DIRECT EXAMINATION

21 BY MR. MCKINNON:

22 Q Doctor Milby, before we had to address an issue out of
23 the presence of the jury we were talking about that textbook
24 there that I handed you.

25 So you go back, can you go back to the textbook?

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1 A Correct.

2 Q And what is that textbook?

3 A The name is Lung Mediastinum Cytohistology.

4 Q And the authors are -- one's a professor at John
5 Hopkins and one is at Cornell.

6 Is that correct?

7 A I believe so. Correct.

8 Q And that's a 2012 textbook, Doctor Milby?

9 A Yes.

10 Q Okay.

11 THE COURT: All right. Doctor, if you would, the lady
12 behind you is a court reporter.

13 THE WITNESS: Okay.

14 THE COURT: She's taking down everything that's said.
15 She's got to hear you as well as that last juror over there.
16 So try to speak up or speak into the microphone.

17 THE WITNESS: Okay.

18 THE COURT: Thank you.

19 Q Doctor, really briefly, can you tell us what that
20 textbook says on Page 122 about spread through the airways?

21 A Lung adenocarcinoma spread via the lymphatic systems,
22 the regional lymph nodes, hematogenously to distance sites,
23 and/or aerogenously to other regions of the lung.
24 Aerogenous dissemination occurs in tumors with lepidic
25 growth forming lesions separate from the main mass involving

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1 from the same lobe or different lobes in the ipsilateral or
2 the contralateral lung resulting in multi-centricity.

3 Q And that's a mouthful.

4 But is it correct, in layman's terms, that
5 adenocarcinomas, the kind of cancer Mr. Farr had, could move
6 through the airways---

7 MR. DAVIS: Objection, Your Honor, to the leading
8 questions. This is his expert.

9 THE COURT: All right. I'll sustain the objection.

10 MR. MCKINNON: I'm sorry, Your Honor.

11 Doctor, would you explain, in layman's terms to the
12 jury, what that means?

13 A Well, lepidic growth pattern means that these cells are
14 lining the alveolar spaces, and what they do, they can break
15 off and then they go by -- just the simple mechanism of
16 breathing in and out, they're transported to other areas of
17 the lung.

18 Q Okay. And, doctor, I'm gonna have one other article
19 for you to look at here.

20 This is the Neutrophils Promote Aerogenous Spread
21 article.

22 MR. DAVIS: Okay.

23 Q From---

24 A Okay. This says -- the title of the article is
25 Neutrophils Promote Aerogenous Spread of Lung Adenocarcinoma

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1 with Bronchoalveolar Carcinoma Features.

2 Q Okay. Doctor, I'm not even gonna get you to get into
3 that article.

4 All I just want to ask you is that an authoritative
5 article in your field?

6 A Yes.

7 Q What's the journal it's from?

8 A It's from the Clinical Cancer Research Firm.

9 Q So it's from a journal from doctors that solely deals
10 with cancer research?

11 A Correct.

12 Q And you believe that to be authoritative?

13 A I do.

14 Q Okay. I'm sorry.

15 Dail Hammar pathology textbook is also authoritative?

16 A Correct.

17 Q All right. No more journals and textbooks I promise
18 for -- at least for this witness.

19 Okay. And again, doctor, in your opinion, does the
20 issue of mechanism, the way it spreads, is that a critical
21 issue in this case?

22 A No.

23 Q Okay. Doctor, have you prepared a PowerPoint
24 presentation for the jury?

25 A I have.

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by Mr. McKinnon

1 Q Okay. Can we fire it up?

2 A Sure.

3 (Witness comes down from the stand.)

4 A Well, what I've done is taken pictures of the slides,
5 the microscopic slides, from both 2010 and then 2012. So
6 what I want to do is try to demonstrate three different
7 patterns of adenocarcinoma to you.

8 Okay. Well, first of all, we have adenocarcinoma.

9 What's the definition, definition of adenocarcinoma?

10 It's tumor that's derived from glandular tissue.

11 We have glands throughout the body. For instance, in
12 your oral cavity you have salivary, salivary glands which
13 produce the saliva. In the lungs you have bronchial glands
14 which produce -- which lubricates the lungs.

15 Now, we can subclassify the different patterns of
16 adenocarcinoma. First, there's adenocarcinoma in situ. The
17 old term would of been bronchoalveolar cell carcinoma and
18 the way it spreads is by the lepidic growth.

19 There's acinar. This is the most common type of
20 adenocarcinoma. Probably about 85 percent of the
21 adenocarcinomas of the lungs that we see are this pattern.

22 Acinar means that it's growing -- imagine, if you will,
23 like a, like a cluster of grapes and the skin of the grape
24 would be the outline of tumor cells, and within that you
25 have an empty space. So I'm gonna show you that here in a

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1 few minutes.

2 Another type is papillary. Papillary is where the
3 tumor cells grow into a space. Papilla, it's like a nipple.
4 Think of it sort of like -- maybe like a cow and the utter
5 and they have the teats that stick out.

6 Does that make sense?

7 But in this case, instead of just having like five or
8 six teats, it would have thousands, and so I'm gonna show
9 you that in a, in a second.

10 Micro-capillary just means they're smaller. A solid
11 pattern means that the tumor is just growing in sheets.
12 There's no gland formation. You just see tumor cells. A
13 mixed pattern means it's a combination of any one of these
14 or it could be another type of tumor.

15 You can have adenocarcinoma mixed with squamous cell
16 carcinoma or with small cell carcinoma. So that would be a
17 mixed tumor.

18 Fetal means it resembles a newborn's lung.

19 Mucinous, there again, they have glands that secrete
20 mucin. They're fairly unique looking. That's what that
21 would mean.

22 Enteric refers to the gut or bowel. So these
23 adenocarcinoma, adenocarcinomas would resemble tumors on the
24 bowel.

25 A signet ring is just like your high school or your

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1 college signet ring. You have the -- a stone on top, and
2 like where your finger would go, sort of cleared out. So
3 these tumors, the, the nucleus is pushed to one side. You
4 have a clear space. So they're called signet rings cause
5 that's what they resemble.

6 Then there's clear cell, which is cytoplasm, which is
7 sort of totally, totally clear.

8 So these are the different types.

9 Q Thank you.

10 A Now, the first two are from 2010, what's called
11 adenocarcinoma with papillary features, and I would agree
12 with that diagnosis. It shows predominately papillary
13 pattern and here, what you see, these are tumors -- this is
14 all tumor cells. This is sort of like a little sticking
15 out.

16 You see this sticking out, over here this kind of
17 sticks out?

18 Now, these grow in all different directions. So if you
19 were to take a section, one of these is cut across here like
20 this, if I just cut across that, you see a cross-section of
21 it. So it would look like that or like that or like that.
22 Like here, here, here, here. And so, when these are cut in
23 different directions, they have this roset appearance. And
24 one of the things about papillary, they do have a---

25 Q Doctor, can I interrupt you just one second?

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by Mr. McKinnon

1 A Uh-huh. (Affirmative).

2 Q If you wouldn't mind, could you just tell the jury
3 about how you're viewing these and the magnification and
4 things like that.

5 A This is probably at about a 4 or 10X magnification. So
6 basically set 40 times normal or 100 times normal. So these
7 are sort of medium power to low power sections. On our
8 microscopes we have objectives that go from -- we usually go
9 2X, 4X, 10X, 20X, 40, and then we have an oil objective
10 lense, which is a thousand times.

11 So -- but just to see the whole, the overall picture of
12 the tumor itself, I'm showing these that are relatively low
13 or medium magnification.

14 Thank you.

15 One of the features these have, this is the supporting
16 structure of this tumor. This is called a fibrovascular
17 core. It's slight pink. It's the supporting tissue and
18 then there's vessels in here.

19 You can see that's red, red. See the red.

20 Those are vessels within there. So it's called a
21 fibrovascular core and that's part of a papillary tumor.

22 Okay. Now, this is from 2012. Again, I think you can
23 see that you have these like rosets here, here, here, here.
24 It's like you have these little papillary projections that
25 are sticking out from here and they get cut, again, in this

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1 cross-section, you're gonna see something that looks like
2 that. So, again, that was the 2012.

3 So let's look at them side-by-side. Again, you have
4 the 2010, the papillary features. Again, these little
5 rosets go over here. I think you see rosets here, here,
6 here. So there is papillary pattern in both the 2010 and
7 the 2012 tumor.

8 Now let's talk about lepidic. Lepidic means scale
9 like. So if you think about like a snake or a lizard where
10 the scales kind of overlap, that's what we have here.
11 But -- in reality, these cells are just side-by-side.

12 With lepidic pattern, what it's doing, the tumor is
13 growing along the alveolar walls. This space here would be
14 an alveolus. That's where the, again, where the gas
15 exchange happens between the oxygen and the carbon dioxide.
16 So this is the smallest part of the lung tissue. It's
17 called an alveoli. So these are alveolar spaces and these
18 tumor cells line the alveoli. They don't invade in it, but
19 they line it.

20 And one of the things I want you to notice, even in
21 this particular ones, I'm gonna show you some better ones,
22 you see these cells that are broken off freely floating?

23 These are tumor cells that are broken off that are
24 fully in the alveolar space. So they're in the air space.

25 Now we're going to 2012. Again, here the tumor cells

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1 are just lining the alveolar spaces. They don't invade it,
2 but they line it. Here's more of a normal alveolus here.
3 Another one here. Part of one. And, again, in addition to
4 the lepidic, these little dark cells are malignant cells
5 that, again, that are broken off in the alveolar spaces.

6 Again, just comparing them side-by-side. So I think
7 you can see the lepidic pattern. It looks the same as in
8 2010 as it does in 2012. Again, just lining the spaces.

9 This one is just to show back in 2010 that you see both
10 the patterns here that have a particular field of view that
11 just showed both. Here you have papillary right here, and
12 over here you have lepidic. Just so can you see that.

13 Let's talk about acinar. Acinar is where they form
14 like glands or image like circles or ovals or irregular
15 ovals and ovals -- irregular circles. So here, which is a
16 little higher magnification, but it's not, anyway, these are
17 the glands and you can see that makes sort of an oval.
18 There's a clear space in-between, an oval. Again, these
19 kinds of irregular ovals. So this is an acinar pattern.
20 Again, this is the most common pattern of lung cancer that
21 we see.

22 Now, this is 2012 with acinar features. Again here is
23 papillary things that have broken off in papillary. But
24 here's an acinar. This is space here and space here. All
25 of these on the outline are acinar glands, and, again,

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1 side-by-side. Just A little bit more difficult to see.

2 But, again, you have the space these glands that have spaces
3 in them. Again, over here. Glands with spaces in them.

4 Again '12, just to show you that it does have papillary
5 features even though it was called predominately acinar and
6 lepidic. Here's the papillary pattern in the 2012 tumor.

7 Now, these particular sections -- this happens to be
8 2010 over here. This was 2012. When I say grossly, I don't
9 mean like yuck, gross. I mean like what I can see with my
10 eyes. When a pathologist talks about gross, that means just
11 what he sees with, with their eye.

12 So, in this case, these slides come from areas that
13 were taken at the time of the surgery, but away from the
14 area that the pathologist could see that the tumor that I
15 just showed you. So when you scan around on the slide, we
16 can move it around, and look at different areas. Here, in
17 2010, I can see this lepidic growth pattern, and, again,
18 these little individual cells, these dark ones are tumor
19 cells that are broken off, and, like I said, when we look at
20 this with your eye you can't see it as well. You can only
21 see this under the microscope.

22 And you go over here to 2012. Again, these are very
23 dark cells, these blue dark look like little dots, are all
24 tumor and, again, you can see that they're just kind of
25 freely floating in the air spaces.

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by Mr. McKinnon

1 Again, just emphasize the lepidic spread, 2010, 2012,
2 again, the lepidic growth pattern going along the alveolar
3 wall freely floating tumor cells in the alveolar spaces.
4 Over here the same thing, lepidic growth, freely floating
5 tumor cells, these dark ones, here, here, here, and here.

6 Now, finally, I want to show you, this is magnified at
7 400 times normal field of view. So what we've done here is
8 I've taken cells -- like I say, it's 400X. This is 2010.
9 This is 2012.

10 Now, this has some rather distinct features. If you
11 remember back to your high school biology or college
12 biology, when you talk about a cell, it has a nucleus and it
13 has cytoplasm.

14 Okay. Okay. It's pink you see here is the cytoplasm.
15 This dark round, that becomes the nucleus, and within the
16 nucleus, that very dark blue, that's a concentration RNA and
17 it's called the nucleolus, and I think you can see these
18 have very very prominent nuclei. All of these are very
19 prominent. There's a little bit of clearing around the
20 nucleolus. They're clearing right there, and then, if you
21 go over here, I think you see the exact same thing. You see
22 this clearing around the nucleus, very prominent nuclei and
23 it stands out. The nucleus looks like, like fried eggs if
24 you will.

25 To me, this -- the fact that, under high magnification,

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by Mr. McKinnon

1 it doesn't matter whether I take this high magnification
2 from a papillary area, an acinar area, or a lepidic area,
3 these nuclei all look alike. So whether it's 2010 versus
4 2012, under high power, these cells look exactly alike.
5 And, to me, this prominent nuclei, this very very dark
6 nuclei, it's seen in both of these, is really sort of a
7 signature of this tumor, and just further defines why I
8 believe that it represents a metastatic tumor.

9 I think that's all I have.

10 Q All right. Thank you, Doctor Milby.

11 A Couple of times, when you were showing the 2010
12 tumor, you pointed out to the jury free floating tumor.

13 Can you explain the significance of that to the jury?

14 A Well, I believe that's the mechanism or -- because it's
15 free floating, I believe that allows for the mechanism, when
16 you're breathing in and out, for those tumor cells to be
17 spread to other portions of the lung.

18 Q Okay. Doctor Milby, after all you -- presentation, the
19 book, the PowerPoint, can you summarize to the jury why you
20 believe that the tumor in the left lung was a spread, that
21 originally was in the right lung, and then spread over,
22 metastasized?

23 A Sure.

24 Well, first of all, going back, a metastatic tumor is
25 much more common than a new primary. As I stated earlier,

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by Mr. McKinnon

1 it's called a 95 to 99 percent more likely to be a
2 metastasis than a new tumor.

3 In this case, it's -- both of them are adenocarcinomas.
4 We have three different types -- sub-types of
5 adenocarcinoma, which is unusual. Most of the time we see
6 one, sometimes we see two, but to see three is fairly
7 unusual, and the fact that papillary is, is relatively rare,
8 probably less than five percent of the sub-type, and to have
9 that in both the original and the second tumor, I find you
10 know, quite compelling that that probably is a metastatic
11 lesion. Again, you have all three types. Not just one.
12 You have all three.

13 So, for that reason -- and then when we looked at that
14 very last slide, when we look at those nuclei under high
15 power where you compare them from the papillary area, the
16 acinar area, or the lepidic area, they have the same
17 appearance in both 2010 and in 2012.

18 Q And, Doctor Milby, the opinions you've given me today,
19 have they all been to a reasonable degree of medical
20 certainty?

21 A Yes.

22 Q And all more likely than not?

23 A Yes.

24 MR. MCKINNON: Nothing further.

25 THE COURT: Lawyers approach a moment.

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by Mr. McKinnon

1 (WHEREUPON, a bench conference was held out of the
2 hearing of the jury at this time.)

3 THE COURT: All right. Ladies and gentlemen, we're
4 going to take the lunch break at this time.

5 I'm gonna ask you, if you would, to please be back in
6 the jury room deliberation by, looking at that clock, by
7 1:30. I need to remind you not to have any discussion among
8 yourselves about anything involving this case nor with
9 anyone else, but you may go to the jury deliberation room.

10 (WHEREUPON, the following takes place outside the
11 presence of the jury.)

12 THE COURT: Doctor, I just need to remind you that
13 you're still in the process of giving your testimony. So
14 you can't have any discussions with anyone about the
15 substance of your testimony. But you may step down.

16 THE WITNESS: Thank you.

17 THE COURT: All right. We'll see everybody back about
18 1:30.

19 (WHEREUPON, Court was in recess for the lunch hour.)

20 THE COURT: Doctor, you come back up.

21 (Witness returns to the stand.)

22 THE COURT: Doctor, I just need to remind you that you
23 remain under oath.

24 Do you understand that?

25 THE WITNESS: Yes, sir.

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by Mr. Davis

1 THE COURT: Good.

2 All right. I'm told we have all jurors present.

3 You want to bring them in?

4 THE BAILIFF: Yes, sir.

5 (WHEREUPON, the following takes place within the
6 presence of the jury.)

7 THE COURT: Yes, sir, Mr. Davis.

8 MR. DAVIS: Thank you, Your Honor.

9 CROSS-EXAMINATION

10 BY MR. DAVIS:

11 Q Good morning, Doctor Milby, how are you or good
12 afternoon. Excuse me.

13 A Uh-huh. (Affirmative).

14 Q My name is Ashby Davis. I represent Doctor Wan. We've
15 not met before.

16 True?

17 A Correct.

18 Q Okay. And you're from Richmond, Virginia?

19 A Correct.

20 Q All right. How many hours have you spent reviewing and
21 giving testimony in this particular case?

22 A Probably, prior to today, about 12 to maybe 15 hours.

23 Q All right. And when were you first contacted in this
24 case?

25 A I don't remember the exact date. It was probably over

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by Mr. Davis

1 a year and a half ago or so.

2 Q A year and a half ago?

3 A A year. It's been a while, yeah. Probably a year.

4 Q Do you know when you were disclosed as an expert in
5 this case by the Plaintiff counsel?

6 A When I was---

7 Q Yeah, when we, when we found out about you.

8 Do you know when that was?

9 A I assume it's some -- prior -- sometime prior to the
10 deposition.

11 Q Okay. And when was your deposition?

12 A I believe it's in March of this year.

13 Q All right. Would you agree that you were disclosed as
14 an expert witness sometime after January or sometime
15 December last year, January this year?

16 would that sound about right?

17 A Sounds about right.

18 Q All right. Okay. At your deposition, had you had the
19 occasion and the opportunity to read medical records in this
20 case to help you to form the basis of any opinions you
21 wanted to give this jury?

22 A The -- you mean the patient's medical records?

23 Q Yes.

24 A The only medical records I've seen are the pathology
25 reports.

Willard Milby - Cross-examination
by Mr. Davis

1 Q Okay. You didn't look at the surgical notes of Doctor
2 Nguyen?

3 A No.

4 Q You understand that Doctor Nguyen was the surgeon who
5 removed all the right lung cancer in 2010?

6 A Correct.

7 Q All right. What you did as a pathologist, you looked
8 at Doctor Wren, W-R-E-N, pathologist, he had about 13 pages
9 of his report where he looked at tissue that was removed
10 from the right lung by Doctor Nguyen on December 2, 2010,
11 and had those tissue samples, lymph nodes, lung tissue,
12 presented to him for a pathology review. That was Doctor
13 Wren.

14 A Correct.

15 Q And you understand that Doctor Wren works at the
16 Spartanburg Regional Medical Center here in Spartanburg as a
17 pathologist?

18 A Correct.

19 Q All right. And you read his report?

20 A Correct.

21 Q All right. And then you also read the report of Doctor
22 Rosanna Lapham that was generated in April of 2012 following
23 a wedge resection of the left lung by Doctor Nguyen?

24 A Correct.

25 Q Okay. And did you also read the Medical University of

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by Mr. Davis

1 South Carolina's pathology report after they looked at the
2 original slides that Doctor Wren looked at?

3 A Yes.

4 Q And that was generated well -- February 14th, 2011,
5 just a few months after -- a couple months after Doctor Wren
6 generated his report?

7 A Correct.

8 Q Any other medical records that you looked at other than
9 those pathology reports?

10 A No.

11 Q And you're limiting your testimony today in the area of
12 pathology?

13 A Correct.

14 Q In your education and training to become a pathologist,
15 you did not go through or complete any fellowship training
16 with respect to any subspeciality of pathology.

17 True?

18 A Correct.

19 Q And that would include oncology, cancer?

20 A Correct.

21 Q There are those fellowships available at certain
22 institutions?

23 A Correct.

24 Q And one has to apply for and compete for those
25 positions.

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by Mr. Davis

1 True?

2 A True.

3 Q You ever heard of MD Anderson?

4 A Yes.

5 Q What is MD Anderson?

6 Where is that and where is it?

7 A It's located in Texas. It's a, it's a pretty famous
8 cancer institute.

9 Q People from all over the world go to MD Anderson for
10 cancer treatment and opinions and diagnosis?

11 A Correct.

12 Q You know Doctor Rosanna Lapham?

13 That's where she got some of her training and
14 fellowship in oncology.

15 You know that?

16 A Correct.

17 Q Did you read her deposition?

18 A I did.

19 Q Did that help to form the basis of any of your opinions
20 that you've rendered today?

21 A No.

22 Q Did not.

23 Did you review the deposition of Doctor Tommy Latham,
24 L-A-T-H-A-M, a pathologist in Greenville, South Carolina?

25 Did you read that, that deposition?

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by Mr. Davis

1 A Yes, sir.

2 Q You did.

3 And you know he's listed as an expert for Doctor Wan?

4 A Correct.

5 Q Did you note that Doctor Latham got his training at
6 John Hopkins University after his Medical School training at
7 Vanderbilt where he got a full scholarship for Medical
8 School?

9 Did you read that?

10 A I don't, I don't recall that.

11 Q Don't recall that.

12 Okay. How about, how about his fellowship training in
13 oncology and pathology/oncology at Sloan Kettering, Memorial
14 Sloan Kettering in New York City?

15 A I believe I---

16 MR. MCKINNON: Your Honor, I'm gonna object. It's
17 outside the scope of the direct.

18 THE COURT: All right. He's on cross-examination. He
19 has some room, but let's try not bolstering witnesses.

20 Q All right. Doctor Latham, expert for Doctor Wan, whose
21 deposition you read, you understand he did a fellowship in
22 oncology for pathology at Memorial Sloan Kettering in New
23 York City?

24 A Correct.

25 Q Can you think of any two more preeminent cancer

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by Mr. Davis

1 institutions than MD Anderson and Memorial Sloan Kettering
2 in the United States?

3 A They're excellent institutions.

4 Q All right. You agree that you're not qualified to
5 offer opinion testimony in the area of pulmonology?

6 A Correct.

7 Q Or radiology?

8 A Correct.

9 Q Oncology?

10 A Correct.

11 Q Surgery?

12 A Correct.

13 Q You're not offering any standard of care opinions
14 regarding my client, Doctor Wan, in this case, are you, sir?

15 A No.

16 Q Who is Doctor Martin Evans?

17 A Doctor Martin Evans is a general surgeon who practices
18 in Richmond, Virginia.

19 Q Do you know Doctor Evans?

20 A I do.

21 Q You understand that Doctor Evans was -- he's done a lot
22 of medical malpractice reviews as an expert for this law
23 firm?

24 A Correct.

25 Q And he -- and that's how they found out about you?

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by Mr. Davis

1 A Yes.

2 Q You're not here to render any opinions about x-rays, CT
3 Scans, PET Scans or bronchoscopies.

4 True?

5 A True.

6 Q And would you agree, doctor, that surgical pathology
7 specimens are a better way, than a chest x-ray, when trying
8 to determine the size of a tumor?

9 A In a chest x-ray, yes.

10 Q In Mr. Farr's case, you reviewed medical records that
11 indicated that he was a life long smoker?

12 A Well, I saw that in the depositions.

13 Q All right. Well, that's right. I apologize. You
14 didn't look at his records.

15 A Did not.

16 Q Okay. All right. Fair enough.

17 And if the records showed that, you wouldn't dispute
18 the records?

19 A Well no.

20 Q Okay. All right. You agree that Mr. Farr's lung
21 cancer probably stemmed from his life long smoking?

22 A Yes.

23 Q And that -- and he's not the first gentleman, woman,
24 man who has the habit of smoking, who is unable or
25 unwilling, and I'm not judging that, to quit smoking and

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by Mr. Davis

1 they develop lung cancer?

2 That's not the first time that's happened?

3 A No.

4 Q In fact, maybe you saw it in the depositions, I know
5 you didn't look at the records and that's okay, where there
6 was a comment, people looking at the records, depositions
7 you've read, where Mr. Farr continued to smoke even through
8 and after his right lung cancer was totally removed?

9 A Correct.

10 Q As a pathologist, do you have an opinion whether or not
11 continued smoking after the right lung cancer is removed
12 surgically, whether continued smoking can cause another
13 primary lesion in the left lung?

14 A In this case I don't believe that's true.

15 Q Can that happen, doctor?

16 A I think the time period's too short.

17 Q Can that happen, sir?

18 A I think the time period's too short.

19 Q Can a person who continues to smoke form a new primary
20 lung cancer after his right lung cancer has been totally
21 resected?

22 A Yes.

23 Q You agree that lung cancer, as a pathologist, is very
24 difficult to diagnose?

25 A No.

Willard Milby - Cross-examination
by Mr. Davis

1 Q Okay. Do you remember being deposed by my partner, Mr.
2 Williford---

3 A I do.

4 Q ---back on March 5, 2015?

5 A Yes.

6 Q Was that in Richmond?

7 A Correct.

8 MR. DAVIS: Your Honor, may I open his original?

9 THE COURT: Yes, sir.

10 MR. DAVIS: Thank you, Your Honor.

11 Doctor, would you turn with me please to Page 61 of
12 your deposition?

13 A Okay.

14 Q Okay. Now, I hope I'm not quoting you out of context.
15 If I do, please -- will you please call me out on it?

16 A Okay.

17 Q Line 12.

18 Q. Would you agree that lung cancer is a difficult
19 cancer to diagnose?

20 Your answer, it is.

21 Did I read that correctly?

22 A Which line is this?

23 Q Line 12, 13, 14.

24 A I think it's a difficult thing to diagnose.

25 Q All right. You, you agree with that?

Willard Milby - Cross-examination
by Mr. Davis

1 A I agree.

2 Q Okay. When a patient is diagnosed with stage 1 or
3 stage 2 lung cancer, that patient has a pretty high
4 mortality rate, doesn't it?

5 A Still do, yes.

6 Q And Mr. Farr, when he was diagnosed, had which stage?

7 A Stage 4.

8 Q All right. First diagnosis, stage 3. MUSC said no
9 because it had, as you explained, multiple levels or two, or
10 two lobes involved, it was stage 4.

11 Did, did I get that right?

12 A Correct.

13 Q Okay. So even somebody with stage 1 or stage 2 lung
14 cancer, they have a high mortality rate?

15 They, they get a high chance of dying from that cancer?

16 A Yes.

17 Q Explain what the term synchronous and metachronous, as
18 it's used in the area of pathology, mean.

19 A Synchronous usually means it occurs at the same time.
20 Metachronous means it occurs at intervals. You have
21 multiple -- both intervals.

22 Q Since March 15 or March 5, in your deposition and
23 today, did you, did you go look up metachronous to find out
24 what the definition was?

25 A I did.

Willard Milby - Cross-examination
by Mr. Davis

1 Q Good.

2 Because, in your deposition, you said you didn't know
3 how to answer that.

4 A That's why I went and looked it up.

5 Q Good for you.

6 Do you know the criteria for determining, as a
7 pathologist, whether a cancer is synchronous or
8 metachronous?

9 A Do you mean if there's a single tumor there or if
10 there's more than -- multiple ones?

11 Did they occur at the same time or not?

12 Q Do you know the criteria, objective criteria, for
13 determining whether or not a cancer is synchronous, happens
14 at the same time, or metachronous?

15 A No.

16 Q You do not.

17 You looked at some slides in this case that were
18 supplied to you and sent to you and those slides were recuts
19 of the original tumor --

20 A Correct.

21 Q -- of the original tissue.

22 Right?

23 A Correct.

24 Q Okay. And when a recut is made, that's, that's not the
25 same as the original slide that Doctor Wren or Doctor Lapham

Willard Milby - Cross-examination
by Mr. Davis

1 looked at.

2 True?

3 A True.

4 Q Wouldn't you agree that, that first permanent section,
5 the first -- if that's a tumor, the first slice made and
6 mounted on a slide, an original slide, and goes under the
7 microscope when Doctor Wren and Doctor Lapham looked at it,
8 that's -- that would be called the original or first cut?

9 A The frozen section.

10 Q Okay.

11 A Yes.

12 Q Well -- and, and subsequent, subsequent to the frozen
13 section, when you don't have frozen sections, or if you do,
14 then other tissues submitted and those are mounted and
15 there's a, there's a first cut or initial cut showing tumor,
16 margin, whatever, and that's exact?

17 A Correct.

18 Q And then when -- and that's gonna -- that's, that's on
19 a slide somewhere?

20 That's the original slides?

21 A Correct.

22 Q And then when you, for example, were supplied recuts, a
23 technologist, somebody who's trained and probably proficient
24 I assume in mounting those slides, they come along with
25 their shaver, and however they do it, and they cut some more

Willard Milby - Cross-examination
by Mr. Davis

1 off that tumor and they put it on a slide and send it to
2 you?

3 A Correct.

4 Q That's gonna -- it could be, it could be that second
5 slide, those recuts, are gonna be a little different from
6 the original slides.

7 True?

8 A True.

9 Q But your opinion is based on the recuts, not the
10 originals?

11 A Correct.

12 Q You've never seen the originals?

13 A I have not.

14 Q When Doctor Wren generated his report in December of
15 2010, after his right lung resection by Doctor Nguyen, when
16 he looked at the original tissue, slides, he looked for
17 margins?

18 A Correct.

19 Q And when you looked for margins, as a pathologist,
20 you're looking to see whether or not the surgeon has been
21 able to get all the cancer?

22 A Correct.

23 Q And when the margins, in a report, are designated as
24 positive, what does that mean?

25 A It means that there's tumor at the, at the cut.

Willard Milby - Cross-examination
by Mr. Davis

1 Q At where the surgeon cut the tumor out, if there's --
2 if the margins are positive, that means there's cancer cells
3 there?

4 A Correct.

5 Q Is that right?

6 A Correct.

7 Q And when it's negative, it means there are no cancer
8 cells there?

9 A Correct.

10 Q Same with lymph nodes. When they take lymph nodes out,
11 13 were taken out by Doctor Nguyen in this case in December
12 of 2010, and those are examined by Doctor Wren under a
13 microscope, and why do you, as a pathologist, look at the
14 lymph nodes under a microscope in a case like this?

15 A Well, you want to see if there's any lymphatic spread
16 into the lymph nodes cause that's part of the staging. If
17 lymph nodes are positive, it usually means a worse
18 prognosis.

19 Q Yes, sir.

20 And, and the 13 lymph nodes that Doctor Wren looked at
21 from Mr. Farr's right lung cancer, all of them were negative
22 for cancer?

23 There was no cancer cells found in any of the lymph
24 nodes.

25 True?

Willard Milby - Cross-examination
by Mr. Davis

1 A Correct.

2 Q If there were, then there'd be a, a huge increase of
3 clinical suspicion, I assume, and tell me if this is right
4 or not, that well, we got, we got cancer cells that have
5 escaped the tumor in the lymph nodes, they're starting to
6 travel, we got a problem here.

7 I mean I'm doing, doing it as a layman, but that's kind
8 of what it means to us laymen, doesn't it?

9 A Right.

10 Q Breast cancer, lung cancer, you want your lymph nodes
11 negative?

12 I mean that's a -- as patients we all want to see that
13 pathology result?

14 A Exactly.

15 Q Because if it's not we know we got potential spread.
16 We got to get in a chemotherapy line. We got to get in a
17 radiation line. It's gonna affect out treatment.

18 A Correct.

19 Q Isn't it?

20 And his were all negative?

21 A Yes, sir.

22 Q And the Medical University of South Carolina, when they
23 looked at the original slides in February of 2011, they
24 agreed with no margins, had cancer, lymph nodes, didn't have
25 cancer.

Willard Milby - Cross-examination
by Mr. Davis

1 True?

2 A True.

3 Q And now they call it, in February of 2011, they call
4 what they saw papillary predominant?

5 A Correct.

6 Q That's a pattern that's predominate?

7 A It's predominant.

8 Q That didn't say that there was not some lepidic or
9 acinar features on that slide, did it?

10 A Right.

11 Q Right.

12 In fact, you'd expect that mixed pattern, wouldn't you?

13 A Possible, yes.

14 Q But if you got 80 or 90 percent of papillary, then
15 that's pap -- you, you got to call that papillary
16 predominate and that's what you need to put on your report.

17 Right?

18 A And they did.

19 Q And MUSC did.

20 Our Medical University of South Carolina did that, the
21 two pathologists looked at it, and that's appropriate,
22 wasn't it?

23 A Right.

24 Q Now, when, when Doctor Lapham, in 2012, did a, a
25 similar process in looking at lung tissue that was removed

Willard Milby - Cross-examination
by Mr. Davis

1 from Mr. Farr's left lung in 2012, she looked at slides that
2 were mounted from that tissue and she called it -- she
3 didn't call it papillary predominant, did she?

4 A No.

5 Q She called it lepidic predominate with acinar features.

6 A Right.

7 Q True?

8 A True.

9 Q Different from papillary predominant, isn't it?

10 A Yes.

11 Q Yes.

12 You would agree that far and away, in your experience
13 as a pathologist, that the metastatic pathway, the way
14 cancer, if it's going to metastasize and go to somewhere
15 else in the body from the original tumor, by far and away
16 it's gonna be through the lymphatic system or through the
17 bloodstream or by the, the tumor itself just getting
18 extended into other tissue?

19 A I'll say that's true for all cancers except for
20 probably lung cancer and this particular type of cancer.

21 Q Okay. And you believe that, that, in Mr. Farr's case,
22 he had free floating cancer cells in his right tumor, that
23 was removed, that somehow got into his airway and floated up
24 through -- what, what's this, is it the trachea?

25 A Go through the main stem bronchus through the corotid.

Willard Milby - Cross-examination
by Mr. Davis

1 Q The main stem bronchus and the main stem bronchus is
2 like part of your lungs?

3 A The main stem that branches off.

4 Q The main stem that branches right and left, doesn't it?
5 It has little trees and it goes off.
6 Right?

7 A Exactly.

8 Q So your, your theory is that, that Mr. Farr had some
9 cancer cell or some break loose from the original tumor and
10 travel in the airway, up the main -- right main stem
11 bronchus over to the left main stem bronchus and lodge
12 somewhere in this left lung and grow cancer?

13 A Correct.

14 Q That's your theory?

15 A Correct.

16 Q Does that mean that, that a lung cancer patient,
17 doctor, if he coughs, he can spread cancer?

18 A I don't---

19 Q Gets in his airway?

20 A I don't know that there's any proof that that's been
21 spread that way.

22 Q It could though, couldn't it?

23 A Well---

24 Q According to your theory?

25 A Well, it can aerosolize as I said.

Willard Milby - Cross-examination
by Mr. Davis

1 Q How did, how do cancer cells survive?

2 How do they survive and grow?

3 What do they need, as a pathologist?

4 A What do they need?

5 Q Yeah.

6 A They're gonna need a blood supply and oxygen.

7 Q They're gonna need a blood supply and oxygen.

8 How are they gonna get a blood supply if they break off
9 here in the right and float all the way up through the
10 airway and hopefully not coughed out onto somebody and float
11 down to the left lung and attach again and start growing?

12 How, how do they survive the journey, sir?

13 A Well, they probably have a certain period of time that
14 they, you know, can survive without being attached and then
15 they reattach and they grow.

16 Q Where's the research to support that?

17 A Well, I think if you look -- I didn't go into all the
18 articles there. But I think this, you know, it's documented
19 in these pathology textbooks. It's in reference textbooks
20 this is a mechanism that this type of tumor spread. It's
21 unique to this.

22 Q Okay. Well, let's look at this Cambridge text that Mr.
23 McKinnon showed you.

24 Now, you -- I mean before this week, you'd never seen
25 that?

Willard Milby - Cross-examination
by Mr. Davis

- 1 A No, I have not seen it.
- 2 Q You didn't, you didn't -- you know it got -- he got it
3 here by some nurse that works for him and produced this five
4 days ago.
- 5 A That's correct.
- 6 Q Right?
- 7 A That's correct.
- 8 Q You never saw it before?
- 9 A No.
- 10 Q Okay.
- 11 A I saw it last night.
- 12 Q Saw it last night.
- 13 Okay. This is the page he had you read from, wasn't
14 it?
- 15 A Yes.
- 16 Q All right. Now, did you read the whole chapter?
- 17 A I did not.
- 18 Q How many pages in that chapter?
- 19 A Let me see. Looks like there's about 22 or three
20 pages.
- 21 Q Okay. You didn't read all those 22, 23 pages?
- 22 A No.
- 23 Q Okay. The, the statement that he had read, would you
24 read that again for me please?
- 25 A Sure.

Willard Milby - Cross-examination
by Mr. Davis

1 Lung adenocarcinoma spread via the lymphatic system to
2 regional lymph nodes hematogenously to distant cites or
3 aerogenously to other regions of the lung.

4 You want me to continue?

5 Q Read whatever you want to read.

6 A I mean that's -- I think that---

7 Q Is that what he had you to read?

8 A Right.

9 Q Okay.

10 A That's what I read.

11 Q Okay. That's what you read.

12 Now, after that sentence, is there a little footnote to
13 help you, as a pathologist, look up where that came from?

14 A I don't see a reference number.

15 Q There's no reference, is there?

16 It's just a statement, isn't it?

17 Sir?

18 A From here, the best I can tell, yes.

19 Q You've seen -- I mean you've seen textbooks before
20 then, right?

21 Pathology textbooks, right?

22 A Uh-huh. (Affirmative).

23 Q Often times, when that statement is made, often times,
24 do you find footnotes after those statements?

25 A Right.

Willard Milby - Cross-examination
by Mr. Davis

1 Q And, at the back of the chapter, you can go well, it's
2 Footnote Number 30 and you can look at Number 30 and it
3 cites an article that supports or tends to support whatever
4 that statement was.

5 Right?

6 A Correct.

7 Q There's nothing like that in that book, is there?

8 A Not in this book.

9 Q Not in that book.

10 Look at the back of the last few pages where they talk
11 about case studies in that chapter, sir.

12 You see that?

13 A I see that case studies.

14 Q How many case studies do they --?

15 A I have one, two -- it looks like three.

16 Q Three.

17 And you understand case studies in this chapter that
18 you did not read, the case studies in a textbook like that
19 are, are sort of examples of the author trying to show real
20 people that real things happen to that they're commenting
21 on.

22 Is that fair?

23 A That's fair.

24 Q In any of those three case studies, do any of them cite
25 or any of them cited to prove that lung cancer, papillary

Willard Milby - Cross-examination
by Mr. Davis

1 predominant, can move from the right lung to the left lung
2 and grow a different pattern, lepidic pattern, in a
3 contralateral opposite lung?

4 Do any of those case studies prove that, sir?

5 A Well, I haven't read them. So I don't know.

6 Q Take your time. I know you didn't see it before today
7 or last night.

8 A It doesn't appear there's any reference to papillary
9 carcinomas in here.

10 Q Doesn't have anything to do with it, does it?

11 A No.

12 Q Okay. So that chapter, all 22 pages in the textbook
13 Mr. McKinnon showed you last night and then today, does not
14 prove your theory, does it?

15 A This one doesn't.

16 Q Okay.

17 A But I think Dail and Hammar does.

18 Q Well, we're gonna look at that next.

19 Dail Hammar, Pathology Pulmonology, Volume II,
20 Neoplastic Lung Disease.

21 What's neoplastic?

22 A It means that a -- any just abnormal growth -- it's
23 growth. New growth.

24 Q New, neo?

25 A New. Neo.

Willard Milby - Cross-examination
by Mr. Davis

- 1 Q Plastic growth?
- 2 A (Witness nods affirmatively.)
- 3 Q Okay. New growth.
- 4 All right. And I just want to ask you if I might
- 5 approach, sir?
- 6 I've got something here.
- 7 Is this, what I've put the little brackets in pen, is
- 8 that what you read from earlier?
- 9 I'm not sure.
- 10 A I did.
- 11 Q Is that what the -- is that the sentence?
- 12 A Correct.
- 13 Q Okay. Well, let's look at it. Let me read this and
- 14 ask you a question, doctor.
- 15 In contrast, what's it in contrast to?
- 16 Do you know?
- 17 A Above where they're talking about a different type of
- 18 tumor above.
- 19 Q Okay. Spread of primary lung cancer to pleural spaces
- 20 is important in staging and usually indicates a lung cancer
- 21 is incurable.
- 22 In contrast, bronchoav---
- 23 A Bronchoalveolar.
- 24 Q Thank you very much.
- 25 Carcinomas can spread aerogenously, and despite their

Willard Milby - Cross-examination
by Mr. Davis

1 extensive and often bilateral spread, avoid the lymphatic
2 pathways and regional nodes.

3 As earlier noted, this tumor and epithelioid -- I don't
4 know the name of that next word.

5 A Hemangio -- hemangioendothelioma.

6 Q What, what is the word is that?

7 A It's a tumor of blood vessels.

8 Q I'm sorry, sir?

9 A Tumor of blood vessels.

10 Q Tumor of blood vessels.

11 Can present as multiple smaller nodules without a
12 predominant tumor mass, and yet may still represent,
13 represent primary lung tumors. However, both tumors may
14 also present patterns of secondary spread.

15 What does that mean, all that?

16 What do you understand that to mean?

17 A Well, I---

18 Q What are they saying?

19 A Well, they're saying the bronchoalveolar and that
20 epithelioid hemangioendotheliomas, on initial presentation,
21 they can show up as multiple tumors, not just one, but
22 multiple tumors within the lung or one lung or both lungs.

23 Q And after that statement that he had you'd read out of
24 this---

25 A And then it says however, both tumors may also

Willard Milby - Cross-examination
by Mr. Davis

1 represent patterns of secondary spread. In other words,
2 metastasis.

3 Q Uh-huh. (Affirmative).

4 So up here in -- after it says contrast, right above
5 that after incurable, it has got a little number 152.

6 Right?

7 A Correct.

8 Q That's a reference to something in the back of that
9 chapter, isn't it, you know like all these---

10 A Sure.

11 Q Right?

12 A Correct.

13 Q It's, it's Article Number, for example, 152 out of --
14 man, there's a bunch of them. 200. Great day. 349. Can't
15 get the book. There we go. 349 references and that little
16 sentence right before the in contrast at Number 152.

17 But would you agree with me, doctor, that there's that
18 statement and there, there is no reference to any supporting
19 article or research textbook of the 349 cited, is there?

20 A Not on that paragraph.

21 Q Now, he also asked you about neutrophils promoting
22 erogenous, aerogenous, excuse me, airway spread of lung
23 cancer with bronchoalveolar carcinoma features.

24 Now, here's purpose.

25 Purpose of the article, right?

Willard Milby - Cross-examination
by Mr. Davis

- 1 A Right.
- 2 Q It talks about adenocarcinoma with BAC.
- 3 True?
- 4 A Correct.
- 5 Q Was Mr. Farr's cancer BAC cancer?
- 6 A He has a portion of that, yes.
- 7 Q I'm sorry?
- 8 A He has a portion that is BAC.
- 9 Q Has a portion of it?
- 10 A Yes.
- 11 Q Which portion?
- 12 A The lepidic pattern, pattern---
- 13 Q Lepidic.
- 14 A ---is BAC.
- 15 Q Was it predominately lepidic?
- 16 A No.
- 17 Q No.
- 18 A The second one, it was.
- 19 Q Well, the first one, I'm talking about the first one.
- 20 A No.
- 21 Q Was not lepidic predominate, was it?
- 22 A No.
- 23 Q Had some cells in there, but it wasn't predominant?
- 24 A No.
- 25 Q So this article talks about basically lepidic cancer?

Willard Milby - Cross-examination
by Mr. Davis

- 1 A Correct.
- 2 Q Not papillary?
- 3 A No.
- 4 Q All right. Was the right lung cancer, the papillary
5 predominant pattern cancer he had in 2010 that was removed,
6 was it mucinous or non-mucinous?
- 7 A Non-mucinous.
- 8 Q The left cancer, the lepidic predominate cancer in his
9 left lung two years later, was it mucinous or non-mucinous?
- 10 A Non-mucinous.
- 11 Q What's the difference?
- 12 A Well, one will have cells that show prominent mucinous
13 type of tissue, tissue -- or glands whereas the other one
14 does not.
- 15 Q What difference does that make as far as spread, sir?
- 16 A Probably not a whole lot of difference.
- 17 Q I mean any difference at all?
- 18 A There's some difference.
- 19 Q Well, what, what are those differences?
- 20 A Mucinous tends to spread more than the non.
- 21 Q Right.
- 22 Mucinous tends to spread more and his was --?
- 23 A Non-mucinous.
- 24 Q -- non-mucinous?
- 25 A Uh-huh. (Affirmative).

Willard Milby - Cross-examination
by Mr. Davis

1 Q Correct?

2 Did I get that right?

3 A No, you're right.

4 Q Okay. All right. Can you cite for this jury, sir, any
5 medical literature that you've reviewed or that has been
6 supplied to you that can support the theory that there is,
7 there was, in this case, an airway spread of his papillary
8 predominant cancer from his right lung tumor to his left
9 lung and it shows up lepidic predominate?

10 Is there any, any, any literature, medical literature,
11 that you can cite that yeah, that's a proven theory?

12 A Well, can I see Dail and Hammar again?

13 (Pause.)

14 A Well, here's one area.

15 Q What, what page are you referring to?

16 A 258.

17 Q Two, 250 -- 258?

18 A Uh-huh. (Affirmative).

19 Q What's the chapter, sir?

20 A The chapter is Chapter 35, Common Non-Small cell
21 Carcinomas and Their Variance.

22 Q Okay.

23 A Okay.

24 Q What's does it say?

25 A Right here, here's -- I'm just gonna say.

Willard Milby - Cross-examination
by Mr. Davis

1 Q Okay.

2 A Historically -- they're talking about bronchoalveolar
3 cell carcinoma.

4 Q BAC?

5 A Uh-huh. (Affirmative).

6 Q which he didn't have in his right lung?

7 A He had some with BAC, yes.

8 Q Not predominate?

9 A No.

10 Q Okay.

11 A Historically considered a well differentiated
12 adenocarcinoma, the tumor itself grows along alveolar ceptor
13 and aerogenous spread throughout the lung. Diagnostic
14 criteria were evading distinctions between BAC and other
15 adenocarcinomas depending on whether any lepidic growth was
16 identified and there's two footnotes.

17 Q Did you look at those footnotes?

18 A I haven't looked at them.

19 Q Did you, did you look at them to see how old those
20 articles were and where they came from?

21 A I haven't looked at them. You were asking for
22 footnotes.

23 Q well, okay. Fair.

24 A Now, the -- bronchoalveolar carcinoma has been around
25 for over 125 years. I mean that's from this paragraph right

Willard Milby - Cross-examination
by Mr. Davis

1 here.

2 Okay. You might get an older article. But that
3 doesn't necessarily change things.

4 Q Well, let, let me ask you, if I might, doctor.

5 The airway spread, isn't it typically seen when a
6 cancer cell breaks off from a -- like right tumor if one is
7 found there, regardless of the predominant pattern or
8 particularly lepidic pattern, a more aggressive type, when a
9 cancer cells breaks off from the right tumor and floats to
10 another part of the right lung?

11 That can happen, can't it?

12 A Sure.

13 Q Yeah.

14 Cause it's pretty close?

15 A Correct.

16 Q Yeah.

17 Can you show me any medical literature that there's a
18 case study, there's a report, a conclusion by any medical
19 doctors, pathologist, or otherwise that has proven your
20 theory where a papillary predominant cancer of the lung can
21 break off a cell, float around through the airway, and lodge
22 in the left lung and grow cancer of a different pattern,
23 sir?

24 Is there any literature anywhere where you can tell me
25 that's been proven in this patient?

Willard Milby - Cross-examination
by Mr. Davis

1 A Well, what, what I'm saying, in this patient, is the
2 lepidic pattern that breaks off and that's what's growing.
3 It says predominate lepidic on the left.

4 Q Did you understand my question?

5 A I understand your question. I don't know that there is
6 any documentation.

7 Q Right.

8 You don't know there's any literature, medical
9 literature out there that's proven your theory in any
10 patient, in any study, in all the 135 years this theory's
11 been kicked around.

12 A I---

13 Q True?

14 A Well, I'm not aware of them.

15 Q You're not aware of them.

16 You agree that the term in situ is tumor that is not
17 invaded the surrounding tissue?

18 Is that, is that what you were describing earlier?

19 A That's correct.

20 Q All right. And you agree that if a cancer is in situ,
21 that means that that is where the cancer originated?

22 A Well, I don't -- he may have in situ component and
23 still not be the exact same site where it originated.

24 Q Okay. Well, I, I may of misread your deposition, but
25 let's turn back to at Page 22. Let me get it up here.

Willard Milby - Cross-examination
by Mr. Davis

1 A My point is---

2 Q Well, just, just hold on. I'll let you explain.

3 A Okay.

4 Q Let me just do this and I'll let you do that.

5 A Okay.

6 Q Okay. Is that fair to you?

7 A Sure.

8 Q Okay. Cause, again, I, I might of gotten this wrong
9 and my memory's not very good, but let's look at Page 22 at
10 Line 22.

11 Q. Line 22. My partner, Mr. Williford.

12 Well, if there is cancer in situ, would you agree that
13 that's where it originated?

14 A. Yes.

15 Did I read that correctly?

16 A You did.

17 Q All right. Now, if you want to explain something---

18 A Well, you would have more---

19 Q ---be happy to hear you.

20 A I think, if you look in the report, they're multiple
21 foci tumors. They can have multiple foci in situ carcinoma.

22 Q Right.

23 Okay. In reviewing both the report of Doctor Wren and
24 the report of Doctor Lapham, not to confuse with Latham, and
25 I'm sorry. This thing's getting all messed up here, but

Willard Milby - Cross-examination
by Mr. Davis

1 there it goes. We have a defective tripod.

2 A Those things clip.

3 MR. DAVIS: Do you mind holding it for me?

4 MR. WILLIFORD: I'll hold it for you.

5 Q How do you spell your name?

6 A M-I-L-B-Y.

7 Q M-I?

8 A L.

9 Q L-B-Y?

10 A Correct.

11 Q All right. Doctor Milby, in reviewing the report of
12 Doctor Wren in 2010 and the report of Doctor Lapham in 2012,
13 you agree that they report separate primary cancers?

14 A They certainly don't. They said multiple---

15 Q Do you agree that they report separate primary cancers
16 in those reports?

17 A Could I see it?

18 THE COURT: Doctor, if you would, slide the microphone
19 over closer to you.

20 THE WITNESS: Okay.

21 THE COURT: I'm having problems hearing you.

22 THE WITNESS: How's that?

23 THE COURT: Thank you.

24 Q I tell you what.

25 why don't we look at your deposition and I'll show you

Willard Milby - Cross-examination
by Mr. Davis

1 whatever else you may want to look at, but if you would---

2 A I would just like to see the pathology report from 2010
3 and, again, again, the one from 2012.

4 Q You hadn't seen them?

5 A I have. I just -- I would like to see where it says
6 multiple focal on it. I believe it says multifocal on it.

7 Q Okay. Well, let me, let me do this and we'll do that.
8 Okay. Is that fair?

9 A Sure.

10 Q I won't, I won't abandon you. I promise.

11 Let's look at Page 36 of your deposition again. Line
12 17. Read this.

13 Q. Prior to your reviewing the slides, would you agree
14 that, just based on the reports, that the right lung cancer
15 of 2010, December of 2010, and the left lung cancer that was
16 resected in 2012, were separate primaries based just on the
17 pathology reports?

18 Your answer at your deposition on March 5th was,
19 under oath, I would.

20 A I still agree with that.

21 Q Okay.

22 A That's --.

23 Q All right. Okay. What I've written here and let me --
24 you can't see it, but show it to you. Doctor Wren, 2010,
25 I'm sorry for my sloppy writing, Doctor Lapham, 2012, agrees

Willard Milby - Cross-examination
by Mr. Davis

1 that she is -- they report separate primary tumors. That's
2 what you just agreed to right there.

3 Right?

4 A I agreed that basis -- upon looking at the reports,
5 they, they appear to be separate tumors.

6 Q Just take it away. I don't need it. Sorry, doctor. I
7 apologize.

8 A Did you hear me?

9 Q I'm sorry.

10 A I'm saying, based upon -- solely upon the reports---

11 Q Uh-huh. (Affirmative).

12 A ---just looking at the reports I would say yes, they
13 are different sub-types of adenocarcinoma.

14 Q Okay. But then you looked at the recut slides, not the
15 originals that they looked at, and you disagree with that?

16 A Well, I don't disagree with the reports. I just think
17 there's additional patterns and sub-types of adenocarcinoma
18 that are present and you can demonstrate those on the first
19 one and you can demonstrate those on the second one and I
20 believe they look alike.

21 Q It is your testimony, doctor, that Doctor Wren failed
22 to see lepidic in the predominately papillary pattern in
23 2010?

24 Is that your testimony?

25 A No, you have to understand, from a pathology

Willard Milby - Cross-examination
by Mr. Davis

1 standpoint, we're interested in communicating what we need
2 to the oncologist --

3 Q Right.

4 A -- so they can be treated.

5 Q Right.

6 A Well, with adenocarcinoma, sub-types really don't
7 matter.

8 Q Staging matters though, doesn't it, doctor?

9 A It does.

10 Q Staging's very important, isn't it?

11 A Correct.

12 Q Tell -- explain to the jury why staging is so important
13 from a pathologist's prospective.

14 A Well---

15 Q I mean you're looking at a cancer, a lung cancer, for
16 example.

17 Are you done with this?

18 I'll be glad to give it back to you if you need it.

19 A Sure.

20 Q Okay! When you're looking at a lung cancer and
21 diagnosing it under the microscope, explain to the jury why
22 staging is so important.

23 A Well, to stage it -- a cancer, it determines a lot of
24 things for the patient. One, it determines their prognosis.
25 Obviously a Stage 1 generally does better than a Stage 4.

Willard Milby - Cross-examination
by Mr. Davis

1 It also helps the oncologist, the radiation oncologist,
2 to decide what treatment they're gonna do. If they have
3 probably -- if there's no nodes involved, they probably
4 wouldn't give him chemo or radiation. If there are lymph
5 nodes involved, they probably perhaps would give chemo and
6 radiation.

7 Depending on the size of the tumor, that's important.
8 Even though there's no evidence of, you know, metastasis in
9 this case, it's a 9-centimeter tumor. It's quite large. So
10 I, I, I believe he received some either radiation or
11 chemotherapy. So these are the reasons why it's important
12 to stage the tumor correctly.

13 Q You don't have any criticism with Doctor Wren and his
14 review of the slides, the originals, and, and his report?

15 A No.

16 Q You don't have any criticism of Doctor Rosanna Lapham
17 in her examination and conclusions and staging of the cancer
18 tumor that she found from the left lung, do you?

19 A No.

20 Q Okay. Do you stage a metastasis, sir?

21 A No.

22 Q No?

23 A No.

24 Q All right. Let's look at Doctor Lapham's report. I'll
25 get it. I thought I had it.

Willard Milby - Cross-examination
by Mr. Davis

1 Can you find that?

2 Excuse me just a minute, doctor.

3 A Sure.

4 Q I thought I had it with me. If I could -- I'm gonna
5 use him as my tripod. I -- the other one doesn't work. He
6 may not either.

7 Okay. Let's, let's hold it so that the doctor can see
8 it, David. Thank you.

9 All right. This is April, 2012, and you understand
10 this is the report generated. Here's a second page --

11 A Uh-huh. (Affirmative).

12 Q -- by Doctor Lapham.

13 You understand that?

14 A Correct.

15 Q Okay. All right. So here's, here's -- right here.
16 And when she generates her report, looking at the original
17 slides of the left lung resection, she puts on here a
18 Pathologic Stage P2, excuse me, P22APNX.

19 What does that mean?

20 A Well, the, the P stands for pathology stage as opposed
21 to a clinical stage. So---

22 Q Okay.

23 A ---the pathologist is looking at it. It's a T2A tumor.
24 The size is 3.5 centimeters. So it falls between three and
25 5-centimeters. So that's P2A. There's no lymph nodes. So

Willard Milby - Cross-examination
by Mr. Davis

- 1 you get P and an X.
- 2 Q And X means unknown?
- 3 A Correct.
- 4 Q If it was zero it would have lymph nodes and none are,
- 5 are, are positive whichever---
- 6 A No.
- 7 Q Is that correct?
- 8 A Correct.
- 9 Q Okay. So, Doctor Lapham, when she looked at the wedge
- 10 resection from his left lung cancer, diagnoses the cancer
- 11 lepidic predominate, right?
- 12 A Correct.
- 13 Q And then she stages that?
- 14 A Correct.
- 15 Q You told me just a moment ago that, if you've got a
- 16 metastatic cancer, you don't stage it?
- 17 A Correct.
- 18 Q She staged it.
- 19 A Well, I think she failed to do some things.
- 20 Q Excuse me?
- 21 A Well, first of all, she knew that the patient had
- 22 another lung cancer.
- 23 Q Sure.
- 24 A Okay. Well, there's no documentation in this report
- 25 that she either looked at that first report or reviewed the

Willard Milby - Cross-examination
by Mr. Davis

1 first slides.

2 Q Did you read her deposition?

3 A She did not look -- it doesn't say---

4 Q Did you read her deposition?

5 A I did. But there's no -- I said there's no written
6 documentation.

7 Q So you dispute her deposition, deposition testimony in
8 either---

9 A She said---

10 Q Wait a minute. Let me finish my question.

11 Where she says, with a 99.9 percent certainty, and I
12 looked at Doctor Wren's report when I did my report.

13 A She didn't document that.

14 Q Do you dispute that?

15 A You need to document it.

16 Q You dispute that?

17 A She failed to document it.

18 Q Do you dispute that her testimony---

19 A I don't dispute it. I'm just saying it was not
20 documented.

21 Q That's documented, isn't it?

22 A Sure it is.

23 Q She didn't, she didn't think this was a metastasis, did
24 she?

25 A Well, sir---

Willard Milby - Cross-examination
by Mr. Davis

1 Q Did she---

2 A I'm just saying---

3 Q Did she?

4 A She did not.

5 Q Did not.

6 Thank you, David.

7 You agree that Doctor Nguyen, the surgeon, did a good
8 job with resecting and removing the right lung cancer,
9 didn't you -- don't you?

10 A Correct.

11 Q And you agree that the surgical specimen of 2010, the
12 right lung, even the recut that you reviewed, is probably,
13 in your opinion, 80 to 90 percent papillary and it's
14 predominant pattern?

15 A Correct.

16 Q And you would agree, that based on your review of the
17 2012 recut slides, not the originals that Doctor Lapham
18 looked at, the recuts, that the predominant pattern of the
19 left lung is lepidic as she documents?

20 You agree with that?

21 A I do.

22 Q That doesn't exclude that there may be some papillary
23 pattern in her specimen, does it?

24 A No.

25 Q But she doesn't document it?

Willard Milby - Cross-examination
by Mr. Davis

1 A She, again, documented predominant pattern, which is
2 appropriate.

3 Q And that's what you're suppose to do according to that
4 2011 article that came out and said hey, we're gonna do new
5 classifications of sub--types?

6 You're familiar with that article, aren't you?

7 A Right.

8 Q I mean she brought it to her deposition.

9 A Right. But the point is you don't document necessarily
10 every sub-type. She documented the predominant sub-type.

11 Q Doctor, if, if you're -- the name of your hospital,
12 again, where you practice?

13 A It's called Chippenham Medical Center.

14 Q Chippenham Medical Center.

15 Is that in Richmond, Virginia?

16 A Correct.

17 Q Four hundred and some bed hospital?

18 A 470 beds.

19 Q All right. When you're doing a pathology review of
20 somebody's lung cancer at your hospital, and that patient,
21 two years before, had cancer taken out of his other lung and
22 that report is available to you because it was done by
23 either you or one of your partners in that hospital, you
24 would certainly look at that report, wouldn't you?

25 A I would.

Willard Milby - Cross-examination
by Mr. Davis

1 Q I mean that's just, that's just routine, isn't it?

2 A Exactly.

3 Q But you're saying what you would do is you'd make sure
4 you'd document I looked at the report?

5 A Um.

6 Q Every time you do that?

7 A Not in my own institution.

8 Q Oh, not in your own institution.

9 You understand Doctor Rosanna Lapham, when she did
10 this, this was her own institution and that Mr. Farr had
11 been in the same institution in 2010 and had the right lung
12 tissue examined by her partner, Doctor Wren, and that was
13 available to her at the same institution---

14 A Well---

15 Q ---the same hospital?

16 A All right. I'll say then, in our institution, we
17 usually consult with the oncologist or treating physician to
18 see whether they want us to review something, if it's from,
19 know, outside or even inside to compare the type of tissue
20 and that's a routine thing. Sometimes it doesn't matter to
21 them cause they say it doesn't matter because it's
22 adenocarcinoma, I'm still gonna treat him with, you know,
23 the same type of treatment.

24 Q Okay. Flip this over.

25 If I say CA, is that a good abbreviation for cancer?

Willard Milby - Cross-examination
by Mr. Davis

1 A Sure.

2 Q Now, I've written up here right lung cancer was
3 papillary predominant and I'm gonna put today from the Year
4 2010 and that's what you told me just a moment ago.

5 Is that fair?

6 A Correct.

7 Q And the left lung, left lung, I've seen it spelled a
8 couple ways today, lepidic, L-E-P, L-I-P?

9 A L-E-P.

10 Q L-E-P.

11 You sure about that?

12 A Absolutely.

13 Q Okay. But if we see it on other documents lipidic --
14 I'm gonna put both spellings.

15 Is that okay?

16 A Well that refers to lipid.

17 Q All right. Okay.

18 Okay. Just a second.

19 (Pause.)

20 Q Even if Mr. Farr had been treated for his right lung
21 cancer in January of 2010 or February of 2010, instead of
22 November/December 2010, you are not sure he would of
23 survived even then.

24 True?

25 A True.

Willard Milby - Cross-examination
by Mr. Davis

1 Q If I put the TX'D, is that an appropriate abbreviation
2 for treated?

3 A That's correct. That's fine.

4 MR. MCKINNON: Ashby, I'm gonna go ahead and object to
5 that.

6 MR. DAVIS: Fine.

7 MR. MCKINNON: You've already said he's not an
8 oncologist. You're asking for an oncology opinion.

9 MR. DAVIS: He's already given---

10 MR. MCKINNON: He can't give a cancer survival rate.

11 MR. DAVIS: He's already given the opinion, Mr.
12 McKinnon.

13 THE COURT: All right.

14 MR. DAVIS: Thank you.

15 THE COURT: You can recross on that.

16 Q What's a board examination in pathology?

17 A What, what is it?

18 Q Yeah.

19 What is it?

20 A It's where they present various cases to you, various
21 different scenarios to both in anatomic and clinical
22 pathology. It's a three day examination.

23 Q Did you pass your board examination the first time out?

24 A Half of it.

25 Q I'm sorry?

Willard Milby - Cross-examination
by Mr. Davis

1 A Half of it.

2 Q You flunked the other half?

3 A The anatomic, yes.

4 Q All right. Hold on a second.

5 (Pause.)

6 MR. DAVIS: That's all I have. Thank you.

7 THE COURT: Any redirect limited to what he went into?

8 MR. MCKINNON: Oh yes.

9 David, can you flip that around please?

10 (Mr. Williford complies.)

11 REDIRECT EXAMINATION

12 BY MR. MCKINNON:

13 Q Doctor, we've heard a lot of wild stuff. Let's go back
14 to the basics.

15 Tell me why you believe the cancer spread from the
16 right lung to the left lung.

17 A As I said earlier, a metastatic lesion on a primary is
18 much more likely than a new primary. Probably 95 to, to
19 99 percent is gonna be a metastasis.

20 Q Doctor---

21 A It's just the nature.

22 Q Stop, stop you.

23 So that means, knowing nothing else, there's a 95
24 percent chance that a different cancer is a spread.

25 Is that fair?

Willard Milby - Redirect examination
by Mr. McKinnon

1 MR. DAVIS: Objection to leading, Your Honor.

2 THE COURT: All right. You want to rephrase?

3 MR. MCKINNON: Sure.

4 Doctor, would you -- that means, knowing nothing else,
5 what is the percentage chance that lung cancer is
6 adenocarcinoma is a spread?

7 A About 95 percent.

8 Q Thank you, doctor. I'm sorry. Go ahead.

9 And if you will -- you were telling me, doctor, the
10 basis for your opinion, that it spread from one lung to the
11 other.

12 A Right.

13 Now, in addition to that, that's number one. That's
14 pretty important.

15 Number two. We have three different patterns of
16 adenocarcinomas or sub-types of adenocarcinoma. You have
17 the papillary, you have the lepidic, and you also have the
18 acinar.

19 Now, when we looked at the slides and I showed you the
20 slides from 2010 and 2012, hopefully you could see that they
21 showed the lepidic pattern, papillary pattern, and the
22 acinar pattern, and when I showed you the slides under high
23 power of those nuclei, hopefully you would agree that they
24 do look alike, and, to me, that is the reason that this
25 represents a metastatic lesion.

Willard Milby - Redirect examination
by Mr. McKinnon

1 Q So, doctor, one of the bases is each tumor, right and
2 left, has the same three types of cancer?

3 A Correct, even though, in the first one, it's 80 percent
4 whatever, papillary, the second one is mostly lepidic and
5 acinar. When a, when a tumor spreads, it can, you know, one
6 type can go more than the other. So, in other words, even
7 though it had a small amount of lepidic in the first, when
8 you have a metastasis, the lepidic can be predominant and
9 acinar.

10 So that's just -- when you have multiple sub-types,
11 when you look at a metastasis, you don't necessarily see the
12 same percentage of the one that had most in the first
13 necessarily have the most in the second.

14 Q Doctor, I'm gonna put up one of these path reports
15 here.

16 Doctor, this is the 2010 report on the right first
17 tumor.

18 Right?

19 A Okay.

20 Q Is there anything in there that contradicts what you
21 said about that tumor having three sub-types?

22 A No.

23 Q So there's nothing in there that disagrees with that
24 opinion?

25 A No.

Willard Milby - Redirect examination
by Mr. McKinnon

1 Q Okay. Doctor, I'm gonna put up now -- this is the
2 report on the left lung tumor in two -- in 2012.

3 Is there anything in that report that disagrees with
4 your opinion that it had three sub-types in the tumor?

5 A No.

6 Q Okay. So the first basis of your opinion, the, the
7 matching sub-types, nothing in those reports disagrees with
8 it?

9 A Correct.

10 Q And the second basis was what, beyond --?

11 A Well, the -- I talked about -- when I spoke about
12 the -- you go to the high power and you look at the
13 individual cells.

14 Q Right.

15 A It doesn't matter whether we're looking at the lepidic,
16 the acinar, or the papillary. Those nuclei look exactly
17 alike.

18 Q And is there anything in either of those reports that
19 contradicts that that says---

20 A No.

21 Q Okay. And, doctor, let's talk about for -- you based
22 your opinion when you first looked at the reports.

23 Right?

24 A Correct.

25 Q But then you went in with a microscope and compared

Willard Milby - Redirect examination
by Mr. McKinnon

1 actual slides, actual tissue from both tumors.

2 Right?

3 A Correct.

4 Q Okay. So, Doctor Wren, the first doctor in 2010, did
5 he compare both tumors?

6 A Well, he didn't have to.

7 Q Exactly.

8 There wasn't, there wasn't any tumor to compare it to
9 in 2010.

10 Is there anything in the 2012 report by Doctor
11 Latham -- by Doctor Lapham that indicates she compared
12 those -- both tumors under the microscope?

13 A There's nothing in the report.

14 Q There's nothing.

15 But you compared them both under the microscope?

16 A I did.

17 Q Okay. Okay. A couple of minor other things, doctor.

18 They made a big deal out of you getting a second set of
19 slides, the hospital made you a different set of slides.

20 The slides you got are slides from the exact tumor, the
21 real tumors, are they not?

22 A Correct. When, when we take sections of the tumor to
23 look at, we put them in what we call a tissue block. So
24 they made three cuts of the exact same blocks that they made
25 the originals from.

Willard Milby - Redirect examination
by Mr. McKinnon

1 Now, you have to understand, these recuts, we're not
2 talking about big differences in thickness. We're talking
3 microns. So I'm seeing something that's very close to the
4 original. It's not the original, no, but it's very close to
5 it, and I don't think that would change the type. I'm sure
6 the type of tumor, if I saw the originals, it would be there
7 as well.

8 Q Doctor, my colleague, Mr. Davis, made a huge deal about
9 case studies, when they're talking about it spread through
10 the airways, about case studies and stuff like that.

11 Did I ask you to find any case studies or any, anything
12 like that?

13 A No.

14 Q No.

15 Okay. Did anything Mr. Davis discussed with you change
16 your opinion in anyway?

17 A No.

18 Q Okay. Would you just summarize, to a reasonable degree
19 of medical certainty before I leave you alone, your opinion
20 to the jury on whether it was spread from the right lung to
21 the left lung?

22 A It is---

23 MR. DAVIS: Your Honor, this is been asked and answered
24 ad nauseam in his direct examination. I didn't even ask him
25 what his opinion was in the second one.

Willard Milby - Redirect examination
by Mr. McKinnon

1 THE COURT: I'm gonna let him -- go ahead and finish,
2 doctor.

3 A Okay. Well, again, I can just repeat what I just said.
4 It's my belief that the right lung tumor spread to the left
5 lung, introduced the second tumor. Again, my reasoning is
6 that it's much more likely to have a metastatic lesion than
7 a new primary.

8 We have three different types of -- sub-types of
9 adenocarcinoma on the right. You have the exact same three
10 on the left. Papillary is relatively rare, and you have it
11 on the right, and you also have it on the left. Lepidic is,
12 again, somewhat, somewhat varies as well. It's not as rare
13 as papillary, but, again, you have it on the right and you
14 have it on the left. Then, when we go up again to the high
15 magnification, you look at the cells from the right, you
16 look at the cells from the left, and I think they look
17 exactly alike.

18 Q And then, doctor, he asked you one question about
19 chances of living and stuff like that.

20 Are you an oncologist?

21 A No.

22 Q Okay. And your field is looking at cells and tissue.
23 Right?

24 A Correct.

25 Q Not predicting whether people are gonna live or not?

Willard Milby - Redirect examination
by Mr. McKinnon

1 A No.

2 MR. MCKINNON: Nothing further.

3 THE COURT: All right. Thank you.

4 All right. All right. Doctor, you may step down.

5 Any reason why the witness can not be excused?

6 MR. MCKINNON: None, Your Honor.

7 MR. DAVIS: No objection, Your Honor.

8 THE COURT: Thank you, doctor. You may be excused as
9 well.

10 MR. MCKINNON: Plaintiff rest, Your Honor.

11 THE COURT: Ladies and gentlemen, this is one of those
12 times when I have to take up matters of law with the
13 attorneys. So I'm gonna have to excuse you from the
14 courtroom. I need to remind you not to have any discussions
15 among yourselves about anything involved in the case. We'll
16 get you back here shortly.

17 (WHEREUPON, the following takes place outside the
18 presence of the jury.)

19 THE COURT: Yes, sir.

20 MR. WILLIFORD: May it please the Court.

21 Defendants make a motion for directed verdict pursuant
22 to Rule 50 of the South Carolina Rules of Civil Procedure
23 based on the failure of the Plaintiff, in their case in
24 chief, to provide sufficient evidence or any evidence on all
25 the causes of action to find against the Defendant.

1 The first basis is, number one, on standard of care.
2 Every single one of their experts, none of which were
3 pulmonologists by the way, they could not criticize her from
4 her clinical standpoint as a pulmonologist. Now, while
5 x-rays were criticized, there are more aspects to her care
6 in terms of pulmonology and reading x-rays and
7 incorporating, incorporating interpretation of x-rays within
8 that clinical decision making.

9 Nobody, not Doctor Singer, not Doctor Woodruff, not
10 Doctor Milby, could testify and nor did they testify that
11 they were critical of her clinical care in this case. On
12 that basis, we would ask Your Honor for a directed verdict
13 on standard of care.

14 Number two, Plaintiff has failed to carry their burden
15 on causation. Very specifically, and this just happened a
16 few moments ago, Doctor Milby, the Plaintiff's causation
17 expert, in talking about and trying to link up Mr. Farr's
18 death to the right lung cancer, which was alleged missed by
19 Doctor Wan, admitted on the stand and it's in evidence that
20 he could not cite any study or authority, any documentation
21 I think was the word, to back up his theory that there was
22 this aerogenous or airway breathing spread, and, therefore,
23 there's no metastasis.

24 His opinion on that is unreliable and this is where I
25 want to bring the Council motion and I believe, Your Honor,

1 with respect to Your Honor, the motion in limine was just
2 that. Your Honor mentioned that we have to listen to the
3 evidence and then make a decision based on the evidence and
4 now we have heard the evidence.

5 So based on our motion and the case law cited on our --
6 in our motion and based on the evidence that we have heard
7 now, that there is no sufficient basis, no reliability
8 attached to the testimony of Doctor Milby. He admitted it
9 on the stand. He said he could not back up his theory.
10 There's no documentation whatsoever in the scientific
11 literature to back up his theory that papillary predominant
12 adenocarcinoma of the right lung can spread by the airways,
13 land in the left lung---

14 THE COURT: Let me slow you down.
15 Start over with the theory.

16 MR. WILLIFORD: Sure. Yes, Your Honor.

17 The Plaintiff's theory, as we have heard in Court, is
18 that papillary predominant adenocarcinoma that was diagnosed
19 and fully resected by Doctor Nguyen in December of 2010
20 somehow spread through the airways, called the aerogenous
21 theory, and landed in the left side meaning his left lung
22 and turned into a lepidic predominant cancer with an acinar
23 pattern.

24 THE COURT: Lepidic -- tell me again.
25 Turn into lepidic?

1 MR. WILLIFORD: Cancer with an acinar pattern,
2 A-C-I-N-A-R, and, therefore, then caused his death. That,
3 that is the Plaintiff's theory, and Doctor Milby, the one
4 expert who testified to that causation link, could not back
5 it up. Under testimony, he admitted there's no -- not, not
6 just a case study, but there's no documentation whatsoever
7 where that has ever been proven at, at all. He had his
8 opinion, but it's just a theory, and he can not back it up.

9 Certainly that kind of medical theory, scientific
10 theory or otherwise, does not meet the Council reliability
11 factors, they're four of them, and a subpart for one of them
12 is the, the Graves versus CAS Systems case in which there
13 must be a link between causation when you have a
14 differential diagnosis of what, you know, what the different
15 possibilities may be.

16 Specifically, in this case, metastasis. Metastasis is
17 the issue that Doctor Milby must carry the baton on to link
18 causation and, and carry the burden in this case.

19 THE COURT: But didn't he -- wasn't his testimony
20 rather clear that his opinion was that it was a, that it was
21 metastasized?

22 MR. WILLIFORD: Yes, Your Honor.

23 THE COURT: He was clear on that.

24 MR. WILLIFORD: He was clear that that was his
25 testimony. However, he could not support it, and,

1 therefore, his opinion testimony is not reliable.

2 THE COURT: On, on the theory of how it got from the
3 right to the other side?

4 MR. WILLIFORD: Yes, Your Honor.

5 THE COURT: Okay. All right.

6 MR. WILLIFORD: That is unreliable and it's unreliable
7 for the reasons that we cited in our motion in limine, which
8 I, hereby, incorporate into this argument.

9 Now that we have heard the testimony, he certainly can
10 not back it up and he admitted to that. He could not back
11 it up. There's no documentation whatsoever.

12 And, so, therefore, the Plaintiffs have failed to
13 provide sufficient evidence for causation in this case, and
14 because they have failed to provide sufficient evidence for
15 causation, then they have failed to meet the elements of
16 negligence against the Defendants and, therefore, directed
17 verdict is proper and should be granted.

18 THE COURT: So you've got two directed verdicts?

19 One on the standard of care and the other on the
20 causation based on Council.

21 MR. WILLIFORD: Yes, Your Honor, except one more.

22 THE COURT: Okay.

23 MR. WILLIFORD: I just wanted to add, for the record
24 and incorporate again our motion in limine discussions in
25 that there is no evidence of gross negligence, recklessness,