1 IN THE DISTRICT COURT OF CASS COUNTY, TEXAS
2 5TH JUDICIAL DISTRICT
3
4 EDDIE CAFFEY, ET AL.,
5 Plaintiffs,
6 vs. CAUSE NO. B-150,896AD
7 FOSTER WHEELER CORPORATION, ET AL.,
8 Defendants.
9
10
11
12 DEPOSITION
13 OF
14 JEFFREY H. BASS, M.D.
15 Taken on behalf of the Defendants
16 9:30 a.m., Saturday, May 10th, 2003
17 before
18 Lisa H. Brown, CSR #1166
19
20
21
22
COAST-WIDE REPORTERS
23 Court Reporters
Post Office Box 95
24 Biloxi, Mississippi 39533-0095
(228) 374-5066 (228) 875-8091
25

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1 The deposition of JEFFREY H. BASS, M.D.,
2 taken on the 10th day of May, 2003, commencing at 9:30
3 a.m., at the offices of Coast-Wide Reporters, 782
4 Water Street, in the City of Biloxi, County of
5 Harrison, State of Mississippi, before Lisa Hood
6 Brown, CSR, Freelance Court Reporter and Notary Public
7 within and for the County of Harrison, State of
8 Mississippi.
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1 JEFFREY H. BASS, M.D.,
2 having been produced and first duly sworn, was
3 examined and testified as follows:
4 - - -
5 EXAMINATION
6 BY MR. SETTER:
7 Q. Doctor, my name is Dave Setter. We met
8 briefly before the deposition. If you'll do me a
9 favor, first for identification purposes, tell me your
10 name.
11 A. Jeffrey Howard Bass.
12 Q. Sir, you are a physician?
13 A. Yes, sir.
14 Q. Dr. Bass, would you tell me your Social
15 Security Number, please?
16 A. 571-88-0760.
17 Q. For identification purposes also, what's
18 your home address?
19 A. 410 Rue, R-U-E, Chateauguay,
20 C-H-A-T-E-A-U-G-U-A-Y, Ocean Springs, Mississippi
21 39564.
22 Q. Thank you. Doctor, how old are you?
23 A. Forty-two.
24 Q. Now, I understand you've been deposed
25 before; is that correct?

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1 A. That is correct.
2 Q. Let me make sure we go through a couple of
3 ground rules so we're clear about what we're doing
4 here. First and foremost, if you answer one of my
5 questions, I'm going to assume you understand the
6 question?
7 A. Uh-huh (indicating yes).
8 Q. That's another rule we have to talk about is
9 what you just did. If you would, you need to answer
10 the questions out loud instead of nods or uh-huhs.
11 It's hard for to distinguish that on the record.
12 Would you do that favor?
13 A. Yes, I will try.
14 Q. Back on the issue of me asking me questions,
15 if you don't understand my one of my questions, please
16 stop me and I'll try to clarify it so you don't
17 understand it; is that fair?
18 A. Yes.
19 Q. If you answer one of my questions, I assume
20 you understand it by answering it. Is that okay?
21 A. I understand.
22 Q. Great. The other thing I ask is if you
23 could, for the court reporter, you're going to have to
24 let me finish my question before you start answering.
25 Is that fine?

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1 A. I will try.
2 Q. And I'll try to let you finish your answer
3 before I talk over you.
4 A. Thank you.
5 Q. The reason we need to do that is the court
6 reporter can only take down one of us at a time. She
7 can't take down two people talking. Is that okay?
8 A. Understood.
9 Q. I need you again to answer out loud instead
10 of these nods or uh-huhs.
11 A. Right.
12 Q. Great. If at any time, Doctor, you need a
13 break just let me know.
14 A. Okay.
15 Q. And the only thing I ask is if there is a
16 question pending, I want you to answer the question
17 before we take a break.
18 A. Sounds fair.
19 Q. Now, I understand you were deposed recently,
20 I believe January 30th of this year; is that right?
21 A. It was in January, sounds about right.
22 Q. Here is my question. Have you been deposed
23 since?
24 A. No, I have not.
25 Q. Have you testified at trial since January

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1 30th this year?
2 A. I have never testified in any trial.
3 Q. So other than the deposition on January
4 30th, you also had another deposition, I believe, back
5 in 1998; is that correct?
6 A. That is correct.
7 Q. Are those the only two depositions that you
8 have ever given?
9 A. Yes.
10 Q. To speed up the process today, what I want
11 to ask you a little bit, and we'll go through the CV,
12 but I want to know what, if anything, has changed in
13 your life since that last of deposition in terms of
14 these type of items. Let me go through them.
15 Have you published anything since January
16 30th?
17 A. No.
18 Q. Have you joined any different organizations
19 and professional organizations since January 30th?
20 A. No.
21 Q. Have you changed your employment --
22 A. No.
23 Q. -- since January 30th?
24 A. No.
25 Q. Let me finish.

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1 A. Sorry.
2 Q. So you're basically working at the same
3 place?
4 A. Yes.
5 Q. Have you changed your residence?
6 A. No, I have not.
7 Q. All right. Now, at the beginning of this
8 deposition, you gave us -- and you were kind enough to
9 give us an updated deposition -- I'm sorry -- an
10 updated CV if I can find it. What I'm going to do is
11 mark that as Deposition Exhibit Number 1. We'll take
12 a look at that. Then at the January 30th, 2003
13 deposition, I believe that an older CV was marked, and
14 I'll mark that here today as Deposition Exhibit 2 and
15 we'll talk about the differences?
16 A. Okay.
17 Q. Hang on for a second and let her do that.
18 - - -
19 (Whereupon, Exhibits 1 & 2 were marked.)
20 - - -
21 MR. SETTER: For the record we marked as
22 Deposition Number 1 the CV you handed to me
23 before the deposition, and we've marked as
24 Deposition Exhibit 2 the CV that you produced
25 back in your January 30th, 2003 deposition.

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1 BY MR. SETTER:
2 Q. Doctor, I'm going to hand you both
3 Deposition Exhibits 1 and 2, please. Will you take a
4 look at those for me?
5 A. Certainly.
6 MR. SETTER: While the doctor is doing that,
7 I just want to be sure we're clear on the record
8 in terms of this deposition being taken pursuant
9 to the Texas Rules of Civil Procedure and the
10 standard stipulations apply; is that correct,
11 counsel?
12 MS. BOONE: Correct.
13 MR. BURNS: Do we agree that one objection
14 is good for everybody here?
15 MS. BOONE: That's fine.
16 BY MR. SETTER:
17 Q. And, Doctor, while I'm looking at that, my
18 question is going to be very simple. In terms of
19 Deposition Exhibits 1 and 2, what are the differences?
20 We can go through those one by one.
21 A. The difference is the older deposition -- I
22 mean the older CV was the one I gave -- was from when
23 I graduated my ER residency, and the newer one I have
24 added my current place of employment, which I have
25 worked at since July 1st of 2000, and it reflects the

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1 things that I have done at my new place of employment.
2 Q. And is -- where is that indicated on
3 deposition Exhibit Number 1, your new place of
4 employment?
5 A. That would be the first entry under
6 Employment on page two of in the middle.
7 Q. Oh, where it says July 2000 to present?
8 A. Yes.
9 Q. The Emergency Room Group, Ltd., out of
10 Pascagoula, Mississippi.
11 A. That is it.
12 Q. So you added that to Deposition Exhibit
13 Number 1?
14 A. Yes.
15 Q. You also changed the address in terms of
16 your residence, correct?
17 A. Correct.
18 Q. And that's the 410 Rue Chateauguay, Ocean
19 Springs, Mississippi. I butchered that.
20 A. So does everybody.
21 Q. Correct?
22 A. That's correct.
23 Q. The other thing I believe you added in
24 comparing Deposition Exhibit Number 1 to Deposition
25 Exhibit Number 2 is the statements about being board

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1 certified in emergency medicine and internal medicine,
2 correct?
3 A. Right. Now I'd like to clarify with regards
4 to internal medicine. I mentioned in the last
5 deposition that my internal medicine certification
6 expired December 31st of 2002, and I was in the
7 process of recertifying. I took the recertification
8 exam, what, Tuesday, the 6th of May, and I think I did
9 very well and I'm pretty confident -- very confident
10 that I passed it.
11 Q. But from December -- if I understand
12 correctly, from the end of December of 2002 until now,
13 you are not currently board certified in internal
14 medicine?
15 A. Correct, it has expired. I should get my
16 results, they said, by August 1st.
17 Q. Doctor, just curiosity on the CV issues, are
18 you licensed in states other than Mississippi?
19 A. Yes.
20 Q. Where else?
21 A. California.
22 Q. Is that license current?
23 A. Yes.
24 Q. Have you ever been licensed in any states
25 other than California and Mississippi?

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1 A. No.
2 Q. For example, have you ever been licensed
3 specifically in Texas?
4 A. No.
5 Q. I notice that you went to med school at
6 Baylor; is that correct?
7 A. That is correct.
8 Q. You didn't obtain a license in Texas back
9 then?
10 A. No, because I did my internship and
11 residency in California and you have to complete an
12 internship before you're eligible for state license,
13 and I was already in California by that time.
14 Q. That raises an interesting question,
15 Doctor. As a resident, do you need to have a license
16 in the state that you are doing your residency?
17 A. I was required to, yes.
18 Q. In California?
19 A. Yes.
20 Q. How about in Mississippi?
21 A. I believe so. I'm not a hundred percent
22 sure. But once you finish your internship, you're
23 required to -- I think most states will require you to
24 get your license to continue with your residency.
25 Q. Rather than put it in the hypothetical, you

Page 15

1 did a residency here in Mississippi?
2 A. Yes.
3 Q. In emergency room medicine?
4 A. That's correct.
5 Q. Did you get a license in Mississippi at the
6 time that you became a resident in Mississippi?
7 A. Yes. I had to have it before I started my
8 residency.
9 Q. So my question specifically is, How long
10 have you held a Mississippi license?
11 A. Since July 1st of 1997.
12 Q. Thank you. All right. You are now working
13 with the Emergency Room Group, Limited, correct?
14 A. Correct.
15 Q. Is that a full-time position?
16 A. Yes, it is.
17 Q. Are you an owner of the Emergency Room
18 Group?
19 A. I am a full partner.
20 Q. And has that been the case since you started
21 with them in July of 2000?
22 A. No, it was one year before I became a
23 partner.
24 Q. And just so I'm clear on the record, I
25 assume that most of your work for the emergency room

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1 group involves doing emergency department medical work
2 as a physician?
3 A. That is correct.
4 Q. Are you practicing as an internist?
5 A. No.
6 Q. Have you practiced as an internist since you
7 left California?
8 A. No.
9 Q. So the last time you held a job as an
10 internist was when you were working at the
11 Buenaventura?
12 A. Buena Ventura Medical Clinic, that's
13 correct.
14 Q. Subsequent to that time, you were doing your
15 residency in the emergency room department, I'm sorry,
16 the University of Mississippi emergency room residency
17 program, correct?
18 A. That is correct.
19 Q. And you did that from 1997 until 2000?
20 A. Correct.
21 Q. And I understand from the prior deposition
22 that you started working with Healthscreen, Inc.
23 sometime around March of 1998; is that correct?
24 A. That is correct.
25 Q. And were you working with Healthscreen at

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1 that time as a resident?
2 A. While I was an emergency department
3 resident, yes.
4 Q. And was that a part-time position with
5 Healthscreen or full-time position?
6 A. Part-time.
7 Q. And we continue with Healthscreen at least
8 through July 2000 when you went over to the Emergency
9 Room Group, correct?
10 A. That's correct.
11 Q. And then after July 2000, have you had an
12 ongoing relationship with Healthscreen?
13 A. Yes.
14 Q. Are you presently working with Healthscreen?
15 A. Yes.
16 Q. Are you currently --
17 A. Well, can I clarify?
18 Q. Sure.
19 A. I was working actively with Healthscreen
20 until December 31st of 2002 when my internal medicine
21 certification expired, so I'm now on hiatus until I
22 officially renew my certification, and then I will go
23 back and work with them some more.
24 Q. Let's go back to -- your point is, until
25 your certification for internal medicine gets renewed,

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1 you're not going to be doing work or you haven't been
2 doing work for Healthscreen?
3 A. That is correct.
4 Q. So you haven't done any work since January
5 1st of this year -- well, you're not doing any work?
6 A. Right.
7 Q. As we sit here today?
8 A. Right. I keep in contact with them and as
9 soon as I get recertified, they said they have more
10 work for me to do.
11 Q. And you haven't worked with Healthscreen in
12 terms of writing reports from January 1st of this year
13 through today?
14 A. Correct. I've done no new reviews.
15 Q. Since January 1st of this year?
16 A. Correct.
17 Q. Let me back up to the year 2002. I just
18 want to understand how it worked in terms of what you
19 were doing at the emergency room group and what you
20 were doing at Healthscreen.
21 A. Okay.
22 Q. How much of your time during the year 2002
23 would have been spent working on Healthscreen as
24 opposed to your work at the Emergency Room Group?
25 A. I'd say on average about five hours a week.

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1 Q. Was involving Healthscreen?
2 A. Yes.
3 Q. For 2002?
4 A. Yes.
5 Q. Now, let's back up to, was that also the
6 case when you first started with the Emergency Room
7 Group in terms of that consistent five hours a week?
8 A. More or less. It's about the same average
9 that I have always done from the beginning.
10 Q. So I'm clear about that, when you started
11 with Emergency Room Group in the year 2000, July of
12 2000, then your work with Healthscreen was on average
13 about five hours a week?
14 A. Correct.
15 Q. To the present or to the end of December of
16 2002, I should say?
17 A. Correct.
18 Q. Before you started working with the
19 Emergency Room Group in July of 2000 in Pascagoula,
20 how many hours a week on average did you work for
21 Healthscreen, let's say in the year 2000?
22 A. Pretty close to the same amount maybe
23 slightly more, maybe five to ten hours max.
24 Q. Would that also be the case going back to
25 1998 and 1999, an average of five to ten hours a

Page 20

1 week --
2 A. Yes.
3 Q. -- of you working with Healthscreen?
4 A. Yes.
5 Q. Now, back between March of '98 and June of
6 2000, did you have any other jobs other than the one
7 that you were done with Healthscreen and your
8 residency?
9 A. Yes. I also did some moonlighting work in
10 various emergency departments around the State of
11 Mississippi.
12 Q. And I believe you talked about that in your
13 last deposition. Do you remember that?
14 A. I don't remember if we did or did not.
15 Q. Well, just for the sake of clarification,
16 just in case you didn't, do you remember what
17 emergency room departments you worked with?
18 A. I worked with the University emergency
19 physicians, which basically the University Hospital
20 had contracts to staff emergency departments at
21 various hospitals, mostly in the Jackson area but also
22 a couple outside the Jackson area, so that included
23 St. Dominic Hospital, Baptist Hospital in Jackson,
24 Grenada Hospital up in Grenada. They also had one in
25 Greenville, but I never worked at the one in

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1 Greenville.
2 Q. How much time would you spend a week doing
3 this moonlighting work roughly during that time
4 period?
5 A. It was very inconsistent work. I might do
6 anywhere from one to four twelve-hour shifts a month.
7 Q. And the work that you were doing was as an
8 emergency physician for University Emergency
9 Physicians?
10 A. That is correct.
11 Q. As part of your residency at the University
12 of Mississippi Medical Center, was there any
13 prohibitions on you doing any type of moonlighting
14 work?
15 A. No, there was not.
16 Q. Who was over you in terms of your residency
17 at the University of Mississippi Medical Center? Who
18 did you report to?
19 A. Well, the residency director's name was Dr.
20 Luanne Woodward, and the chief of emergency medicine
21 was Dr. Robert Galli, G-A-L-L-I.
22 Q. Was that the case the whole time you were
23 doing your residency, or did those positions or people
24 change, I should say?
25 A. They did not change.

1 Q. Did any of those -- did Dr. Robert Galli or
2 Dr. -- I believe you said Woodward?
3 A. Yes.
4 Q. Did they ever work with Healthscreen at any
5 point in time?
6 A. No, they did not.
7 MR. SETTER: Let's go ahead and mark another
8 deposition exhibit, please. Let's go off the
9 record for a second.
10 - - -
11 (Off the record.)
12 - - -
13 MR. SETTER: We're going to mark a new
14 Exhibit Deposition Exhibit 3, please.
15 - - -
16 (Whereupon, Exhibit 3 was marked.)
17 - - -
18 BY MR. SETTER:
19 Q. Doctor, I'm going to hand you Deposition
20 Exhibit 3, and for the record I can identify it as a
21 multi-page deposition exhibit, which is the First
22 Amended Notice of Intention to take of Jeffrey H.
23 Bass, M.D. with Subpoena Duces Tecum.
24 I'll hand that to you, sir. A very simple
25 question before we go through any of the particulars

1 of Deposition Exhibit 3, is this, Have you seen that
2 before today?
3 A. No.
4 Q. Has anyone provided you a copy of Deposition
5 Exhibit Number 3?
6 A. No, not that I'm aware of.
7 Q. Doctor, in these cases in Cass County,
8 Texas, I understand that you're endorsed as an expert
9 witness. Is that your understanding as well?
10 A. That is my understanding.
11 Q. Well, just to cut through the chase on
12 Deposition Exhibit 3, I'll make it very simple. Have
13 you brought with you today any exhibits or documents,
14 I should say, that we can take a look at?
15 A. The only ones I brought are my written
16 reports from Healthscreen, my summaries, along with
17 copies of their B-Readings that were given to me, and
18 the pulmonary function tests that were performed by
19 Healthscreen. And a couple of these people have some
20 additional medical record data. For example, this
21 person has a chest CT, and someone else here has, Mr.
22 Doelitsch, I have copies of a pathology report from
23 his colon cancer and a letter from some other doctor
24 stating that he feels asbestos caused his colon
25 cancer.

1 Q. Let me ask you, if you don't mind, are you
2 willing to share those materials with us today?
3 A. Sure.
4 Q. Would you mind handing those to me and we'll
5 go ahead and mark them as an exhibit.
6 MR. SETTER: Let's go off the record for a
7 second.
8 - - -
9 (Off the record.)
10 - - -
11 BY MR. SETTER:
12 Q. While we're waiting for copies we're going
13 to go back on the record. Doctor, I appreciate the
14 production of the reports that you gave us. We're
15 going to get those copied. In the meantime, we're
16 going to go forward and we'll come back and talk about
17 those materials that you have given to us. We'll
18 probably mark those respectively 4, 5 and 6.
19 I believe it's three sets of files that you
20 produced, correct?
21 A. That is correct.
22 Q. All right. In the interim, let me talk to
23 you a little bit about your compensation with
24 Healthscreen. How much money have you made working
25 with Healthscreen, or how can we determine a good way

1 to break that up?
2 A. Since March of 1998?
3 Q. Yes, sir.
4 A. Approximately three hundred and thirty-seven
5 thousand dollars.
6 Q. Okay. And are you paid on a per-case or
7 per-report, I should say, basis?
8 A. Yes, I am.
9 Q. Has that always been the case with
10 Healthscreen?
11 A. Yes.
12 Q. And what is it --
13 A. If I can clarify.
14 Q. Absolutely.
15 A. When I just do dictated summaries where
16 someone else has done the history and physical
17 examination and they just give me all the stuff, I
18 have always been paid on a per-case basis. When I
19 first started at Healthscreen, the very first month I
20 traveled on the road and did the history and physical
21 and dictations by myself, and at that time I was paid
22 per day regardless of how many patients I saw.
23 Q. All right. Fair enough. Let's take and
24 break that down. With respect to the first month when
25 you were physically examining folks and doing

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1 dictation, I believe is what you said?
2 A. Yes.
3 Q. How much were you being paid per day by
4 Healthscreen?
5 A. Two thousand dollars.
6 Q. And if I understood correctly, you only did
7 this for a period of a month?
8 A. Correct.
9 Q. And how many days approximately for that
10 first month did you do that?
11 A. I believe I did four days.
12 Q. And is that the only time you've actually
13 physically examined patients on behalf of
14 Healthscreen?
15 A. There were a couple other specific instances
16 where one person needed to be examined, so I went to
17 the Healthscreen office in Jackson. I was living in
18 Jackson at the time and I just examined that one
19 patient, and at that time I charged them fifty dollars
20 for the physical exam and fifty dollars for the
21 dictation.
22 Q. All right. Now, setting aside those
23 occasions, how much did you get paid by Healthscreen
24 for doing only the dictation reports?
25 A. Fifty dollars per report.

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1 Q. Would it be fair to say that you have seen
2 over six thousand -- I shouldn't say seen. Let me
3 back up. Strike that.
4 Would it be fair to say that you have
5 written reports on over six thousand individuals?
6 A. Yes.
7 Q. Would it be fair to say that you've looked
8 at or physically examined around the neighborhood of a
9 hundred individuals on behalf of Healthscreen?
10 A. I'd say between a hundred and a hundred and
11 fifty.
12 Q. Now, I believe in your prior deposition you
13 were talking about the issue of negatives or instances
14 where you would find an individual did not have an
15 asbestos-related condition. Do you recall that?
16 A. Yes.
17 Q. And I believe your testimony at that point
18 was around one to two percent of the individuals that
19 you had written reports on were determined by you not
20 to have an asbestos-related condition?
21 A. That is correct.
22 Q. Has that changed?
23 A. No.
24 Q. And the basis for them being determined that
25 they didn't have an asbestos-related condition was

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1 generally what overall?
2 A. Any conceivable abnormal findings that they
3 had on x-ray or pulmonary function testing, physical
4 exam, could easily be explained by some other medical
5 condition they had so that I felt I could not
6 attribute their findings to asbestosis, or some people
7 had just completely normal exams.
8 Q. So one of the ways that you would make that
9 determination, there would be something indicative in
10 their history that would obviously explain their
11 condition being related to that condition which was
12 not related to an asbestos-related condition?
13 A. Correct.
14 Q. If that made sense.
15 A. Yes. If you'd like, I can give you an
16 example.
17 Q. Sure.
18 A. One patient that stuck in my mind, was
19 relatively young, had a history of tuberculosis, had a
20 gunshot wound to the chest, had some pleural scarring
21 from the gunshot wound, had some interstitial changes
22 from the tuberculosis, so he had a very abnormal chest
23 x-ray, but he had -- he only worked in the shipyard
24 for about three months, did not have an adequate
25 latency period, and had an abnormal pulmonary function

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1 test. So felt like I could not attribute, even though
2 he had abnormal findings on both x-ray and pulmonary
3 function testing, I just did not feel that I could
4 explain that by asbestosis.
5 MR. PPANSKE: We know a few doctors who
6 could.
7 MS. BOONE: I'll object to that.
8 MR. PRANSKE: Not from your firm.
9 BY MR. SETTER:
10 Q. Doctor, I gather it's very important from
11 what you do with Healthscreen to have as much
12 information as you can concerning other alternative
13 causes that should be ruled out as opposed to
14 asbestos-related conditions?
15 A. Absolutely. The more information I have,
16 the more accurate a determination I can make.
17 Q. Well, wouldn't it be important then, Doctor
18 -- let's see. Healthscreen doesn't do
19 bronchodilators, do they?
20 A. No, we do not.
21 Q. Wouldn't it be important to rule out
22 obstructive airways disease or reversible airway
23 obstruction with bronchodilators to help you make that
24 determination as to whether someone has a condition
25 other than an asbestosis-related condition?

1 A. Well, bronchodilators help with obstructive
2 disease in determining whether the obstruction is
3 reversible or not reversible, but restrictive disease
4 is somewhat different in that if you have restrictive
5 lung disease, your lung volumes are low, and a
6 bronchodilator is not going to change your lung
7 volumes. What it will change is how rapidly you can
8 expel air.
9 Q. And that's fair, Doctor. I understand your
10 answer. So are you telling me that asbestosis or
11 asbestos-related conditions are only a restrictive or
12 exhibit a restrictive impairment pattern?
13 A. You can have combined restrictive and
14 obstructive lung disease. And also some people with
15 asbestosis, especially early in the disease may not
16 exhibit a restrictive pattern at all. They may only
17 have a diminished diffusion coefficient or they may
18 even have normal pulmonary function tests and just a
19 abnormal chest x-ray if it's early in the course of
20 the disease.
21 Q. Right. And here's where I'm going with it,
22 Doctor. If there is any component of obstruction that
23 you believe is significant for making a conclusion or
24 diagnosis of asbestosis, wouldn't it be helpful to
25 make sure that we're ruling out reversible airway

1 obstructive lung disease?
2 A. Well, obstructive lung disease can be
3 reversible or irreversible. It's always helpful to
4 know if you have obstructive lung disease complicating
5 the picture.
6 Q. Okay. Would you agree with me that it would
7 be a better practice to go ahead and get
8 bronchodilators if you're going to make this type of
9 evaluation or diagnosis of an asbestos-related
10 condition?
11 A. To tell you the truth, I don't think it
12 makes that big a difference. The purpose of
13 determining if someone has reversible disease with a
14 bronchodilator is for therapeutic, so that if you are
15 treating the patient you want to know if this disease
16 is reversible with a bronchodilator because if it is,
17 you're going to prescribe them a bronchodilator and
18 make them feel better.
19 But we do not have a doctor-patient
20 relationship with these patients in that we are not
21 treating them. We are not trying to make them feel
22 better. We are simply evaluating them to see what
23 type of disease they have. So for us, for our
24 purposes, it really doesn't matter. It would matter
25 to the primary care doctors trying to make the patient

1 feel better.
2 Q. But isn't the sole purpose of Healthscreen
3 is basically to evaluate and diagnose individuals on
4 behalf of attorneys?
5 A. Yes.
6 Q. All right. So you're not really interested
7 in treating these individuals whatsoever in terms of
8 your function with Healthscreen?
9 A. That is correct. We do not treat these
10 people. We do not give medical advice. We do not
11 prescribe medications. It's the equivalent of doing a
12 physical exam for a life insurance company. All we're
13 doing is collecting information. We're not treating
14 them.
15 Q. All right. And then are you, in your mind,
16 making a diagnosis or not, Doctor?
17 A. Yes.
18 Q. So you are making a diagnosis, but you're
19 not going to the extent of doing what a treating
20 physician would?
21 A. No, we're not checking to see what's going
22 to make them feel better. We're just checking to see
23 is the disease there or is it not there. If it's
24 reversible that would be something the primary
25 physician would be interested in because, as I said,

1 because they're trying to make them feel better.
2 Q. And if you're diagnosing these individuals,
3 are you doing so by holding yourself out for
4 vulnerability to be sued for malpractice?
5 A. Yes.
6 Q. Do you carry malpractice with Healthscreen?
7 A. No, because we are not treating patients.
8 Q. But you are diagnosing them, right?
9 A. We are for legal purposes.
10 Q. And you're shooting them with x-rays; are
11 you not, Doctor?
12 A. I do not.
13 Q. Healthscreen does?
14 A. Healthscreen, at the request of attorneys,
15 does do some -- takes some x-rays.
16 Q. Who orders the x-rays that are shot by
17 Healthscreen?
18 A. I believe the attorneys request them and
19 the patients consent to them.
20 Q. Well, you were the former medical director,
21 were you not, of Healthscreen?
22 A. Yes, I was.
23 Q. Are you telling me no physician prescribed
24 an x-ray that was shot by Healthscreen?
25 A. The physicians do not prescribe the x-rays,

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1 no, we do not, because we are not treating them. This
2 is strictly an evaluation process that the patient
3 agrees to. And, you know, the attorneys say, You need
4 an x-ray. The patient agrees to have it done, and
5 Healthscreen does it.
6 Q. All right. Doctor, in your practice as an
7 emergency room physician, do you have to prescribe an
8 x-ray?
9 A. I order them.
10 Q. Is that not the equivalent of a
11 prescription?
12 A. No, a prescription is for a medication.
13 Q. All right. Isn't it true, Doctor, that an
14 individual cannot have an x-ray shot of him without
15 orders from a physician in the State of Mississippi?
16 A. I am not all that familiar with the laws. I
17 know in our hospital, it is our hospital policy that
18 only a doctor who has hospital privileges at the
19 hospital can order an x-ray in my hospital. Now, what
20 happens outside of hospitals I cannot answer.
21 Q. Back in California when you were doing
22 emergency room work there in California, did you as
23 the physician have to order the x-ray as well? In
24 other words, no one could just walk in and get an
25 x-ray without at least Dr. Bass or a doctor at that

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1 hospital ordering the x-ray?
2 A. At my hospital or my clinic, you would have
3 to have doctor privileges at my hospital or at my
4 clinic in order to order one.
5 Q. Now, with Healthscreen you're telling me
6 that the attorneys are the ones ordering the x-rays;
7 is that right?
8 A. As far as I know, yeah. They refer them to
9 us, and if the patient agrees to have it done, then
10 Healthscreen will do it.
11 Q. And as the former corporate director --
12 A. I'm sorry. Can I add, Healthscreen only
13 started doing x-rays recently. Many of these people
14 had x-rays done elsewhere, and I don't know who
15 ordered those.
16 Q. One of your positions with Healthscreen was
17 director of corporate planning; was it not?
18 A. Not director of corporate planning. I was
19 medical director, and as medical director part of my
20 responsibilities included helping with corporate
21 planning.
22 Q. Back -- well, at any point in time with
23 Healthscreen did you also receive in addition to this
24 per-day or per-diem amount or per-report amount, any
25 type of bonuses?

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1 A. No, I did not.
2 Q. Were you also responsible for recruiting
3 physicians to work with Healthscreen?
4 A. Yes, I was.
5 Q. Were you paid any type of fees or
6 compensation in terms of that recruitment work above
7 and beyond what we talked about already?
8 A. No, I was not.
9 Q. Did the three hundred and thirty-seven
10 thousand dollars include that type of work or those
11 type of tasks?
12 A. The three hundred thirty-seven thousand
13 dollars was strictly for my work on patient reports.
14 The additional responsibilities you could say I did
15 voluntarily. I just figured they were paying me
16 extremely well and we had a good working relationship
17 and we just sort of worked as a team.
18 Q. What I'm gathering is you would recruit
19 doctors for Healthscreen and that was just part of the
20 gig?
21 A. Yes, because it was so busy that I couldn't
22 do all the work myself, so they needed some extra
23 help, so I helped them find some other doctors.
24 Q. All right. Can we break down per year
25 roughly what you made in 1999 and 1998 doing this

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1 work for Healthscreen?
2 A. In 1998, I believe I made approximately
3 sixty-five thousand dollars; 1999, approximately
4 seventy thousand dollars.
5 Q. And has that been about the same amount in
6 the year 2000?
7 A. Yes.
8 Q. Sixty-five to seventy thousand or so?
9 A. About seventy thousand in 2000.
10 Q. And how about 2001, how much did you make?
11 A. Let me think. Might have been closer to
12 eighty in 2001.
13 Q. And then 2002 would have been?
14 A. It was, I think, about fifty-five thousand
15 dollars.
16 Q. And then year to date you haven't made
17 anything?
18 A. Correct.
19 Q. All right. Let's just hang on for a second
20 here. I'll keep going. We'll mess with the exhibits
21 later.
22 Did you ever have any type of written
23 agreement or contract with Healthscreen?
24 A. The only written confirmation would be I
25 signed a form stating that I'm an independent

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1 contractor for IRS purposes.
2 Q. But you didn't have any type of written
3 contract with the owners of Healthscreen?
4 A. No.
5 Q. Did you ever receive or relinquish -- let me
6 start with the first one. Did you ever own any stock
7 in Healthscreen?
8 A. No.
9 Q. Were you ever paid any stock?
10 A. No.
11 Q. Were you paid any bonuses?
12 A. No.
13 Q. How about benefits? Were you provided any
14 type of benefits by Healthscreen?
15 A. No.
16 Q. Such as health insurance or anything like
17 that?
18 A. None.
19 Q. Back in 1998, what kind of income were you
20 making outside of Healthscreen?
21 A. Just my income from my residency program,
22 and I may have done a little moonlighting in some
23 emergency departments.
24 Q. From a comparative standpoint, you were
25 making about sixty-five thousand dollars. Were you

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1 making more or less for this other work, your
2 residency work and moonlighting work?
3 A. Less.
4 Q. Was that also the case in 1999?
5 A. Yes.
6 Q. And how about in the year 2000?
7 A. In the first half of the year 2000, I was
8 making less. In the second half of 2000, I was making
9 considerably more once I started working at Emergency
10 Room Group, Limited.
11 Q. And in 2001 you made about eighty thousand
12 dollars at Healthscreen, and roughly just so I have an
13 idea, how much more were you making in your other
14 practice?
15 A. I guess about two hundred sixty thousand.
16 Q. Okay. I appreciate it, Doctor. Thank you.
17 Now, with respect to your work at Healthscreen did you
18 submit 1099s to Healthscreen?
19 A. Well, they gave me an 1099, yes.
20 Q. So there is 1099s that exist for your
21 employment with Healthscreen?
22 A. Correct.
23 Q. Do you have those still?
24 A. At home.
25 Q. Did you submit any invoices to Healthscreen?

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1 A. No.
2 Q. At any point?
3 A. It was all done orally. Pretty informal
4 handshake-type stuff. They call me every month and
5 say how much do we owe you, and I'd keep a running tab
6 at home.
7 Q. On the business end of Healthscreen, who did
8 you primarily deal with?
9 A. Jack Jamison who is the -- I don't know what
10 his official title is. I guess you call him the CEO
11 or whatever you want. He runs the show.
12 Q. All right. Have you maintained tax returns,
13 income tax returns, since 1998?
14 A. Yes, I have.
15 Q. Do you have an accountant?
16 A. Yes, I do.
17 Q. Who is that?
18 A. Mr. Scott Freeman, F-R-E-E-M-A-N, and he is
19 located in Los Angeles.
20 Q. Does he prepare your tax returns?
21 A. Yes, he does.
22 Q. You've never been paid for your work with
23 Healthscreen by the lawyers directly? In other words,
24 Healthscreen pays you, not the lawyers?
25 A. That is correct. The only time attorneys

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1 pay me is when I do depositions.
2 Q. And you've only done two depositions to
3 date?
4 A. Not including today, correct.
5 Q. Back to the negatives that we were talking
6 about in terms of the one to two percent, do you know
7 how those files would be maintained? Here's my
8 question specifically. If I asked you to go back and
9 find the one to two percent of individuals that you
10 found negative for Healthscreen, how would you go
11 about doing that?
12 A. It would be -- you'd just have to go through
13 every single one and look for the ones I said were
14 negative. We don't separate them by positive or
15 negative. We divide them by what day they were
16 tested.
17 Q. Do you know if you got paid more or less for
18 negatives than positives?
19 A. I got paid exactly the same no matter what
20 the result was.
21 Q. Now, you testified before that you examined,
22 or I shouldn't say examined, that you wrote reports
23 and I guess examined approximately sixty-six hundred
24 individuals?
25 A. I examined the medical records and did

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1 reports on that many people, yes.
2 Q. Out of the total business of Healthscreen,
3 how many folks do you think Healthscreen has seen?
4 A. I could not begin to tell you.
5 Q. Would it be more than the sixty-six hundred
6 that you looked at?
7 A. Yes, I have seen definitely much less than
8 fifty percent of the people. They have many other
9 doctors that work for them.
10 Q. All right. Since your last deposition, you
11 did note that at one point you were the medical
12 director for Healthscreen, but you are no longer in
13 that position?
14 A. That is correct.
15 Q. When did that change?
16 A. When I moved away from Jackson in July of
17 2000.
18 Q. Do you know who took over in your place as
19 medical director?
20 A. Yes, Robert Magee.
21 Q. Is he still in that position at
22 Healthscreen?
23 A. No, he left about a year ago.
24 Q. So Magee was doing it from 2000 through
25 sometime in --

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1 A. Through probably July -- through June 30th
2 of 2002.
3 Q. And then who took Magee's place?
4 A. Actually, I don't think there is one right
5 now.
6 Q. There's no medical director right now?
7 A. I think they're just sort of more anarchy.
8 There may be one, but I'm not aware.
9 Q. Did Magee end up finishing a residency as
10 yourself and move on?
11 A. Yes. Robert Magee did a pulmonary
12 fellowship and moved on.
13 Q. Would it be fair to say that at least until
14 you started working back down on the Gulf Coast -- I
15 shouldn't say back down -- when you started working
16 down here in Pascagoula --
17 A. And Ocean Springs.
18 Q. -- and Ocean Springs but before doing that,
19 basically this work with Healthscreen was supplemental
20 income while you were doing your residency?
21 A. Correct.
22 Q. And that's what you were doing is making a
23 little money on the side in addition to your residency
24 money by working with Healthscreen?
25 A. Yes.

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1 Q. Do you intend to stay with Healthscreen in
2 the near future?
3 A. Yes.
4 Q. Do you have plans not to continue on with
5 Healthscreen down the road?
6 A. I have plans to continue with Healthscreen
7 as long as they'll have me.
8 Q. Going back to the organization of
9 Healthscreen, if I understand it correctly, there is a
10 couple of individuals that own the entity; is that
11 right?
12 A. That is correct.
13 Q. Were you one of the original founders of
14 Healthscreen in terms of the original discussions
15 about how to set up this organization?
16 A. I was not a founder, but I was the first
17 doctor hired, and they have grown tremendously since
18 then and they would consult me regarding
19 doctor-related issues and other corporate growth
20 issues and I would help them with that. But I did not
21 actually found the company.
22 Q. Who did actually do that?
23 A. There were three initial founders; Dr. Karen
24 Shackleford; Dr. Marci Petrini, who is a Ph.D as
25 opposed to medical doctor; and Karen Shackleford's

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1 father, whose first name is Paul and I do not know his
2 last name.
3 Q. Is it Bergstrom?
4 A. Yes.
5 Q. How do you spell it? Is it B-E-R or B-U-R?
6 A. I believe it's B-E-R-G-S-T-R-O-M, I believe,
7 but I could be wrong.
8 Q. All right.
9 A. And since that time, very shortly after the
10 company started going, probably within six to nine
11 months after the company was founded, Karen
12 Shackleford was bought out by the other two owners.
13 Q. By Petrini and Bergstrom?
14 A. Yes.
15 Q. Back in March of 1998, had the company --
16 was the company up and running when you were consulted
17 by the three owners initially?
18 A. The company was in existence, but I was the
19 first doctor, so it started running -- I mean, they
20 first started seeing patients after they hired me.
21 Q. And here's is my question. That's fair.
22 Before you started, to your knowledge they had not
23 examined or did a report on anybody?
24 A. That is correct. I worked the very first
25 day that they saw patients.

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1 Q. In other words, for example, Dr. Shackleford
2 wasn't out there seeing patients?
3 A. No, she was not. She was strictly
4 administrative.
5 Q. Did she ever go see patients on behalf of
6 Healthscreen?
7 A. No, she did not, not one.
8 Q. How about Dr. Petrini?
9 A. No.
10 Q. Did she ever do pulmonary function tests on
11 individuals?
12 A. No. Dr. Petrini is a Ph.D in pulmonary
13 function testing, and she basically instructed all of
14 the technicians how to perform proper pulmonary
15 function tests and helped make sure that all the
16 doctors were reading the tests properly and
17 established protocols for testing and did quality
18 assurance to make sure that the tests were of the
19 absolute highest quality and reproducible.
20 Q. Does she continue to do that or is she still
21 in that role?
22 A. Yes, she does.
23 Q. In fact, she's the president of
24 Healthscreen, isn't she?
25 A. Well, she is one of the two owners, yes.

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1 Q. But isn't she the corporate president, to
2 your knowledge?
3 A. I don't know. She could be.
4 Q. All right. Now, Dr. Karen Shackleford is
5 someone that did her emergency residency with you?
6 A. That is correct. She was one year ahead of
7 me in the program.
8 Q. Do you know where she is at now in terms of
9 her practice?
10 A. I do not.
11 Q. Is she up in Jackson?
12 A. I believe she's living in Jackson.
13 Q. Do you know where she practices?
14 A. No, I do not.
15 Q. Or if she practices?
16 A. I do not.
17 Q. Dr. Shackleford and Dr. Petrini and Mr.
18 Bergstrom, did all three of them approach you about
19 your position at Healthscreen initially?
20 A. Dr. Shackleford is the one who got me
21 involved.
22 Q. Tell me, Dr. Bass, how did it all come about
23 that you got involved with Healthscreen?
24 A. Well, they had established this company and
25 they needed to find a board certified internist who

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1 had a flexible schedule so that he could work
2 midweek. And I was the only board-certified internist
3 that Dr. Shackleford knew that didn't have to work
4 Monday through Friday full time, so she asked me if
5 I'd be interested.
6 Q. And did you have some initial organizational
7 meeting with Dr. Shackleford and Dr. Petrini and Mr.
8 Bergstrom?
9 A. Most of my contact initially was with Dr.
10 Shackleford, but I guess you could say we had informal
11 meetings with Dr. Petrini and Paul Bergstrom just so
12 we all could come to agreement on how it was going to
13 be run.
14 Q. And during those initial meetings, were
15 there any lawyers involved in those meetings as well
16 when you were setting up this organization?
17 A. Not directly, no.
18 Q. Okay. Indirectly were they involved in the
19 setup of this organization? When you said not
20 directly, what does that mean?
21 A. Well, Karen Shackleford's husband is an
22 attorney who has done asbestos cases. And I know
23 that's what -- she formed the company in response to
24 the fact that she kept hearing her husband complaining
25 about how unhappy he was with the companies that were

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1 out there doing pulmonary function tests. And when
2 she got tired of listening to him complaining, she
3 asked him how much he was paying them. And when he
4 told her, she told him, I can set up a company to do
5 that. Now how much he helped her, I don't know. But
6 I'm sure he had something to do with it.
7 Q. Did you ever meet with Steve Shackleford in
8 the early months of the setup of Healthscreen?
9 A. I met him a couple of times.
10 Q. Did he ever meet with you and others at
11 Healthscreen as part of a business meeting?
12 A. No.
13 Q. So if I can go back to your earlier
14 statement, this is a brain child of Karen Shackleford
15 because her husband was the plaintiff asbestos lawyer
16 and he said, Eureka, you know, Karen, I got these
17 testing entities out there and I pay them all kinds of
18 money. And Karen came back and said, Gee, I can do
19 that?
20 MS. BOONE: Objection to the form.
21 BY MR. SETTER:
22 Q. Is that right?
23 A. To the best of my knowledge, yes.
24 Q. So this is the Shackleford screening entity,
25 right?

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1 MS. BOONE: Objection to form.
2 A. Not anymore.
3 BY MR. SETTER:
4 Q. Well, that's how it got started?
5 A. That's how it got started, but she did it as
6 her own company. It was not Steve's company. It was
7 Karen's idea because she felt she could do a good job
8 of it. And she was bought out quickly in large part
9 because they were having difficulty attracting
10 business from other attorney firms because -- strictly
11 because she was a Shackleford and they were afraid
12 that -- I guess they didn't want Steve Shackleford to
13 know what was going on in their firms because he was a
14 competitor. So that's why she was bought out and
15 taken out of the company, and they very rapidly had
16 nothing to do with it anymore.
17 Q. And do you know who forced that issue for
18 her to be bought out? Who was behind that?
19 A. I think it was -- to the best of my
20 knowledge, it was the other owners and Jack Jamison
21 who realized the company wasn't going to make it
22 because they weren't getting any referrals.
23 Q. From a marketing standpoint, it didn't look
24 too good to have Steve Shackleford's wife being a
25 principal owner; is that correct?

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1 A. That is correct.
2 Q. And the other plaintiffs attorneys didn't
3 think that was too swift as well, so the owners
4 decided we better buy out Karen and change that
5 relationship?
6 A. Yes.
7 Q. And as a result of doing that, they -- did
8 they have Paul Bergstrom involved from the get-go or
9 did they put him in at a later date?
10 A. Yes. Paul was involved from the very
11 beginning. He was critical. He's a retired corporate
12 executive, so he's really the guy who was involved in
13 putting the corporate structure together.
14 Q. But Paul is Karen Shackleford's father,
15 correct?
16 A. That is correct.
17 Q. Now, going back a little bit about the ins
18 and outs and startup of this business, do you know
19 when Dr. Petrini got involved with Healthscreen? Was
20 she on board when you were consulted with Karen
21 Shackleford?
22 A. Karen, Marci and Paul were the three
23 original people. They started it, Jack Jamison was
24 the first person hired to run the company.
25 Q. Do you know if Karen went out and recruited

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1 Marci to get on board with Healthscreen as part of
2 this brilliant idea by Karen and Steve Shackleford to
3 do screenings for lawyers?
4 A. Like I said, it was a brilliant idea of
5 Karen's, not of Steve's. Marci was the very first
6 person she approached to put it together because she
7 knew that Marci had a Ph.D in pulmonary function
8 testing, is probably one of the world's foremost
9 authorities in it, and so that's the first person she
10 went to to form the company.
11 Q. And she needed somebody with real expertise
12 about how to do pulmonary function tests and how to
13 train technicians and doctors in terms of the
14 administration and interpretation of pulmonary
15 function tests?
16 A. That's exactly right.
17 Q. And that was a business objective because
18 Karen was concerned with not having an individual of
19 that type of expertise would affect the company by any
20 means? I don't understand why it was necessary to
21 have Dr. Petrini involved. That's my real question.
22 Why was it necessary to have someone like Dr. Petrini?
23 A. Because she wanted to have the absolute best
24 quality pulmonary function tests available and she
25 knew that Dr. Petrini, who also was a personal friend

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1 of hers, was one of the best anywhere. Dr. Petrini's
2 job at University of Mississippi Medical Center, in
3 addition to being primarily researcher, she teaches
4 the medical students and the pulmonary fellows how to
5 read pulmonary function tests. If she's going to run
6 a company where the primary objective is to examine
7 people and perform pulmonary function tests, she
8 wanted to have a foremost authority running the show
9 making sure the tests were the best quality possible.
10 Q. Right. And she wanted to be sure she had an
11 individual who knew how to do tests and how to
12 interpret the software and so on and so forth?
13 A. Exactly.
14 Q. An expert in pulmonary function tests, so to
15 speak?
16 A. Correct.
17 Q. Do you know if Dr. Petrini had been at the
18 University of Mississippi -- well, let me go back.
19 How long do you think Dr. Petrini was with the
20 University of Mississippi before she got involved with
21 Healthscreen?
22 A. I have no idea, but she had been there a
23 number of years before this started.
24 Q. When -- go ahead.
25 A. I know Dr. Petrini was there when Dr.

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1 Shackleford was a medical student, so it had to be at
2 least five years.
3 Q. Do you know how much Dr. Petrini makes from
4 this Healthscreen organization?
5 A. I have no earthly idea.
6 Q. Do you have any idea how much Dr. Bergstrom
7 makes -- I mean Mr. Bergstrom makes from this entity?
8 A. I have no idea.
9 Q. Do you know what Healthscreen charges on a
10 per-test basis for their examinations and evaluations
11 for these lawyers that they test and screen people?
12 A. Back when I was medical director, it was
13 five hundred dollars a test. I do not know if that
14 number has changed or not.
15 Q. All right. Let's see if I can do the math.
16 If I did five hundred per test and you did six
17 thousand, that's how many zeros, Doctor? Help me out
18 here. That's thirty to ten to fifth is what.
19 A. Three million.
20 Q. Three million. So at least -- Healthscreen
21 made at least three million dollars gross, I should
22 say, in the tests you were involved in?
23 A. And I know they reinvested a dramatic amount
24 in the business. How much was taken out as profit, I
25 don't know.

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1 Q. You also know that they've done much more
2 than what you did. In fact, you believe that you were
3 under fifty percent?
4 A. That is correct.
5 Q. So they've probably done at least six, seven
6 million dollars in business since you've been
7 involved; is that correct?
8 A. I'd say that sounds fair.
9 Q. At least?
10 A. At least.
11 Q. Now, when you initially were discussing this
12 and setting up Healthscreen back in 1998, were there
13 any B-Readers involved with Healthscreen?
14 A. No.
15 Q. Has there ever been any B-Readers involved
16 with Healthscreen?
17 A. Not that have are employees with
18 Healthscreen. They're all independent contractors.
19 Q. If I came to Healthscreen and you and the
20 former medical director, and I said, "Dr. Bass, I want
21 to go screen some individuals and I understand you
22 don't have any B-Readers on board. Can you make some
23 recommendations to me, Dr. Bass, as to who would
24 B-Read my folks," would you be able to do that?
25 A. You mean could I give you the names of some

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1 good B-Readers?
2 Q. Yes. Who would you recommend to a lawyer if
3 they asked you?
4 A. I've read a lot of reports from a lot of
5 B-Readers, so yeah, I think I could give names of
6 people who I think do good work.
7 Q. Were you ever asked to recommend B-Readers
8 for Healthscreen's clients, the lawyers?
9 A. No, I was not.
10 Q. By the way, the real clients for
11 Healthscreen are the lawyers, correct?
12 A. True.
13 Q. As opposed to individuals that are being
14 tested?
15 A. That is correct.
16 Q. Healthscreen doesn't do any work except for
17 lawyers? In other words, it doesn't do any type of
18 work except for testing for lawyers?
19 A. To the best of my knowledge.
20 Q. It doesn't do work, for example, of doing
21 testing for hospitals?
22 A. No.
23 Q. It doesn't do any type of testing for
24 preemployment examinations, that type of thing for
25 industry?

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1 A. To the best of my knowledge, no.
2 Q. It doesn't do any type of governmental
3 contracting work; is that correct?
4 A. Not that I'm aware of.
5 Q. Doctor, are you aware of any provisions, for
6 example, in the State of Texas or Mississippi that
7 require you as a physician to report to the Texas
8 Department of Health a finding of an asbestos-related
9 condition?
10 A. I am not aware of that.
11 Q. Have you ever done such things for Texas,
12 Mississippi, or any other states, reported those
13 findings that you had for Healthscreen to a health
14 department?
15 A. Me personally?
16 Q. Yes, sir.
17 A. No, I have not.
18 Q. Do you know if Healthscreen has notified,
19 for example, the Texas Department of Health in terms
20 of any findings you made on your reports?
21 A. No, I am not aware of that.
22 Q. Have you directed them to do so?
23 A. No, I have not.
24 Q. Have you made any type of reports whatsoever
25 to the Centers for Disease Control concerning your

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1 findings with respect to your work at Healthscreen?
2 A. I personally have not.
3 Q. Do you know if anyone has on behalf of
4 Healthscreen?
5 A. Not that I'm aware of.
6 Q. Do you know a Dr. John Evans?
7 A. He is a B-Reader.
8 Q. Is he one of the individuals that was
9 involved with Healthscreen?
10 A. I would not say he was involved with
11 Healthscreen. I would say he has done B-Readings on
12 some reports that have been sent to me, and so -- I
13 mean, he is a B-Reader that I have read -- I have read
14 some of his materials on some of our patients, but I
15 do not believe that he was directly employed by
16 Healthscreen.
17 Q. Going back to my earlier question, who would
18 you recommend for B-Readers? If I were an attorney
19 coming to Healthscreen and I asked you as the medical
20 director or the owners for recommendations of
21 B-Readers, who would you recommend?
22 A. There are many good ones that I've read
23 reports from that I believe are good. Dr. Evans, Dr.
24 Phillip Lucas, Dr. Dominic Gaziano (phonetic).
25 There's more. There's lots more. Dr. Richard Levine

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1 to name a few.
2 Q. You're not a B-Reader yourself?
3 A. No, I'm not.
4 Q. In fact, for the evaluations that you do for
5 Healthscreen, if I understand correctly, you never see
6 the x-rays?
7 A. That is correct.
8 Q. All you look at in terms of the radiological
9 issue is someone else's B-Reading?
10 A. Their official report, correct.
11 Q. So your whole reliance on the finding of
12 x-ray changes is dependent upon what a B-Reader has
13 found that has been submitted to Healthscreen or
14 that's been obtained by the lawyers and submitted to
15 Healthscreen, better stated?
16 A. That is correct.
17 Q. So you're solely dependent upon the B-Read
18 that's been selected by the plaintiff's attorney for
19 the radiological changes; is that right?
20 MS. BOONE: Objection to form.
21 A. I rely on the B-Read that's provided to me.
22 BY MR. SETTER:
23 Q. But you don't independently review the film,
24 so if I provided you B-Reads done by, for example,
25 defense doctors, would you rely on those as well?

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1 A. If they are a NIOSH certified B-Reader, yes.
2 Q. And if there's a conflict or a difference of
3 opinion, for example, in the three cases or five cases
4 we're going to talk about today in terms of -- let me
5 just pose a hypothetical. For example, let's assume
6 for the sake of argument that Dr. Levine or Dr.
7 Segarra says this individual has a 1/0 with no pleural
8 abnormalities, on the one hand, and a different doctor
9 who is also a NIOSH B-Reader says they are completely
10 normal.
11 Presented with those circumstances, Doctor,
12 would you agree that you would not be able to reach
13 any type of diagnostic conclusion with that conflict
14 of medical opinion?
15 A. I would not be able to reach an opinion with
16 regards to the B-Read report. I would still also rely
17 on other information such as the pulmonary function
18 testing, physical exam. But with regards to the
19 B-Read record, I would have to say I can't make a
20 conclusion.
21 Q. So if we had B-Read reports that are in
22 conflict, we would scratch out the radiological
23 element or variable to this calculus formula of
24 diagnosis?
25 A. Correct.

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1 Q. All right. And to make that clear, in other
2 words it's a wash, and therefore, Dr. Bass, who has
3 not looked at the x-rays, will say, I can't really
4 make an issue or make a determination of the
5 radiological changes because of this conflict of
6 opinion?
7 A. That's correct.
8 Q. And you're not a radiologist, so you would
9 defer to some other mechanism to resolve that conflict
10 other than you?
11 A. With regard to the radiology reports, yes.
12 Q. And if an individual is normal upon the
13 physical examination and has, in essence, normal
14 pulmonary function testing, under those circumstances
15 then you wouldn't be able to reach any type of opinion
16 other than the fact that the individual maybe had an
17 occupational history with latency?
18 A. If they had a completely normal pulmonary
19 function test, completely normal physical exam and
20 conflicting radiology reports, yes, I would not be
21 able to make the statement.
22 MR. SETTER: Let's go off the record and
23 take a break. We've been going for a little over
24 an hour.
25 ---

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1 (Whereupon, Exhibits 4-6 were marked.)
2 - - -
3 BY MR. SETTER:
4 Q. Doctor, off the record we went and had
5 copies made of the various files that you produced,
6 the three files for Larry Drosche, George Doelitsch
7 and Pat Lehmann. And we have now marked those
8 respectively, for Mr. Drosche Number 4. It's a
9 multi-page exhibit for Mr. Drosche. We'll come back
10 through that.
11 For purposes of identification Deposition
12 Exhibit Number 5 are copies of your file that you
13 produced of George Doelitsch. That's a multi-page
14 exhibit as well. We'll come back about that.
15 I'm handing you now Deposition Exhibit
16 Number 6, which is the file of materials that you
17 produced today for Pat Lehmann; is that correct?
18 A. That is correct.
19 Q. Going back to our discussion concerning
20 Healthscreen I'm curious when was Jack Jamison brought
21 on? Was he already on board when you started?
22 A. Yes.
23 Q. What is Mr. Jamison's background and
24 experience, to your knowledge?
25 A. When Healthscreen hired him he was fresh --

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1 freshly retired from the Air Force. He had spent
2 twenty years there and he had some sort of
3 administrative position, which I don't know what it
4 was.
5 Q. So he was in some type of military Air Force
6 position as an administrative --
7 A. Yes. To the best of my knowledge, the way
8 Jack got hired is Paul Bergstrom, who is retired
9 military himself, went to the Air Force base and said,
10 Who do you have that's a great administrator that's
11 retiring now? That's who I want to run my company.
12 Q. And what Air Force base did Paul go to?
13 A. I believe it was Keesler.
14 Q. Okay. And at the time that Healthscreen
15 started, were there pulmonary function technicians
16 already on board, to your knowledge?
17 A. No, Jack Jamison hired all the technicians.
18 Q. I assume by the time you first started doing
19 physical examinations you were doing pulmonary
20 function technicians with somebody?
21 A. Yes.
22 Q. Who was the first technician or group of
23 technicians that were on board with Healthscreen when
24 you started?
25 A. I don't remember their names, but they would

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1 be written down on the PFT read sheets.
2 Q. Is there, for lack of a better term, a chief
3 pulmonary function technician at Healthscreen?
4 A. No, not that I'm aware of. I believe -- I
5 don't know, but I don't think so.
6 Q. Who is Mr. Larry Pickering? Do you know
7 him?
8 A. I believe he is one of the technicians.
9 Q. Is he not the head technician or you just
10 don't know?
11 A. I don't know.
12 Q. Jamison would know that better?
13 A. Yes, he would.
14 Q. Who works for Jamison? What type of
15 administrative staff does Jamison have? Does he have
16 an office manager, receptionist, typist, that type of
17 thing?
18 A. Jack Jamison is for all practical purposes
19 the head honcho. He has -- there are receptionists,
20 there are techs. I guess if there were an office man
21 -- he usually had the office manager
22 responsibilities. I guess they've gotten so busy he's
23 delegated a lot to his wife, Sue Jamison. I guess I
24 would call her the office manager now, although I do
25 not know if that's her official title. Then there are

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1 secretaries and there are transcriptionists, but the
2 transcriptionists work out of their homes.
3 Q. That raises a point that I'm curious about.
4 With respect to the reports that you do, absent the
5 first month of operations with Healthscreen, I assume
6 that you are doing your dictated reports in a location
7 other than at the screening?
8 A. That is correct.
9 Q. In other words, they go in and screen and do
10 their testing and a file of materials is somehow
11 transmitted to you for review, and then you dictate
12 your report; is that correct?
13 A. That is correct.
14 Q. How do you receive these reports? Are they
15 mailed to you? I shouldn't say reports, these files.
16 Are they sent to you or transmitted to you by somebody
17 at Healthscreen?
18 A. They are sent to me by overnight mail,
19 Federal Express or UPS.
20 Q. I just raised -- for example, take a look at
21 Deposition Exhibit Number 4. Maybe this will help out
22 my issues. For Mr. Drosche, for example, he's tested
23 on May 8th, 2001, correct?
24 A. Correct.
25 Q. And he had a chest x-ray done January 18th,

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1 2001, correct?
2 A. Correct.
3 Q. And you dictate -- I guess you dictated the
4 report May 21st, 2001?
5 A. That is correct.
6 Q. Then it's date June 6th, 2001?
7 A. June 6th is the date I signed the report.
8 Q. So I want to make sure I understand the
9 differences. We have an x-ray date which would be
10 under your category for chest x-ray on your report.
11 Do you see that?
12 A. Yes.
13 Q. Then we have the date that Mr. Drosche, if
14 I'm saying that right, was physically examined and
15 submitted to pulmonary function test and the physical
16 exam; is that right?
17 A. That's correct.
18 Q. And then for Mr. Drosche, he was physically
19 examined by Kendall McKenzie as opposed to you; is
20 that right?
21 A. That is correct.
22 Q. And that would have been May 8th, 2001?
23 A. Yes.
24 Q. And then on May 21st, you dictate this
25 report and it's eventually finalized and signed by you

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1 on June 6th?
2 A. That is correct.
3 Q. I just want to understand those various
4 dates. How do I go about determining, for example,
5 for Mr. Drosche where he was physically examined?
6 A. If you were to call the Healthscreen office,
7 they could tell you.
8 Q. Do they have like sign-in sheets for May
9 8th, 2001?
10 A. Yes, they would.
11 Q. Would Mr. Drosche's file indicate where he
12 was physically tested?
13 A. The file that they have at Healthscreen
14 would.
15 Q. Do you know if Dr. -- I assume Kendall
16 McKenzie has an M.D. He is a doctor?
17 A. Yes, he is.
18 Q. Do you know if he is an internist, resident?
19 What he is?
20 A. I believe he's an emergency medicine
21 physician.
22 Q. Is he board certified?
23 A. I do not believe that he was board certified
24 at the time of the exam because he was still in
25 residency.

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1 Q. Did he prepare, as part of his duties with
2 Healthscreen -- and let's just stay with Mr. Drosche
3 -- a separate physical examination report?
4 A. Yes.
5 Q. Would that be part of the file that you
6 would you have received?
7 A. Yes.
8 Q. Now, with respect to Mr. Drosche, would
9 there be other items? We have your report, correct?
10 A. Correct.
11 Q. We have a B-Read report and a narrative
12 report by Dr. Levine?
13 A. Correct.
14 Q. We have several pages of pulmonary function
15 testing reports?
16 A. Yes.
17 Q. Correct?
18 A. Yes.
19 Q. And then at the back we have some
20 information about a CT; is that correct?
21 A. Correct.
22 Q. Was that part of the Healthscreen file or
23 was that something else that you obtained?
24 A. I believe that I did not have that at the
25 time that I dictated the report. This was provided to

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1 me by the people at Nix after I was told that I was
2 going to be doing a deposition on this patient.
3 Q. All right. So the last three, four pages of
4 deposition Exhibit Number 4 were subsequently provided
5 to you by the Nix Patterson law firm?
6 A. Correct.
7 Q. Now, staying with the Healthscreen file,
8 would there also be in addition to your report the
9 B-Read reports, the pulmonary function tests, other
10 items in the file that you would see before you
11 dictated the report?
12 A. Well, the history and physical report from
13 Dr. McKenzie that you mentioned previously.
14 Q. Okay. So there would be some type of work
15 history and medical history report?
16 A. Yes.
17 Q. Would that have been filled out by Dr.
18 McKenzie?
19 A. Yes, and occasionally when they were really
20 busy, they would have someone else do the history
21 portion, the work history portion. The doctor always
22 does the medical history portion and all the medicines
23 and the physical exam.
24 Q. And there's a form that is part of the --
25 just so I understand, I guess there's a work history,

1 medical history, physical examination form that is
2 altogether in one document?
3 A. Yes.
4 Q. But the work history portion would be filled
5 out by someone other than a physician when things were
6 very busy?
7 A. Correct.
8 Q. And the other people that would fill out
9 that work history form were whom?
10 A. Essentially receptionists who were trained
11 by Jack Jamison and the Healthscreen people to what
12 questions to ask. It's a form that sort of got check
13 mark boxes to check on, and it just says -- it just
14 asks them, you know, basically who did you work for;
15 from what year to what year; what was your job title;
16 what were your job responsibilities; did you come in
17 contact with these particular materials; how did you
18 contact them; was it with your bare hands; what type
19 of tools did you use when working with these; did you
20 have direct exposure or was it bystander exposure to
21 someone next to you who was working with it, that type
22 of stuff.
23 Q. But we don't have that form for these three
24 individuals with us today, do we?
25 A. Not today, no.

1 MR. SETTER: All right. Counsel, do you
2 know if that is going to be produced in this
3 case?
4 MS. BOONE: That would be something that
5 Healthscreen has. I don't know that that's even
6 something they produced to us. I don't have it.
7 We don't have it in our file.
8 BY MR. SETTER:
9 Q. Doctor, could you make a phone call and see
10 if we can get that form today?
11 A. We cannot get it today because there's no
12 one in the office today. It's Saturday.
13 Q. How about this, Counsel? Doctor, if the
14 wouldn't mind doing it, the court reporter will give
15 you her card. If you will make that phone call on
16 Monday, and then we'll designate those work history,
17 medical history, and exam form -- it's one form -- as
18 subsequent deposition exhibits to this deposition
19 depending on where we end up with the last deposition
20 exhibit numbers. And I'll ask somebody to remind to
21 do so that we can make the record clear. In other
22 words, if we end with ten exhibits, then they will be
23 Deposition Exhibits 11, 12 and 13.
24 Would you be so kind to do that, Doctor?
25 A. I'd be happy to.

1 Q. And you just would there be other materials
2 that would be in the files other than this work
3 history, medical history, exam forms?
4 A. There would be a form called a QA sheet that
5 the techs fill out. It's one page. Basically if
6 there's a problem with the test, it gives an
7 explanation of what was wrong. And I think I have one
8 of them here. I think it was on Mr. Lehmann.
9 Q. So we're looking at --
10 A. I think we have one example of one of those
11 sheets.
12 Q. And Deposition Exhibit Number 5 is Mr.
13 Lehmann's file, correct?
14 A. 6. It's Exhibit 6, and here is that sheet.
15 This is a QA sheet here.
16 Q. Why don't you keep it on there. So the last
17 page of deposition Exhibit 6 is a QA sheet. Is there
18 also something called an unacceptable test comments?
19 A. Occasionally, if there is an unacceptable
20 test. That only appears when there is an unacceptable
21 test result, so not always but sometimes.
22 Q. But that would also be part of the file you
23 would review in preparing your report?
24 A. Yes.
25 Q. All right. Can we ask for the QA sheets and

1 unacceptable test sheets if they exist for these three
2 individuals, and we will likewise make those
3 deposition exhibits?
4 A. Yes.
5 Q. And you'll send those to the court reporter
6 on Monday or Tuesday, as soon as you can possibly do
7 that?
8 A. Certainly.
9 Q. Thank you. Would there also be something --
10 I believe in your prior deposition you said that these
11 individuals that the lawyers send to Healthscreen sign
12 some type of form permitting Healthscreen to do
13 x-rays?
14 A. It permits us to evaluate them and states in
15 there -- it's primarily a disclaimer on Healthscreen's
16 part stating that we do not have a doctor-patient
17 relationship. We are not here to treat your
18 problems. We are not here to do a full history and
19 physical of all your medical problems. All we're
20 doing is an evaluation to see if you have evidence of
21 asbestos-related disease.
22 Q. Would you do me a favor on Monday or Tuesday
23 and ask Healthscreen for copies of those for these
24 three individuals as well?
25 A. Yes, I will.

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1 Q. Because that's part of this file that you
2 didn't have correct?
3 A. They do send me the disclaimer sheets most
4 of the time but I pay no attention to them.
5 Q. Now, going back to the pulmonary function
6 tests that are done by Healthscreen, with respect to
7 the pulmonary function tests, you're not present when
8 they're performed, correct?
9 A. Correct.
10 Q. Other than the first month that you did
11 this?
12 A. Correct.
13 Q. Some other physician like Dr. McKenzie is
14 there?
15 A. Yes, whoever is doing the histories and
16 physicals that day.
17 Q. Is there an order by Dr. McKenzie or the
18 doctor who's performing the physical examination for
19 the technicians to perform a pulmonary function test?
20 A. No.
21 Q. In your experience with Healthscreen, has
22 there ever been any type of blanket written order by
23 you, Dr. Shackleford, or even Dr. Petrini telling the
24 technicians sort of a standing order, for lack of
25 better terms, to go ahead and administer a pulmonary

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1 function test?
2 A. No.
3 Q. Is there any documentation in these files
4 about these individuals being ordered by a physician
5 to perform a pulmonary function test?
6 A. Not that I am aware of.
7 Q. When you were in the get-go or the startup,
8 I should say, of Healthscreen, did Sheila -- I'm sorry
9 -- did Marci Petrini, Karen Shackleford, and Mr.
10 Bergstrom already possess pulmonary function
11 equipment?
12 A. When I was hired, they had just purchased
13 the equipment. They had already purchased some
14 pulmonary function testing equipment.
15 Q. Do you know who ordered that equipment?
16 A. I believe it would have been -- well, Jack
17 Jamison would have written the order, but Marci
18 Petrini would've been the one who would have directed
19 him and told him what type of equipment to order.
20 Q. Doctor, do you know whether or not a
21 pulmonary function machine that does lung volumes with
22 nitrogen washout and diffusion capacity with carbon
23 monoxide is a regulated medical device?
24 A. I do not know.
25 Q. Do you know whether the Federal Drug

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1 Administration requires a written prescription by a
2 physician for the use of such equipment such as a
3 Sensormatic V-max 22?
4 A. I do not know.
5 Q. Isn't it true that Healthscreen uses a
6 Sensormatic V-max 22 machine?
7 A. I believe so.
8 Q. As the medical director at Healthscreen
9 after you were up and running, did you ever order any
10 pulmonary function equipment for Healthscreen?
11 A. No.
12 Q. Did you ever sign any orders requesting
13 Sensormatic to provide Healthscreen with the medical
14 device known as pulmonary function equipment?
15 A. No, I did not.
16 Q. Why is it, Doctor, that you need to have a
17 physician, such as Dr. McKenzie, go do the physical
18 examinations and medical histories as opposed to you
19 going to do that? Maybe I got it reversed. Why
20 doesn't Dr. McKenzie -- let's put it this way. Why
21 doesn't he just write the report? Why do they need
22 you do it?
23 A. They need me to do it because I was board
24 certified in internal medicine, and to my
25 understanding the person doing the report had to be as

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1 a minimum board certified in internal medicine for the
2 report to be acceptable to the attorneys, or
3 preferentially someone trained in pulmonary medicine.
4 But my understanding was as a minimum they had to be
5 board certified in internal medicine.
6 Q. Do you know if Dr. McKenzie is licensed in
7 the State of Texas?
8 A. I do not know.
9 Q. Do you know if these individuals were, in
10 fact, tested in the State of Texas?
11 A. I do not know where they were tested.
12 Q. We would have to go back to Healthscreen and
13 determine where the test location was?
14 A. Yes.
15 Q. For these three individuals, could you
16 obtain that information from Healthscreen as well?
17 A. Certainly.
18 Q. Would you provide that as one of the
19 additional exhibits so we know exactly where they were
20 tested for Mr. Lehmann on May 8th, Mr. Drosche on May
21 8th, 2001, and for Mr. Doelitsch on May 9th, 2001?
22 A. Yes, I will.
23 Q. Thank you. Doctor, do you know if you --
24 let me back up. When you were doing these physical
25 examinations and work history reports, medical history

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1 reports, and the physical examination reports in the
2 first month you worked with Healthscreen, you would
3 obviously meet with these individuals that you were
4 testing for Healthscreen?
5 A. Yes, I would.
6 Q. Would you at that point in time render any
7 type of opinions about their health and tell them your
8 opinions at that point?
9 A. No.
10 Q. Okay. Would these doctors such as Dr.
11 McKenzie, would he evaluate these individuals and as a
12 matter of practice advise them in any way about their
13 health?
14 A. All of the doctors at Healthscreen who
15 performed history and physical examinations are given
16 very explicit instructions not to provide any health
17 advice whatsoever, not to prescribe any medications
18 whatsoever. The most powerful thing we allow them to
19 do or say if a patient brings up a question is say,
20 That sounds interesting, you should check that out
21 with your personal physician; or in the event of an
22 emergency, such as chest pain or something, they would
23 call 911 for them, but they are not to provide any
24 medical care or advice.
25 Q. If they found some type of condition that

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1 needed almost immediate treatment but not necessarily
2 911 treatment, what would a doctor for Healthscreen
3 do?
4 A. He would recommend that the patient see his
5 physician immediately about the problem.
6 Q. Would you do any type of evaluations of
7 these individuals for smoking cessation?
8 A. No.
9 Q. Would you then tell these patients or not
10 tell these patients that they need to quit smoking?
11 A. No.
12 Q. No one would tell a smoker that they should
13 cease smoking then?
14 A. We were not in the business of taking care
15 of these patients. We are strictly gathering
16 information.
17 Q. And working for the lawyers, right?
18 A. Yes.
19 Q. Would you tell these individuals that they
20 needed to be followed up immediately, for example, if
21 you found a case of tuberculosis?
22 A. If we felt they had tuberculosis, yes.
23 Q. Would you do any type of evaluation for
24 pneumonia problems and immediate inoculation concerns
25 for pneumonia?

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1 A. With regards to inoculations, no. If we
2 felt as we were examining a patient that they had
3 pneumonia, we would recommend that they go to their
4 doctor or to the closest hospital immediately.
5 Q. Now these physician who are doing the
6 physical examinations and completing at least the
7 medical history portion of these forms, is it fair to
8 say that most of them were residents that were not
9 board-certified internists or pulmonologists?
10 A. Most of them, yes.
11 Q. So they were doing that type of work as some
12 type of part-time work in addition to doing their
13 residency?
14 A. Correct.
15 Q. And that's because, as you stated earlier,
16 they were available and flexible with their schedules
17 and they could travel during the week, unlike a
18 full-time internist could?
19 A. Correct.
20 Q. Are there any pulmonologists that are
21 associated with Healthscreen other than Dr. Magee, who
22 was not a pulmonologist at the time but in his
23 pulmonary fellowship?
24 A. There were others who were pulmonary
25 fellows.

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1 Q. Okay. Were there any actual pulmonologists,
2 board-certified pulmonologists associated with
3 Healthscreen?
4 A. Not that I'm aware of.
5 Q. Who, other than Dr. Magee, were some of the
6 pulmonary fellows?
7 A. Donna Casell (phonetic).
8 Q. Is she up in Jackson, Mississippi?
9 A. Yes, to the best of my knowledge.
10 Q. Who else?
11 A. Dr. William Edmonson.
12 Q. Where is he located?
13 A. Also in Jackson, the last I heard.
14 Q. Anyone else?
15 A. I believe they did hire a couple other
16 pulmonary fellows, but I do not know their names.
17 Also I'd like to make one statement. I do believe
18 that some of the other doctors doing dictations are
19 either pulmonary fellows or possibly board-certified
20 pulmonologists out of Birmingham, but I don't know
21 their names and I don't know their exact
22 qualifications. But Jack Jamison had mentioned to me
23 that he had gotten some of them involved.
24 Q. Is that a recent --
25 A. Within the past year or two.

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1 Q. All right. Now, with respect to Dr.
2 Petrini, I understood that she initially trained the
3 pulmonary function technicians?
4 A. Yes.
5 Q. Does she do that type of training on an
6 ongoing basis with the technicians?
7 A. She does continuing education if she feels
8 -- if she feels test results are not adequate or if
9 she thinks there's a problem with a tech, she will
10 have a session with them to try and get them to
11 improve their tests. She's also trained Jack so well
12 over the years that Jack now takes care of a lot of
13 that because he's very comfortable at it.
14 Q. Do you know if the technicians get graded or
15 reviewed as to the number of unacceptable tests they
16 perform?
17 A. I believe they are, but I can't tell you
18 with absolute certainty how it is done.
19 Q. Have you ever been brought in to a review of
20 a technician?
21 A. No.
22 Q. Have you ever written up a technician in
23 terms of how they have performed tests?
24 A. No.
25 Q. Do you know who is it in the Healthscreen

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1 organization that receives the unacceptable test
2 comments or unacceptable test sheets that we were
3 talking about earlier?
4 A. Well, if there is an unacceptable test
5 sheet, it comes to me as I do it and they keep a copy
6 of it at Healthscreen, and Marci Petrini will get a
7 copy of it.
8 Q. Doctor, when you were doing these physical
9 exams early on for Healthscreen, do you know what
10 states you did those in?
11 A. Louisiana and Mississippi.
12 Q. Since then, from the reports you have
13 written, do you know where the individuals have been
14 tested for Healthscreen, what other states?
15 A. All over the United States, almost all
16 states.
17 Q. And do you know if the physicians who are
18 writing the reports for Healthscreen other than you
19 are licensed in all those other states?
20 A. I do not know.
21 Q. Do you know if the residents who are doing
22 the physical examination are licensed in the state in
23 which they are doing the examination?
24 A. I do not know, but I know that sometimes
25 they are not.

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1 Q. For example, we'll use Kendall McKenzie.
2 You don't know whether or not he's licensed in Texas
3 or not?
4 A. Correct.
5 Q. And if we go to other states such as I think
6 -- well, let's go back. Do you think Healthscreen has
7 done work, for example, in the State of Florida?
8 A. I'm not sure.
9 Q. How about in the State of New York?
10 A. They definitely have in New York.
11 Q. How about the State of California?
12 A. Yes, they have.
13 Q. All right. What other states off the top of
14 your head do you think Healthscreen has done work?
15 A. The majority of the states, more than half.
16 Q. For example, Ohio?
17 A. I think so.
18 Q. West Virginia?
19 A. I believe so.
20 Q. Michigan?
21 A. Not sure.
22 Q. Illinois?
23 A. Not sure. I know they did Hawaii, Arizona,
24 New Mexico, Arkansas.
25 Q. Colorado?

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1 A. Yes.
2 Q. Nevada?
3 A. I think so.
4 Q. Washington and Oregon?
5 A. Yes.
6 Q. Didn't they do some work up there for Nix
7 Patterson?
8 A. I don't know who they did the work for.
9 Q. Maine?
10 A. Yes, I believe they were in Maine.
11 Q. Kentucky?
12 A. I'm not sure.
13 Q. Missouri?
14 A. I think so.
15 Q. How about outside the United States other
16 than Hawaii?
17 A. I am not aware of any countries outside the
18 United States.
19 Q. And who would know where Healthscreen has
20 tested the most? Who would be the most knowledgeable
21 about that?
22 A. Jack Jamison or Sue Jamison.
23 Q. And would they have some type of minimum --
24 I think we established that there would be sign-in
25 sheets for each day of testing?

1 A. Yes.
2 Q. Would that somehow indicate the screening
3 location?
4 A. Yes.
5 Q. Now, Healthscreen has some for lack of
6 better terms, trailers; is that correct?
7 A. They have a motor home that I'm aware of.
8 Q. When did they start using a motor home? Was
9 that at the get-go or the beginning?
10 A. It was not at the beginning.
11 Q. All right. When did they acquire a mobile
12 home or a trailer?
13 A. I can't give you an exact date. I can
14 guess.
15 Q. Roughly what year?
16 A. I think it was about 2000.
17 Q. Before the year 2000, would it be fair to
18 say -- I think you said they were not doing x-rays?
19 A. Correct.
20 Q. Was this mobile trailer equipment to shoot
21 -- or I shouldn't say shoot. Is it equipped with
22 x-ray equipment?
23 A. Yes.
24 Q. Does it also carry in it the pulmonary
25 function testing equipment?

1 A. I believe it has space for the pulmonary
2 function equipment. I don't know if they keep the
3 equipment in there. They usually travel in big vans
4 and have the pulmonary function equipment in the back
5 of that, but they might keep it in the x-ray thing.
6 I'm not sure.
7 Q. Here's where I'm going. Is that trailer
8 mainly for x-ray as opposed to also doing pulmonary
9 function tests in the trailer?
10 A. It is mainly for x-ray.
11 Q. All right. So the pulmonary function tests
12 are done someplace else?
13 A. No, they're done in the same location.
14 Q. But not in the trailer?
15 A. Not in the trailer.
16 Q. I just want to make sure I'm clear. Let's
17 go before the year 2000. We don't have a trailer.
18 Isn't it true that Healthscreen did most of its
19 testing of these individuals before the year 2000 in
20 motel rooms?
21 A. Frequently.
22 Q. And as a doctor, the doctor would examine
23 them in the very room the doctor was staying in for
24 the night?
25 A. Sometimes.

1 Q. And that would also be true for the
2 pulmonary function technicians, that they would
3 evaluate these folks in the very motel room that they
4 stayed in for the night?
5 A. Sometimes.
6 Q. So the technician gets up, makes their bed,
7 and examines the folks; is that right?
8 A. That's possible, yes.
9 Q. And they weren't doing this in conference
10 rooms; they were doing it actually in their own motel
11 rooms?
12 A. Well, they did it in some conference rooms.
13 Sometimes they did it in conference rooms; sometimes
14 the did it in motel rooms.
15 Q. And the lawyers would be traveling as this
16 caravan would go screening with these folks or lawyer
17 representative?
18 A. Sometimes lawyers were there; sometimes the
19 lawyers weren't there.
20 Q. Would lawyers also be staying at some of
21 these motels at the time that they were doing these
22 screenings?
23 A. I don't know.
24 Q. Do you remember seeing lawyer
25 representatives there at some of these screenings?

1 A. When I was there the first month, one time
2 there was an attorney there.
3 Q. And who was that?
4 A. I don't remember the name.
5 Q. Was it Steve Shackleford?
6 A. No.
7 Q. Was it somebody that works for Steve
8 Shackleford?
9 A. No. It was from some other law firm.
10 Q. Do you know if paralegals from these law
11 firms would travel with the caravan road show for
12 Healthscreen?
13 MS. BOONE: Objection to form.
14 A. I'm not sure. I believe on occasions there
15 were paralegals there.
16 Q. Do you recall the names of any paralegals
17 that would be there for Healthscreen or for the
18 lawyers, I should say, that were traveling with
19 Healthscreen?
20 A. I do not recall their names.
21 Q. Do you know any of the attorneys that
22 Healthscreen did work for other than Nix Patterson?
23 A. The names of the corporations?
24 Q. The law firms.
25 A. Some of them. One was Lundy and Davis. One

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1 was a big one up in New York, Whites and something.
2 Q. Whites and Luxemborg (phonetic)?
3 A. Yes, that's another one. Scott and Scott,
4 they're a small firm.
5 Q. Morris, Sakalaris and Blackwell?
6 A. I've seen that name.
7 Q. How about John Arthur Reeves?
8 A. I think I've seen that name, too.
9 Q. Farris and Morgan?
10 A. That does not ring a bell.
11 Q. Tom Roden?
12 A. Don't know that one.
13 Q. Campbell, Cherry, Harrison and Davis?
14 A. Vaguely sounds familiar.
15 Q. How about Stacy Foster Taylor? Ever heard
16 of --
17 A. Don't know that name.
18 Q. LeBlanc and Waddell?
19 A. I think I've seen that name before.
20 Q. Kevin Graham?
21 A. Don't know that name.
22 Q. Baron & Budd?
23 A. Vaguely sounds familiar.
24 Q. Foster and Seer?
25 A. Doesn't ring a bell.

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1 Q. Silbur Pearlman?
2 A. Don't -- no, I don't recognize that. I'd
3 like to make clear, it's possible Healthscreen could
4 have worked for those people.
5 Q. I understand this is your memory. If you
6 don't remember, you don't remember. They could be
7 working with them, you just don't know?
8 A. No.
9 Q. How about the Ness Motley firm?
10 A. Yes, definitely.
11 Q. Out of the names that are raised, who would
12 you say were the top three law firms that Healthscreen
13 did work for?
14 A. I can't tell you definitively. I can only
15 tell you occasionally when I would receive these
16 reports, occasionally it will have the letterhead of a
17 law firm on it. The letterheads -- I can tell you the
18 letterheads I recall seeing most frequently.
19 Q. All right.
20 A. It would be Ness Motley, Lundy and Davis,
21 and Nix Patterson.
22 Q. How about the Whites firm?
23 A. I've seen that name also.
24 Q. Now back at Healthscreen's offices on 30 --
25 let me start over. Healthscreen is located in

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1 Jackson, Mississippi, correct?
2 A. That's correct.
3 Q. It's at 30303 Lakeland Cove?
4 A. Correct.
5 Q. Do you know if anyone else is next door to
6 Healthscreen in terms of the businesses that are next
7 door to Healthscreen?
8 A. I know there are businesses next door to
9 Healthscreen, but I don't know what business those
10 are.
11 Q. Wasn't it true that the Campbell Cherry
12 Davis firm was located next door to Healthscreen?
13 A. I don't know.
14 Q. Would you have individuals from the Campbell
15 Cherry Davis firm at the Healthscreen offices when you
16 were there?
17 A. Not that I'm aware. I don't ever remember
18 meeting an attorney at the Healthscreen office. Of
19 course, I didn't spend much time at the Healthscreen
20 office.
21 Q. And when you were dictating these reports,
22 would you mainly dictate those reports from home?
23 A. Yes.
24 Q. As opposed to the Healthscreen office?
25 A. Correct.

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1 Q. Or some other location, correct?
2 A. Almost -- yeah.
3 Q. Almost always at home?
4 A. Almost always at home. Excuse me. Mind if
5 we take a quick break?
6 MR. SETTER: Absolutely.
7 - - -
8 (Off the record.)
9 - - -
10 BY MR. SETTER:
11 Q. Doctor, we're back on the record. Just some
12 preliminary questions about what you did in
13 preparation for this deposition. First and foremost,
14 have you read any depositions before this deposition
15 of the individuals, such as Larry Drosche, or any of
16 these patients that you've seen?
17 A. I reread my first deposition that I did in
18 October '98.
19 Q. Did you reread the deposition you did in
20 January of this year?
21 A. No. I wanted to, but I was never provided a
22 copy of it.
23 Q. Have you read any other depositions?
24 A. No.
25 Q. Have you read any depositions of

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1 particularly these plaintiffs who have filed suit?
2 A. No.
3 Q. Have you read any depositions of any other
4 physicians involved in the asbestos litigation?
5 A. No.
6 Q. Or technicians?
7 A. No.
8 Q. To get ready for this deposition, did you
9 meet with anybody?
10 A. I spoke to Ms. Boone yesterday.
11 Q. And did you -- well, was that over the
12 telephone?
13 A. Yes.
14 Q. How long was that conversation?
15 A. About fifteen minutes.
16 Q. And how were you notified that this
17 deposition was going to occur?
18 A. The people at Healthscreen notified me that
19 their law firm wanted me for a deposition.
20 Q. Who particularly notified you from
21 Healthscreen?
22 A. Jack Jamison.
23 Q. How long ago was that?
24 A. I guess about a month ago.
25 Q. Did you have any conversations with Mr.

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1 Jamison about the substance of the deposition?
2 A. No.
3 Q. Or was it just that there was going to be a
4 deposition?
5 A. That's all, that they wanted me for a
6 deposition.
7 Q. Did you ask Mr. Jamison for copies of any
8 records?
9 A. Yes. I asked them to send me the copy of my
10 summaries on the patients that I was going to be
11 deposed about.
12 Q. Did you ask Mr. Jamison to send you in
13 addition to your summaries the pulmonary function
14 tests?
15 A. Yes.
16 Q. What else did you ask him to provide?
17 A. The B-Reads.
18 Q. But you didn't ask him to provide the other
19 materials I asked you about?
20 A. Correct.
21 Q. So you are the one that made the
22 determination of what to show up with today as opposed
23 to Mr. Jamison?
24 A. Actually, the stuff that was brought with me
25 today was sent by the Nix law firm.

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1 Q. The Nix Patterson law firm?
2 A. Yes, which is essentially the same stuff I
3 received from Jack Jamison.
4 Q. Some of it is, some of it isn't, as we
5 discussed, and we'll go through the files
6 specifically.
7 Some of the individuals that take the
8 exposure history for Healthscreen are called greeters;
9 are they not?
10 A. Yes.
11 Q. And they are trained by Jack Jamison to do
12 the exposure information?
13 A. Yes.
14 Q. Or exposure work history?
15 A. Yes.
16 Q. Does a physician ever train these greeters?
17 A. Not to my knowledge.
18 Q. Are the greeters the same personnel from one
19 screening to the next, to your knowledge?
20 A. To the best of my knowledge, they are
21 usually the same people, yeah.
22 Q. Do the pulmonary function technicians, as
23 part of their duties, fill in and fill out work
24 history information, medical history information?
25 A. I'm not sure. They might.

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1 Q. With respect to an occupational exposure to
2 asbestos, you would agree from a diagnostic standpoint
3 you need a reliable exposure as one of the components
4 or elements to make a diagnosis; is that true?
5 A. Yes.
6 Q. Would you agree that a reliable history of
7 exposure would encompass a sufficient amount of
8 exposure that you would make the conclusion that it is
9 more than just background exposure, background level
10 exposure?
11 A. It depends on the work environment. Some
12 people can work in a very dense, dusty environment for
13 a long period of time without ever having handled the
14 materials themselves can still develop signs and
15 symptoms of asbestosis.
16 Q. Are you familiar with the concept of fiber
17 per cc years?
18 A. Fiber for cc years?
19 Q. Fiber per cc year.
20 A. I've heard of it, yeah.
21 Q. What's a fiber per cc year?
22 A. A fiber per -- it would be how many fibers
23 per how many cc's of lung tissue per how many years of
24 exposure.
25 Q. And are you aware of whether there is a

1 threshold for asbestosis of twenty-five fiber per cc
2 years at which you would have a risk of two or greater
3 from an epidemiological standpoint?
4 A. I was not familiar with that number.
5 Q. Have you ever reviewed anything by the
6 Environment Protection Agency about that number?
7 A. Not from the EPA, no.
8 Q. Does it sound reasonable to you, based upon
9 your training and experience, that one would generally
10 not be expected to have a sufficient reliable history
11 of exposure unless he had an exposure of at least
12 twenty-five fiber per cc years?
13 A. I really can't say.
14 Q. Are you aware of whether the Royal -- the
15 commission for -- the Royal Ontario Commission for
16 Canada has also adopted the twenty-five fiber per cc
17 year standard as the dose threshold for asbestosis?
18 A. I was not aware of that.
19 Q. Are you aware whether that's been also
20 adopted by the World Health Organization at the
21 Helsinki Conference in 1997?
22 A. I was not.
23 Q. Do you know who Dr. Irving Selikoff is?
24 A. I've heard the name.
25 Q. What is his role in terms of your

1 familiarity with him?
2 A. I've just seen him name on papers, but I
3 couldn't tell you exactly where or what his position
4 is.
5 Q. Do you know whether Dr. Selikoff is involved
6 with asbestos issues?
7 A. I don't know. I just remember seeing the
8 name somewhere.
9 Q. Do you know or have you ever heard of a Dr.
10 Samuel Hammer?
11 A. Samuel Hammer?
12 Q. Yes.
13 A. No.
14 Q. With respect to your background and
15 training, if I understood correctly, you have seen
16 personally a handful of individuals with
17 asbestos-related conditions outside of Healthscreen?
18 A. Yes.
19 Q. And that would be out of literally thousands
20 of individuals that you have treated, outside of
21 Healthscreen you've only seen a handful that had an
22 asbestos-related condition?
23 A. That was before I moved down to the
24 Mississippi Gulf Coast. I've seen quite a few more
25 since I've been living here.

1 Q. How many more, order of magnitude?
2 A. A few hundred.
3 Q. You've seen a few hundred outside of
4 Healthscreen with asbestos-related conditions?
5 A. In Pascagoula because Pascagoula has the
6 Ingalls Shipyard, which is the second largest shipyard
7 in the United States. They have all sorts of
8 asbestos-exposed workers and we are, at Singing River
9 Hospital, the primary care provider for patients from
10 Singing River -- from the shipyards. So since I've
11 moved down there, I have seen all sorts of people in
12 the emergency department who have been diagnosed with
13 asbestosis. I am not the person who diagnosed them
14 necessarily.
15 Q. They were previously diagnosed by some other
16 entity or physician?
17 A. Right.
18 Q. Over at Singing River Hospital, who is the
19 head of pulmonology?
20 A. That would be Dr. Timothy Hebert.
21 Q. And who is the head of the pulmonary
22 function laboratory at Singing River Hospital?
23 A. I don't know.
24 Q. At Singing River Hospital do they perform
25 pulmonary function tests?

1 A. I believe they do.
2 Q. As an emergency room doctor, do you ever
3 have pulmonary function?
4 A. I never order pulmonary function tests from
5 the emergency department. It's not considered an
6 emergency test.
7 Q. So it's an outpatient issue or something --
8 A. Right. It'd be something the pulmonologist
9 or general internist would order. It's just not an
10 emergency issue.
11 Q. Do you know what predicted values they use
12 at Singing River Hospital for the pulmonary function
13 tests?
14 A. No, I do not.
15 Q. Going back to the issue of a reliable
16 history of occupational exposure to asbestos, would
17 you agree that an individual would need to have an
18 exposure more significant than just holding an
19 asbestos product in his hand for one day?
20 A. Yes.
21 Q. And would you agree he would need to have an
22 exposure on a daily basis for at least some number of
23 years?
24 A. Usually. I have read reports of some people
25 who have very intense exposures for just a few months

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1 that many years later developed evidence of disease.
2 But the overwhelming majority of people with
3 asbestos-related disease have been exposed for much
4 greater times.
5 Q. Would you agree with me that the general
6 rule in your mind would be an individual would have to
7 work day in, day out, eight hours a day with an
8 asbestos-containing product for at least a period of
9 some years to have a significant occupational
10 exposure?
11 A. Usually, yes.
12 Q. All right. And the only exception would be
13 individuals who worked for periods of month with great
14 excessive doses of exposure?
15 A. Yes.
16 Q. What type of individuals would that be, the
17 latter category; what type of trades?
18 A. Perhaps boilermakers, pipe fitters, people
19 who work in enclosed spaces with large amounts.
20 Q. For individuals who are production workers
21 in product factories, such as aluminum plants, would
22 you expect them to have a significant occupational
23 exposure to asbestos by being merely a production
24 worker?
25 MS. BOONE: Objection to form.

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1 A. For what period of time?
2 BY MR. SETTER:
3 Q. For their career.
4 A. If they were doing it for long periods of
5 time, yes.
6 Q. Let's take aluminum workers making aluminum
7 product not doing insulation work. They're not doing
8 anything like that, but they are production workers
9 making aluminum products. Do you believe that's a
10 sufficient occupational history, Doctor?
11 A. If there is a large amount of asbestos dust
12 in the air, if there's a lot of -- if they're working
13 in close proximity to other pipe fitters, places where
14 they're in an enclosed environment where there may be
15 a lot of ambient exposure in the air, I would say it
16 would be possible.
17 Q. How about if an individual worked in a
18 production facility that made tires. Making tires
19 would be the individual's job. Would that be the same
20 answer?
21 A. If there was a large amount of
22 asbestos-insulated steampipes and people working on
23 the pipes, if it was a very dusty environment and they
24 were there a long time, it would be possible.
25 Q. And would that be the same for any

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1 production workers who made paper products?
2 A. Yes.
3 Q. So basically anybody that's in any type of
4 industrial facility doing production work would have a
5 sufficient occupational exposure in your view as long
6 as at some point there is some asbestos dust being
7 generated by someone?
8 A. If they were working -- if they were working
9 in an area where there's a large amount of asbestos
10 materials, people working on them and there's a large
11 amount of asbestos fibers in the air, it would be
12 possible for them to develop signs of disease.
13 Q. It would be possible, but would it be
14 probable?
15 A. I would say possible.
16 Q. You would agree with me it's not very
17 probable, though?
18 A. I can't give you exact numbers. I'd say
19 probably less than fifty percent.
20 Q. All right. Because you do need some
21 frequent exposure, correct?
22 A. Yes.
23 Q. You need a sufficient dose?
24 A. Yes.
25 Q. And it needs to be of a long enough

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1 duration?
2 A. Correct. And an adequate latency period.
3 Q. And an adequate latency period. Back on the
4 issue of ruling out other causes, we talked about the
5 bronchodilators and how you don't believe that's
6 necessary to rule out the obstructive component. I
7 was just unclear about that.
8 Do you consider obstruction as part of your
9 evaluation for asbestos-related conditions or not?
10 A. Yes, but obstruction can be reversible or
11 irreversible, so the fact that it's reversible doesn't
12 mean that there's obstruction or not. It's there, but
13 the question of is the obstruction reversible, it's
14 strictly a matter of therapeutics. It's a matter of
15 how am I going to treat this patient to make him feel
16 better. It's not a matter of evaluating whether
17 obstructive disease is present or not.
18 Q. Okay. But if we found that the individual
19 did have reversible airways disease and it resolved
20 the problems you see on the pulmonary function test in
21 terms of the obstructive component or the mixed
22 obstructive-restrictive component, wouldn't that be of
23 some interest to you?
24 A. It would be of interest to me if it improves
25 their airflow, but if their lung volumes are low, they

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1 would still have restrictive disease whether or not
2 obstructive disease is also present.
3 Q. Are you familiar with and have you ever --
4 with pulmonary function tests of exercise testing?
5 A. Yes, somewhat.
6 Q. Have you performed those?
7 A. For pulmonary function exercise testing?
8 Q. Yes.
9 A. No.
10 Q. Have you ever supervised those?
11 A. No.
12 Q. Do you know what they do in terms of ruling
13 out other causes other than asbestos-related
14 conditions?
15 A. Could you ask that again, please.
16 Q. Yes. I'm sorry. Would you conduct exercise
17 testing to rule out restriction?
18 A. Exercise testing to rule out restrictive
19 disease?
20 Q. Yes, sir.
21 A. I do not, no.
22 Q. Do you know whether that would do that? You
23 could use an exercise test to rule out restriction?
24 A. I'm not familiar with using it to rule out
25 restriction.

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1 Q. You're not familiar with it at all to rule
2 in or rule out restriction, correct?
3 A. Correct.
4 Q. You're not familiar with exercise testing to
5 rule out or rule in obstruction?
6 A. To rule in or rule out -- they use exercise
7 testing to evaluate their function and to see if it
8 changes with exercise, and that can sometimes give you
9 an idea that they have -- you know, if it gets better
10 or worse with their obstruction. I don't know if they
11 use that to rule out obstruction.
12 Q. All right. Fair enough. At Healthscreen,
13 in any event, we don't do exercise testing? You don't
14 see Healthscreen doing that; they've never done it?
15 A. Correct.
16 Q. Did you ever recommend that they do it?
17 A. No.
18 Q. Why?
19 A. Because my job is to make -- is just to
20 determine based on the information I'm given if there
21 is evidence of restrictive or obstructive, or both or
22 neither.
23 Q. Doctor, really, isn't your job just
24 basically to come in there for the six thousand five
25 hundred individuals you've seen to confirm the B-Read

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1 report and say the individual has an asbestos-related
2 condition? Isn't that really your job?
3 A. It is to -- my job is to evaluate is there
4 evidence here of asbestos-related disease. That is my
5 primary job.
6 Q. You're not looking for any other alternative
7 causes; is that correct?
8 A. That is not correct. I am looking for other
9 causes that would explain the findings.
10 Q. But you're not looking very hard by
11 considering bronchodilators, exercise testing, or
12 other testing techniques that might give you a clue as
13 to what's going on with this individual?
14 MS. BOONE: Objection to form.
15 A. I'm asked -- I'm given information. I'm
16 asked to give my opinion. Based on the information
17 that I'm given, is this consistent with
18 asbestos-related disease or not.
19 Q. And out of the sixty-five hundred or
20 sixty-six hundred individuals that you've seen, with
21 the exception of about a hundred, you found all of
22 them to have an asbestos-related condition; isn't that
23 right?
24 A. About two percent of sixty-five hundred
25 would be about what; about a hundred and thirty.

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1 Q. So the answer to my question is, that is
2 correct?
3 A. Between a hundred and a hundred fifty, yeah.
4 Q. So out of the sixty-six hundred individuals
5 you've seen, you've seen only about a hundred and
6 fifty, is that right, that didn't have an
7 asbestos-related condition?
8 A. Yes. But I would like to add that these
9 people have been prescreened before they were referred
10 to Healthscreen, so the normals are for the most part
11 taken out of the pool, and the people sent to
12 Healthscreen are only people that the attorneys
13 already feel like they have adequate evidence that
14 there is evidence of asbestos already present. So
15 basically, the people that I find that do not have
16 evidence of asbestos are mistakes because they only
17 really send us people that they're pretty confident
18 already have the disease.
19 Q. So basically, you're there to confirm what
20 the lawyers have determined with their B-Readers as
21 somebody having an asbestos-related condition?
22 MS. BOONE: Objection to form.
23 BY MR. SETTER:
24 Q. Is that right?
25 A. I'd say that's --

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1 Q. A fair characterization?
2 A. Yeah, it's fair.
3 Q. As we stated earlier, if we had conflicting
4 B-Reading reports for those sixty-five, sixty-six
5 hundred individuals, you wouldn't be able to rely on
6 the radiographic component as part of your diagnostic
7 analysis, correct?
8 A. That is correct.
9 Q. Have you ever asked Healthscreen to ask the
10 lawyers -- the clients of Healthscreen are the
11 lawyers, right?
12 A. Yes.
13 Q. Have you ever asked Healthscreen, Maybe,
14 guys, we ought to ask those plaintiffs lawyers for the
15 B-Reading reports by the defendants? Have you ever
16 thought about doing that?
17 A. I have asked Healthscreen that we be
18 provided with all B-Read reports available.
19 Q. Have you been provided by Healthscreen
20 defense B-Reading reports?
21 A. I don't know.
22 Q. You've only got the B-Reading reports that
23 you think the lawyers have provided, correct?
24 A. Correct.
25 Q. The lawyers who are the clients of

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1 Healthscreen?
2 A. Correct.
3 Q. Would you agree with me that before you see
4 anyone for Healthscreen, whether it's you or someone
5 else that's working for Healthscreen in terms of
6 physician, that that individual would first be signed
7 up with a lawyer and represented by a lawyer?
8 A. Yes, for the most part.
9 Q. Well --
10 A. I don't know if there may be -- there may be
11 exceptions, but to the best of my knowledge, that's
12 how it works.
13 Q. As you sit here today, you don't know of any
14 exceptions to that rule?
15 A. I believe there were some times where
16 Healthscreen was present at actual screenings and I
17 don't know if those patients were signed up with the
18 attorneys before or on that day.
19 Q. So the only difference would be whether they
20 had a preexisting relationship with a lawyer as
21 opposed to a contemporaneous relationship?
22 A. Correct.
23 Q. In other words, they were getting signed up
24 as they were getting tested?
25 A. Possibly.

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1 Q. With respect to the work that you do for
2 Healthscreen, do you in fact consider it a diagnosis
3 of an asbestos-related condition?
4 A. Yes.
5 Q. With respect to Deposition Exhibit Number 4,
6 as an example, for Larry Drosche, Mr. or I should say
7 Dr. McKenzie, Kendall McKenzie -- and I think he did
8 all three reports, Doctor. He also signed off on the
9 report, correct?
10 A. Correct.
11 Q. Do you know why he has to sign off on that
12 report?
13 A. Why, because he was the one who did the
14 report, so he's signing it. It's sort of a legal
15 document, so he's signing, this is what I found.
16 Q. But the reason you have to sign the report
17 is you are the board-certified internist and he's not?
18 A. Correct.
19 Q. At least at this time.
20 A. My understanding is he's signing saying his
21 physical exam is what he did to the best of his
22 ability, and I'm signing because I did the summary and
23 I'm signing that's what I did to the best of my
24 ability.
25 Q. With respect to these reports, and let's

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1 just stay with Deposition Exhibit Number 4, would you
2 agree with me that some of the last parts such as the
3 assessment, prognosis and the last sentence, at least
4 in what I've seen seem to be, for lack of better
5 terms, boilerplate language?
6 A. You mean template.
7 Q. Okay, template. Is that fair?
8 A. Yes, with just minimal changes depending on
9 the individual.
10 Q. Does somebody actually draft these reports
11 for you, Doctor, and then you review and sign them?
12 A. No, I drafted them myself.
13 Q. Do you have a signature stamp, Doctor --
14 A. No.
15 Q. -- that you use with Healthscreen?
16 A. No, I sign them all by myself by hand.
17 Q. As part of the template, would the history
18 be part of the template as well that someone else puts
19 together at least in draft for you for the
20 occupational history and the social history, surgical
21 history, medications, that type of thing?
22 A. I actually developed the template myself for
23 the history and physical form and it's got check marks
24 on -- you know, it's an open spot for where did you
25 work, what were your responsibilities. That's open.

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1 But with regard to what type of materials were you
2 exposed to, it's a bunch of check marks, you know, how
3 were you exposed, was it ambient exposure directly by
4 hand or bystander exposure, those are check marks.
5 Q. Let me make this easier so I understand,
6 Doctor. Let's just assume that for the sake of
7 argument we have the complete file for Larry Drosche
8 before us today but we don't have your report. Okay?
9 A. Yes.
10 Q. Give me an example of what you would say
11 into the dictaphone for Mr. Drosche to the
12 transcriptionist? What would you tell the
13 transcriptionist to do?
14 A. I would be reading off the history and
15 physical form. At the top, it would say -- first, I
16 would look in the back on the pulmonary function test.
17 It says how old they were. I would say, "This is an
18 X-year-old man or woman who worked," and I look at the
19 top of the history and physical, "for this company
20 from these years, and this was their job title and
21 this was their job responsibilities." Then I would
22 look at the columns where boxes are checked to say,
23 "He came in contact with these types of asbestos
24 materials." And then I would say, "He manipulated
25 these materials with these tools." And I would say,

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1 "His exposure was, you know, ambient or bystander or
2 direct."
3 And then below that, it will say he smoked
4 and there will be a box, X amount of cigarettes for X
5 many years; and whether or not he's still smoking or
6 quit; and if he quit, when he quit. Then I'll say,
7 "Past medical history," and that's just an open box
8 for them to fill in all their medical problems. And
9 then there's a box for what medications they're
10 taking. There's a box for what surgeries they've had,
11 and then there's a review of systems and there's check
12 boxes on that. Do you have shortness of breath or
13 cough, or do you get short of breath on exertion; if
14 so, how far can you walk before you have to stop. Do
15 you have swelling in your legs or chest pain, or
16 various things like that. Do you have any rashes.
17 Then after that is the physical exam. The
18 physical exam, there are also check boxes for the
19 doctors to say, you know, do they have any abnormal
20 jugular venous distention; what do their heart sounds
21 sound like, what do their lung sounds sound like; are
22 there any abnormalities on the abdominal exam. What
23 do their extremities look like; what are pulses like;
24 do they have clubbing; do they have rashes.
25 Then after that, I basically take the

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1 B-Reading and read it essentially word for word, and
2 then we'll have the pulmonary function tests. I will
3 read the numbers on the summary sheet and I will check
4 the back of the test to make sure they look reliable,
5 and then I will give my own personal interpretation of
6 the pulmonary function tests. And then I give the
7 assessment and prognosis.
8 Q. The assessment and program noises are pretty
9 boilerplate templates?
10 A. Basically templates, and I say use the
11 standard assessment except make this change or that
12 change, and the standard prognosis with this change or
13 that change.
14 Q. Thank you. With respect to these residents
15 such as Kendall --
16 A. I'm sorry. Can I interrupt one more time?
17 Q. Sure.
18 A. Occasionally someone doesn't fit into the
19 standard assessment or prognosis and I'll say, "Forget
20 the template," and I'll just dictate it word for word.
21 Q. Thank you for doing that. I appreciate it
22 and that will help us when we go through these to
23 expedite the process.
24 Back with Dr. Kendall McKenzie, do you know
25 how much the residents were paid by Healthscreen to do

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1 these physical exams and medical histories?
2 A. Back at the time when I was medical
3 director, they were paid a thousand dollars a day
4 regardless of how many patients they saw.
5 Q. And roughly how many patients would they see
6 in a day? Do you know?
7 A. Anywhere from twenty to forty, probably
8 average about twenty-five.
9 Q. Did you get any type of percentages from
10 those screening doctors who did the exams?
11 A. No.
12 Q. In other words, did you get part of that
13 thousand dollars per day or anything like that?
14 A. Not one penny of it.
15 Q. Back on the template, on the history
16 information, would you make some type of notations
17 about the frequency of exposure as well?
18 A. Basically it would say, Did you have heavy,
19 light, moderate exposure, frequent or -- well,
20 actually, no. It was just like heavy, moderate, or
21 light exposure.
22 Q. But we wouldn't get into the frequency? In
23 other words, did this happen once a week or once a
24 month, those type of frequency questions?
25 A. It's not explicit in the history and

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1 physical. They would usually add that.
2 Q. Would we get into the duration of the
3 exposure in terms of how long of a time period they
4 would in fact be exposed to that circumstance?
5 A. It would have the work dates at that place.
6 Q. But just because you worked at a place
7 doesn't necessarily mean you've been exposed, right?
8 A. That is correct.
9 Q. So we didn't really get the duration of
10 specific exposures; is that correct?
11 A. That is correct, not specifically. A lot of
12 these patients can't tell you that because they don't
13 even know themselves.
14 Q. With respect to the work history forms,
15 wouldn't it be important to have those available to
16 us, which I know you're going to ask for, to make a
17 determination as to how specific Mr. Drosche was in
18 this instance?
19 A. I think it would be a valuable addition.
20 Q. All right. With respect to occupational
21 exposure histories, do you assume a time-weighted
22 average of exposures? Do you know what that is,
23 Doctor?
24 A. The time-weighted exposure?
25 Q. Yes. Do you know what a time-weighted

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1 average is for occupational exposure?
2 A. I would assume time-weighted average is the
3 average amount of exposure you have over a certain
4 period of time, yes.
5 Q. Do you know what the permissible exposure
6 limit is for asbestos these days?
7 A. No.
8 Q. Do you know whether that's on a
9 time-weighted basis or not?
10 A. I do not know. Do you mind if I take a
11 quick break?
12 MR. SETTER: Sure. We're off the record.
13 - - -
14 (Off the record.)
15 - - -
16 BY MR. SETTER:
17 Q. Doctor, on these pulmonary function tests
18 that we have for Deposition Exhibits 4, 5 and 6, Mr.
19 Lehmann, Drosche, and Doelitsch, there are notations,
20 are there not, Doctor, on these tests of something
21 called an E code?
22 A. Yes.
23 Q. What is an E code?
24 A. An E code is a code telling us whether or
25 not these tests are reliable, whether they, you know,

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1 are reliable in that they'll be duplicated with
2 recurrent testing.
3 Q. Do you know who came up with these E codes?
4 A. No, I do not.
5 Q. Do you know if they are also known as error,
6 E-R-R-O-R, codes?
7 A. Yes, they are.
8 Q. Do you know if that's part of the equipment?
9 A. It's programmed into the computer.
10 Q. Do you know if Ms. Petrini was involved in
11 programing these computers for error codes?
12 A. I do not know that.
13 Q. Do you know if these error codes have any
14 type of tie-in to any type of standards or criteria?
15 A. I believe they do.
16 Q. And do you know what standards or criteria
17 they tie in to?
18 A. I believe they use the Crapo/Hsu criteria.
19 Q. And, Doctor, I don't means to mince words
20 with you, but those are predicted values, not error
21 codes.
22 A. Okay.
23 Q. Are you a member of the American Thoracic
24 Society?
25 A. I am not.

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1 Q. Do you know who the American Thoracic
2 Society is?
3 A. I'm aware of the American Thoracic Society.
4 Q. What is it?
5 A. I believe it's largely a group of
6 pulmonologists and pulmonary researchers who formed a
7 society to -- I know among their standards they make
8 consensus statements on establishing criteria for
9 various illnesses and recommendations to doctors.
10 Q. Do you know if the American Thoracic Society
11 has issued a consensus statement about asbestosis?
12 A. Yes, they have.
13 Q. Do you know what year that was?
14 A. I believe it was 1988 or '86. It was in the
15 eighties.
16 Q. And have you read that statement?
17 A. Yes, I have.
18 Q. Do you agree with it?
19 A. I mean, it's a guideline. It's a consensus
20 statement, a guideline issued to people who are
21 evaluating people for asbestos-related disease, and I
22 follow the guidelines in general.
23 Q. Do you know whether the ATS 1986 criteria
24 requires a 1/1 as opposed to 1/0 for diagnostic
25 purposes?

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1 A. They recommend a 1/1. They do not issue
2 strict guidelines stating that if it's not a 1/1 it
3 does not meet it. They state there are many criteria
4 for diagnosing whether or not asbestosis is present
5 and they have also said explicitly in their statement
6 that it is possible to have asbestosis despite a
7 completely normal chest x-ray. They also said it's
8 possible to have it with a normal chest x-ray and
9 normal pulmonary function testing, although if those
10 are normal, it's very, very difficult for a doctor to
11 back up his opinion, so they warn that you should be
12 very careful when making these diagnoses without
13 adequate criteria. But they do not issue strict
14 standards stating that if you don't have a 1/1, you
15 cannot have asbestosis.
16 Q. Thanks. If I understood part of your answer
17 correctly, you're saying technically under the ATS you
18 could have only an occupational history and latency
19 and that could be sufficient to make a diagnosis?
20 A. I wouldn't say it would be sufficient to
21 make a diagnosis. They said it's possible that
22 asbestosis could be present. But if those tests are
23 normal, about the only way to determine would be to do
24 an open lung biopsy, which is not recommended because
25 it's potentially dangerous to the patient and it

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1 specifically says they don't recommend doing lung
2 biopsies strictly for financial reasons.
3 Q. Here's where I'm going, Doctor.
4 Specifically with what you have done with
5 Healthscreen, if we now say, for lack of better terms,
6 there's a conflict of opinion about the ILO so,
7 therefore, you can consider it, and if we find
8 individuals with basically normal pulmonary function
9 so that's not a factor, then we're left with either
10 findings on a physical exam, latency, or occupational
11 exposure; is that right?
12 A. Would you say that again, please.
13 Q. Well, I guess basically what I'm saying is,
14 if there's no pulmonary impairment and the x-rays are
15 not in the picture because there's a conflict, then
16 we're left with what is found on the examination, the
17 history of exposure, and the latency?
18 A. That would be correct.
19 Q. Would you agree with me that you could never
20 make a diagnosis of asbestosis solely upon the x-rays?
21 A. I don't like to say "never" at any time with
22 regards to medicine.
23 Q. All right. Let me back up. That's a fair
24 comment. Would you say it's more likely than not that
25 you shouldn't medically make a diagnosis in most cases

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1 based solely upon an x-ray of asbestos-related
2 conditions?
3 A. I disagree. If you have a patient with a
4 history of exposure that's adequate, a documented
5 latency period, a positive chest x-ray, but has a
6 normal physical exam and normal pulmonary function
7 tests, it is still possible to make that diagnosis and
8 it says so in the ATS consensus statement because
9 frequently the chest x-ray will be the first thing to
10 turn abnormal. Frequently or usually the pulmonary
11 function tests will then turn abnormal after the chest
12 x-ray, and frequently you don't see the physical
13 findings until late in the disease.
14 Q. I understand. But here was my question.
15 Let me try it again. If you only have the x-ray,
16 that's the only information you have, okay?
17 A. So you don't have a history and physical,
18 and you don't have --
19 Q. You don't have anything else other than the
20 fact that you're presented with an x-ray. The best
21 you can say is you have lung markings that are
22 consistent with; isn't that right, Doctor?
23 A. That is correct.
24 Q. Because that "consistent with" could be also
25 consistent with many other factors?

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1 A. That is correct.
2 Q. In fact, I notice in many of your reports
3 you'll have a tendency to say that the
4 asbestos-related condition is consistent with
5 asbestosis based upon the abnormalities on the chest
6 x-ray; is that right?
7 A. Correct. Well, I read the chest x-rays
8 basically almost verbatim from the B-Read. If the
9 B-Readers say that, then I just translate it directly.
10 Q. Okay.
11 A. And then in my own assessment, I go down
12 lower and state.
13 Q. Going back to Mr. Drosche, for example, on
14 your assessment, you say he has a history, he has a
15 latency, and he has parenchymal abnormalities on x-ray
16 which are consistent with asbestosis?
17 A. Yes.
18 Q. And then you talk about diffusion capacity
19 as well that correlates the interstitial radiographic
20 abnormalities?
21 A. Correct.
22 Q. And specifically, you don't come in there
23 and say on a diagnostic basis he has asbestosis; you
24 say, at best it's consistent with?
25 A. I did not say this patient definitely has

1 asbestosis. I said these findings are consistent with
2 asbestosis.
3 Q. Thank you. With respect to those error
4 codes, would you want to see any of the trials that
5 are performed that had error codes? I mean, in other
6 words -- let me perfect that question. Would you like
7 to see all the trials performed with all of the error
8 codes?
9 A. To tell you the truth, I'd prefer to see the
10 tests that don't have the error codes because those
11 are the ones that are considered to be more reliable.
12 If a test isn't reliable due to error codes, then I
13 don't really even care to bother looking at it because
14 I don't consider it to be a reliable test.
15 Q. Do you know if Healthscreen provides you
16 only the trials that have no errors on the error codes
17 as opposed to all the trials that are performed for
18 the individual?
19 A. To the best of my knowledge, they provide me
20 with all the tests they've done. But if there are
21 tests with error codes, they usually disable those so
22 they are not factored into the summary.
23 Q. And specifically, Doctor, what I'm asking is
24 whether you get -- whether you see the trials that are
25 performed on pulmonary function tests that have

1 errors?
2 A. I frequently do. And sometimes patients
3 will do numerous tests and they can never get a test
4 without an error code, and then they just send me the
5 tests that have the error codes. Well, I get the
6 tests with error codes even when they have good tests.
7 So, yeah, they frequently send me the ones with and
8 without.
9 Q. Would you want Healthscreen to send you all
10 the trials that have been performed or is it okay with
11 you if they delete trials that are being performed on
12 these individuals?
13 A. It is okay with me if they delete trials
14 that are considered to be -- that have error codes.
15 But even when they're deleted, they would usually be
16 on the printout, and then they're just deleted with
17 respect to the summary sheet. But it will usually be
18 on the printout.
19 Q. Let's go to Deposition Exhibit Number 6,
20 which is Mr. Lehmann. Mr. Lehmann is a fifty-seven
21 year-old individual, correct?
22 A. He was at the time he was tested on May 8th,
23 2001.
24 Q. That's right. And he was two hundred
25 thirty-four pounds at that time, wasn't he?

1 A. Yes.
2 Q. And he was five foot six?
3 A. I have six foot four.
4 Q. Six foot four. I'm sorry, you're right. I
5 read that wrong. Now, on his original test, and I
6 don't know what you've done on Deposition Exhibit
7 Number 6?
8 A. If I can add, if you look at the copies that
9 I brought.
10 Q. Deposition Exhibit Number 6 you're referring
11 to?
12 A. Yes.
13 Q. Copies being the PFT sheet?
14 A. If you're looking at the summary sheet of
15 the PFTs, you'll see that I have hand crossed out the
16 numbers under the lung volumes.
17 Q. I see that.
18 A. And written in new numbers. I did that
19 yesterday. This is embarrassing to me as well as to
20 Healthscreen. There was a problem with that test that
21 somehow got by me when I initially dictated it, and I
22 didn't pick it up until I was reviewing this after I
23 had already been notified I was going to be deposed on
24 this person.
25 I picked that up a couple of days ago and I

1 immediately called Dr. Petrini and had her pull up a
2 copy, and we went over it together and we agreed that
3 there was a problem there. And I'm sort of stunned
4 because this is so unbelievably rare that it could get
5 by all of our different quality assurance measures
6 because we have very strict quality assurance and it's
7 very rare for something like this to happen.
8 Q. So you met with Dr. Petrini about this
9 particular test?
10 A. Over the a phone a couple of days ago after
11 I reviewed this and said, Uh-oh, there's a problem
12 here.
13 Q. Let's pick up and identify what that problem
14 is.
15 A. The problem was on the lung volumes. If you
16 go to lung volume page -- it doesn't have a page
17 number. I'll show you the one that has the error
18 codes on it. There are two tests.
19 Q. Let me describe that for the record. For
20 the record, it would be on Deposition Exhibit Number
21 6. It would be the third page of the pulmonary
22 function test.
23 A. After the summary sheet.
24 Q. I'm sorry. It would be the fourth -- fifth
25 page, and the page you're referring to starts with a

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1 value of TLC and at the bottom has LVol date?
2 A. Yes.
3 Q. Is that the page we're referring to?
4 A. That is the page.
5 Q. All right. So if we look at that page, what
6 do we get?
7 A. We get two different lung volume readings
8 that are -- have a pretty large variation between the
9 two sets of readings with regard to the lung volumes.
10 Test one says 6.86; test two says 5.23.
11 Q. Okay.
12 A. And they want to pick the best test for the
13 lung volume.
14 Q. Right.
15 A. And the tech -- there were no error codes
16 listed. And the tech apparently -- after I consulted
17 with Dr. Petrini, it appears the tech disabled the
18 wrong test and disabled the better test accidentally,
19 and so we got the poor lung volume readings. Now,
20 this has happened a couple of the times in the past
21 with other patients and it's rarely changed my
22 diagnosis, but in this case it does.
23 Q. It changes your diagnosis significantly,
24 doesn't it, Doctor?
25 A. It does. Yes, it does.

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1 Q. We're not longer restrictive; is that right,
2 Doctor?
3 A. That is correct.
4 Q. Okay. Now, let's get to the bottom of what
5 happened here on Deposition Exhibit Number 6, okay?
6 You're telling me Exhibit 6 has two lung volume
7 trials, correct?
8 A. Yes.
9 Q. And you're telling me initially we listed
10 the second lung volume trial as the summary; is that
11 correct?
12 A. Well, it was a combination of the two. It
13 was an average. But when I went over it with Dr.
14 Petrini, she agreed that that second lung volume was
15 not adequate and they disabled the wrong test and they
16 should have used the good test.
17 Q. Well, here's the problem I've got, Doctor,
18 and let's go through these one by one. On the summary
19 sheet you have a total lung capacity originally of
20 5.66 liters, correct? I'm talking on the summary
21 sheet for this individual.
22 A. On the summary sheet, yes.
23 Q. Deposition Exhibit Number 6, the first page
24 of the PFTs, before you crossed it out -- it says 5.66
25 where it's crossed out?

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1 A. Right.
2 Q. And he would have a lung volume of
3 sixty-nine percent?
4 A. That is correct.
5 Q. Where did that come from?
6 A. That came from -- the second lung volume was
7 5.23, and I don't know how it got to 5.66. But the
8 5.23 volume was not correct. It was -- we wanted --
9 are you going somewhere?
10 Q. No, I'm listening.
11 A. They used both of these lung volumes.
12 According to Dr. Petrini, they accidentally disabled
13 the good test and empowered the bad test.
14 Q. Can you do that?
15 A. The 5.23. You're not supposed to do that.
16 Q. You can accident -- let's go back and read
17 back on the record his answer, please. I didn't hear
18 that quite -- "You can accidentally," starting there.
19 A. They --
20 Q. Hang on.
21 - - -
22 (Whereupon, the desired portion of the
23 testimony was read back.)
24 - - -
25 BY MR. SETTER:

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1 Q. Thank you. So you can accidentally take out
2 the good test and put in a bad test; is that right?
3 A. Yeah, apparently it was done.
4 Q. And did you talk to Dr. Petrini about how
5 this was done that you accidentally take out the good
6 test and put in the bad test?
7 A. She said they hit the wrong button.
8 Q. Okay. Now getting back to my question about
9 the 5.66, we don't know how that's derived, do we?
10 A. I don't.
11 Q. There's also a value there for residual
12 volume of 0.39 that you crossed out?
13 A. Correct.
14 Q. Does that show up on the fourth -- fifty
15 page here of the PFT, that value as well for residual
16 volume? It does; does it not?
17 A. Yes, it does.
18 Q. 0.39, it comes from the second trial?
19 A. Correct.
20 Q. All right. How about any of these other
21 values? The VC for 5.27, where does that come from?
22 A. I don't know where that came from.
23 Q. Doctor, could it be we have a phantom trial
24 in here that's altering the values?
25 A. I suppose that's possible.

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1 Q. Has this happened more than once at
2 Healthscreen?
3 A. I think it has happened very, very rarely.
4 Q. All right. Dr. Petrini would be very
5 knowledgeable about this particular test?
6 A. Extremely knowledgeable.
7 Q. Does she have an opinion as to how this
8 exactly happened?
9 A. She said that the tech disabled the wrong
10 test.
11 Q. And the tech can disable the wrong test. Do
12 you know if there's been training about how to, as you
13 put it, get rid of the good test and put in the bad
14 test at Healthscreen?
15 A. They are trained not to do that. They are
16 trained to keep the good test and get rid of the bad
17 test.
18 Q. But in doing that training, don't they also
19 show them how they could get rid of the good test and
20 put in the bad test, just like they did here with this
21 individual?
22 A. This was accidental. They are trained. Dr.
23 Petrini is very, very strict and wants -- has made it
24 very clear that we are to do everything aboveboard at
25 all times to do the best testing possible. Sometimes

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1 accidents happen. And this happened and that's why I
2 was volunteering that they gave the wrong numbers and
3 that the numbers were not as good as they should have
4 been. We --
5 Q. Has Dr. Petrini -- I'm sorry.
6 A. We do not try to hide anything. We try to
7 be as straight -- a hundred percent honest all the
8 time.
9 Q. Would Dr. Petrini be so knowledgeable that
10 she could teach technicians how to get rid of the good
11 test and put the bad test in?
12 A. If she wanted to do that, she could, but
13 that is absolutely against everything she stands for.
14 Q. And she has that kind of expertise and
15 knowledge to do it, doesn't she?
16 A. Sure she would, but she would not do that
17 because she -- it has always been the mission of
18 Healthscreen to do the best quality, most honest
19 testing that can possibly be done and that is what she
20 always drills these techs on.
21 Q. All right. But we have a phantom result
22 showing up and interfering with your conclusions on a
23 diagnostic basis of restriction on this particular
24 individual, Mr. Pat Lehmann, correct?
25 A. That is correct. That is very rare.

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1 Q. The tests that you tell me that are now
2 reliable, he has normal spirometry, correct?
3 A. Correct.
4 Q. He has no restriction whatsoever?
5 A. That is correct.
6 Q. But we still have a diffusion problem?
7 A. Yes.
8 Q. Are we sure that's accurate and true?
9 A. Yes.
10 Q. How do you know that, Doctor?
11 A. I went over all of these tests with Dr.
12 Petrini.
13 Q. Okay. And she told you that's true and
14 accurate?
15 A. And we went over all of them and the tech
16 did everything right on the spirometry and the
17 diffusion; it was a mistake on the lung volumes only.
18 Q. Okay. Doctor, do you know if you used
19 different predicted sets for diffusion capacity what
20 that would do for this individual, Pat Lehmann, for
21 his diffusion capacity?
22 A. If we used different predictions of what
23 the --
24 Q. Normal?
25 A. -- of what normal would be?

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1 Q. Yes.
2 A. Well, it could change the answer.
3 Q. And are you familiar with a predicted set
4 called Miller?
5 A. I've heard of it.
6 Q. Doctor, if I represented to you that if we
7 used the Miller predicted sets for Pat Nelson Lehmann
8 that he would in fact have a diffusion capacity of
9 eighty-one percent of those predicteds --
10 A. I would have to take your word for it.
11 Q. Okay. Let's just assume for the sake of
12 argument that is the case. Would that show that he
13 doesn't have a diffusion capacity problem?
14 A. I would prefer to consult with Dr. Petrini
15 to see why she used the Crapo/Hsu as opposed Miller
16 criteria. I'm sure she has a reason for it.
17 Q. Well, the reason is the Crapo predicted
18 values for diffusion capacity are the highest
19 predicted values that exist. Is that one of the
20 reasons she uses them?
21 A. I wouldn't --
22 MS. BOONE: Object to form.
23 A. I would not know. You would have to ask her.
24 BY MR. SETTER:
25 Q. Isn't that why she does that? That helps

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1 her clients get the result that they want, that is a
2 lower diffusion capacity being shown on people tested.
3 MS. BOONE: Objection to form.
4 A. I would not know. I would have to ask Dr.
5 Petrini.
6 BY MR. SETTER:
7 Q. Aren't you the doctor? Aren't you the
8 medical doctor? Aren't you the one setting predicted
9 values?
10 A. No, I am not. It is Dr. Petrini who is a
11 Ph.D in pulmonary function testing.
12 Q. Is she a Ph.D in pulmonary function testing
13 or physiology?
14 A. Pulmonary physiology. Her specialty is
15 pulmonary function testing. That is what she does.
16 That's what her thesis is on. As I said, she teaches
17 the pulmonologists how to read PFTs. She's the one
18 who taught me to read PFTs, and her knowledge is
19 vastly superior to mine when it comes to pulmonary
20 function testing.
21 Q. She also taught the technicians on how to
22 not get rid of a good test, but how to get rid of a
23 bad test and put a good test in; is that right?
24 A. That's correct. She teaches the technicians
25 how to do proper testing.

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1 Q. With respect to Mr. Lehmann, do you know
2 whether or not he has high cholesterol?
3 A. Yes, it was written in my medical history.
4 Q. Would high cholesterol have an effect on
5 diffusion capacity?
6 A. It should not.
7 Q. You don't believe it does. Have you ever
8 seen anything put out by the American Thoracic Society
9 about that, Doctor?
10 A. No.
11 Q. If we had the Miller predicted values as I
12 represented and he was normal, we would then basically
13 have, in light of these changed tests for lung
14 volumes, normal diffusion capacity, normal lung
15 volumes and normal spirometry, assuming my
16 representation about the Miller predicteds?
17 A. I can only assume based on what you're
18 telling me.
19 Q. But that would be true. We have normal
20 spirometry, correct?
21 A. We do.
22 Q. We have normal lung volumes?
23 A. Well, according to Crapo/Hsu, we have normal
24 spirometry, normal lung volumes. I don't know what it
25 would be according to Miller because that's not what

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1 was plugged into our computer.
2 Q. All right. Let's go back over that then.
3 According to Crapo, we would have normal spirometry
4 and normal lung volumes?
5 A. Yes.
6 Q. And for diffusion capacity, if you assume my
7 agreement of using the Miller predicted that it would
8 be normal, that would also be a normal value. What
9 I'm going after, Doctor, is if those were normal
10 spirometry, normal lung volume, and normal diffusion
11 capacity. That's my hypothetical, okay? Just assume
12 that.
13 A. If we're assuming everything is normal, then
14 everything is normal.
15 Q. Right, for pulmonary function tests?
16 A. For a pulmonary function test.
17 Q. Okay. Then this individual would only have
18 x-ray changes which may be subject to another
19 B-Reader's report as being normal, so we would rule
20 that out as well, correct?
21 MS. BOONE: Objection to form.
22 BY MR. SETTER:
23 Q. All right. Let me start over. If we use
24 the Miller predicted values, the diffusion capacity
25 would be normal under my hypothetical, correct?

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1 A. If you say so.
2 Q. So if we have now normal pulmonary function
3 tests, that's no longer an issue for your evaluation
4 for Mr. Lehmann?
5 A. That would be correct.
6 Q. If we have an adverse ILO opinion saying
7 that he's normal, you would say that the x-ray
8 evaluation does not become a determination that you
9 can rely upon?
10 A. That would be correct.
11 Q. So then for Mr. Lehmann, we're back to what
12 components of significance to you in terms of the
13 issues presented by the lawyers, Nix Patterson?
14 A. If -- well, first of all, the physical exam
15 by Dr. McKenzie, the extremities say demonstrate
16 clubbing, so he said there was clubbing. Okay. Now,
17 asbestosis is not the only thing that causes clubbing.
18 Other diseases cause that, too.
19 Q. Staying with that, such as what, as some
20 examples?
21 A. Such as some congenital heart disease, other
22 types of pulmonary fibrosis. Sometimes lung cancer
23 can do it.
24 Q. Coronary artery disease?
25 A. Does not cause clubbing. So, the chest

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1 x-ray that I was provided with said it was positive.
2 But if you're telling me if you were to give me a
3 normal chest x-ray and if you were to give me
4 completely normal pulmonary function tests, I
5 personally, on this patient, would not feel
6 comfortable diagnosing him with asbestosis.
7 Q. Okay. And that's all I'm saying, is if we
8 just take those two elements out, the x-rays and the
9 pulmonary function tests, for the sake of argument,
10 then you have no basis to make a diagnosis of
11 asbestosis without them?
12 A. Correct. I would only say that he had an
13 exposure history and a latency period.
14 Q. You wouldn't expect the finding of clubbing
15 to resolve itself in a later physical examination by
16 another physician?
17 A. I would not expect clubbing to resolve
18 itself; however, clubbing is a subjective finding, and
19 one doctor might say there's clubbing and another
20 doctor might say there isn't.
21 Q. Let's go to Deposition Exhibit Number 5, if
22 you don't mind. That's Mr. Doelitsch.
23 A. Okay.
24 Q. I hope I didn't butcher his name too badly.
25 Now, the materials that you had for Deposition Exhibit

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1 Number 5 do not include this first page by Roderick
2 Mitchell. That's been given to you by Nix Patterson?
3 A. Correct.
4 Q. And then I'm just looking through the
5 exhibits so we're clear. What else has been provided
6 to you, if anything, by Nix Patterson?
7 A. The pathology report from Scott and White
8 Memorial Hospital about the colon cancer, and let's
9 see what else. The CT scan performed by Red River
10 Valley Radiology Associates, the colonoscopy report,
11 there is another pathology report, pathology report on
12 the prostate biopsy.
13 Q. Let's make this clearer for the record, if
14 you don't mind, Doctor.
15 A. And a surgery report.
16 Q. The materials that you relied on as part of
17 your evaluation would -- and your evaluation report is
18 dated June 7, 2001, correct?
19 A. Correct.
20 Q. Would include only the pulmonary function
21 tests dated May 9th, 2001?
22 A. Yes.
23 Q. And the January 19th, 2001 radiological
24 report, for lack of a better term, by Dr. Levine?
25 A. Correct.

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1 Q. And the B-Read report by Dr. Levine dated
2 January 25th, 2001?
3 A. January 19th, 2001.
4 Q. I'm sorry, January 19th.
5 A. And the history and physical form.
6 Q. And the history and physical form. Now,
7 have you read the other materials from the Red River
8 Radiology Associates, Roderick Mitchell, et cetera?
9 A. Yes, just in the last few days.
10 Q. Have they changed your opinion?
11 A. No.
12 Q. Let's stay with your report first. Mr.
13 Doelitch is tested on May 9th, 2001, correct?
14 A. Correct.
15 Q. You dictate your report May 23rd, 2001 and
16 it's actually signed, presumably by you, at that time?
17 A. On June 7th.
18 Q. June 7th, I'm sorry. When would Dr.
19 McKenzie sign these? Would he sign them before or
20 after you signed?
21 A. After.
22 Q. Would you dictate the report and then the
23 report would be shipped back to you for signature?
24 A. Yes. What happens is I dictate the report.
25 I send the tape to the transcriptionist. They

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1 transcribe it. They e-mail it to me, the transcribed
2 report. I then download the report, print it out at
3 my home, sign it. I send the report to Healthscreen
4 and then Healthscreen takes the report to Dr. McKenzie
5 to sign.
6 Q. Thank you. Now, with respect to this
7 individual, George Doelitsch, we reached the
8 conclusion from an impairment standpoint he has
9 obstructive lung disease; is that right?
10 A. That is correct.
11 Q. He does not have a restrictive pattern; is
12 that correct?
13 A. That is correct.
14 Q. All right. And you make a note for Mr.
15 Doelitsch that he should see his personal physician as
16 soon as possible for a complete evaluation of his
17 chest discomfort?
18 A. That is correct.
19 Q. And was this picked up by Dr. McKenzie as
20 part of the examination?
21 A. It was picked up in the review of systems.
22 Q. But almost a month goes by before that's
23 actually signed off in a report; is that correct?
24 A. Before it's signed off on a report. Whether
25 or not Dr. McKenzie advised him to see his personal

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1 physician at the time of the history and physical, I
2 don't know.
3 Q. Do you know if your report ever ended up in
4 the hands of George Doelitsch?
5 A. I do not know.
6 Q. It would be sent back to Healthscreen and
7 they would send it to?
8 A. The attorneys.
9 Q. Where I'm going with that, Doctor, was there
10 any other follow-up by you concerning that concern
11 about his chest discomfort?
12 A. No.
13 Q. By the way, I don't know if you answered the
14 question. I'm sorry if I repeat myself. Do you carry
15 malpractice for Healthscreen's work?
16 A. No, I do not.
17 Q. Does Healthscreen carry any type of medical
18 malpractice?
19 A. I do not know.
20 Q. Thank you. Does Mr. Doelitsch have coronary
21 artery disease?
22 A. He had not been diagnosed with it.
23 Q. Do you know if his prior stroke condition
24 could be part of the reasons that he has chest pain
25 that worsens with exertion?

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1 A. Stroke does not typically cause chest pain,
2 but the same problem that can cause a stroke can also
3 cause coronary artery disease, so it puts him at high
4 risk.
5 Q. Fair enough. Would you agree that the
6 pulmonary function tests show an obstructive lung
7 disease on an individual that was a smoker, that is
8 Mr. Doelitsch?
9 A. What is the question?
10 Q. He's got an obstructive lung issue and he
11 was a smoker, correct?
12 A. That is correct.
13 Q. Are you saying the obstructive lung issue is
14 attributable to asbestos or are you making a
15 distinction as to what it's attributable to in this
16 report?
17 A. I believe his obstructive lung disease is
18 due to his smoking.
19 Q. It's not attributable to asbestosis?
20 A. No.
21 Q. That's all I'm asking. I just want to make
22 sure I'm clear. So you know he has obstructive lung
23 disease and it's attributable to smoking. Would that
24 also be part of the issue in terms of his diffusion
25 capacity problems?

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1 A. It could.
2 Q. If he has COPD, for example?
3 A. That can definitely lead to a diminished
4 diffusion coefficient.
5 Q. Now, if we go to the pulmonary function
6 test, are you familiar with the value called
7 inspiratory vital capacity?
8 A. Inspiratory capacity, yes.
9 Q. What is the inspiratory vital capacity for
10 George Doelitsch in Deposition Exhibit Number --
11 MR. BURNS: 5.
12 Q. -- 5?
13 A. Huh.
14 Q. 5, Deposition Exhibit Number 5.
15 A. Oh, okay. The inspiratory capacity here was
16 listed as 2.22 was his best.
17 Q. I'm sorry. Where are you looking?
18 A. Page --
19 Q. I'm sorry. I meant to say inspiratory vital
20 capacity.
21 A. You mean the vital capacity?
22 Q. Inspiratory vital capacity determined on
23 diffusion.
24 A. Oh, on the diffusion. On the diffusion
25 sheet, the inspiratory vital capacity was determined

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1 to be 3.34.
2 Q. And his best inspiratory vital capacity was
3 3.46; was it not?
4 A. Correct.
5 Q. Now, going back to the summary sheet for his
6 PFTs, his vital capacity for lung volume and forced
7 vital capacity is 3.25; is it not, Doctor?
8 A. 3.25, yes.
9 Q. All right. What's the difference of a 3.46
10 for inspiratory vital capacity and a 3.25 for forced
11 vital capacity or the vital capacity on the lung
12 volume?
13 A. I believe the inspiratory vital capacity on
14 the diffusion coefficient is done with the diffusion
15 method of nitrogen washout, whereas the vital capacity
16 obtained on lung volumes is done by an equation. It
17 is done in a totally different manner where they take
18 the total lung capacity and subtract the residual
19 volume to get a vital capacity, so they're calculated
20 by two different methods, so that can explain a small
21 difference.
22 Q. But my question is this, Aren't they
23 measuring the same thing? Vital capacity is vital
24 capacity is vital capacity?
25 A. Yes, but one is a direct measurement and one

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1 is derived from an equation based on other readings,
2 so they're not going to be absolutely exact, but they
3 should be very close in the same ballpark.
4 Q. Well, wouldn't you agree with me
5 statistically a .2 liter difference of that magnitude
6 of a 3.25 versus a 3.46 is probably very significantly
7 different?
8 A. Well, the average here, what it does on the
9 DICO is it averages the two best. And the average of
10 the two best is 3.34, which I would say is not
11 significantly different from 3.25. That is a minimal
12 difference. So I would say they agree with each
13 other. They're in the very same neighborhood.
14 They're very close.
15 Q. That is the average, but the 3.46 is not
16 within the balance park of 3.25?
17 A. They're still -- I think they are still
18 within the realm of laboratory error on any good test.
19 I don't think that's unreasonable at all. And if you
20 want more information, I'm sure Dr. Petrini can get
21 into a very long dissertation on that for you if you'd
22 like.
23 Q. Good. I look forward to it. All right.
24 For Mr. Doelitsch, let's go now to the lung
25 volume sheet, if you will, the one with the graphs for

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1 the lung volumes. There you go. We have three trials
2 there, one, two and three; do we not, Doctor?
3 A. Yes.
4 Q. Do you see that?
5 A. Yes.
6 Q. The second trial, we're missing the TLC?
7 A. Right.
8 Q. What's going on there?
9 A. That was an inadequate test. The computer
10 did not even register the number because the patient
11 -- I don't know if he had an air leak or he had bad
12 technique. For some reason, it didn't even measure on
13 the computer, so they disabled the test. It's just a
14 bad test.
15 Q. So that's one of those bad tests that we
16 didn't delete?
17 A. It was a bad test that did not figure in the
18 summary sheet. They deleted it. I mean, it printed
19 out, but for the purpose of determining what his true
20 lung volumes are, that was not used to calculate on
21 the summary sheet.
22 Q. Okay. But we've got a 3.29 for the VC on
23 that one, and that's best VC you got on the lung
24 volumes?
25 A. Yeah, but that's a completely inaccurate

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1 test. It didn't even register a total lung volume.
2 It's worthless test.
3 Q. And we got rid of the one with the highest
4 VC, that's all my point is, correct?
5 A. The point is, that's not a reliable number.
6 Q. But we did get rid of the one with the
7 highest VC; isn't that right, Doctor?
8 A. Yes.
9 Q. Thank you.
10 A. Because it was not reliable.
11 Q. For FRC, we have a statement there in graphs
12 of 4.11 liters; is that correct?
13 A. Where are you looking?
14 Q. I'll point for you. I don't know if you can
15 read that copy.
16 A. I can't.
17 Q. You can't read your copy?
18 A. No.
19 Q. I'll show you mine.
20 A. Okay.
21 Q. Mine says 4.11 liters.
22 A. Yes, that's what it says.
23 Q. Let me have that back. Assume for the sake
24 of argument that it says 4.11, and we'll have to make
25 different copies. In fact, we will do this. I will

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1 be happy to mark this as a deposition exhibit so you
2 can clearly see it and the record is very clear maybe,
3 if I can find it.
4 MR. SETTER: Let's mark this as 7.
5 ---
6 (Whereupon, Exhibit 7 was marked.)
7 ---
8 BY MR. SETTER:
9 Q. Doctor, I'm going to mark Deposition Exhibit
10 Number 7, which is another photocopy of the pulmonary
11 function test for Mr. Doelitsch and specifically, so
12 it shows up in the record, I'll show you the FRC in
13 the graph area of his test is 4.11 liters. Do you see
14 that, Doctor?
15 A. Yes, I do.
16 Q. Where is that test? Because the ones I have
17 for trial one, we have an FRC of 3.37 for trial one.
18 For trial two, what's the value there?
19 A. 0.06 that's why that whole test was
20 considered --
21 Q. I understand, but that's not 4.11 liters, is
22 it?
23 A. No, it's not.
24 Q. And then the third trial that's shown there
25 is 3.85 liters, right?

1 A. That's correct.
2 Q. So where is the test with the 4.11 liters?
3 A. I have no idea.
4 Q. Must be missing that one, too, huh?
5 A. I guess.
6 Q. Better call Dr. Petrini up?
7 A. I agree.
8 Q. Okay. Let's keep these together.
9 A. What was that?
10 Q. I said, Keep these together. I'm not going
11 to throw them down there so she keeps track of them.
12 With respect to Mr. Doelitsch on Deposition
13 Exhibit Number 5, just to finish that up, again if we
14 take the chest x-ray out from the standpoint that
15 there is a conflicting x-ray B-Read report, then we
16 cannot make any determinations from a radiological
17 standpoint concerning Dr. -- I mean Mr. Doelitsch?
18 A. To clarify, if the chest x-ray report were
19 normal according to a certified B-Reader, with the
20 pulmonary function results that I have here, I would
21 not feel comfortable diagnosing him with asbestosis.
22 Q. Fair enough, Doctor. Do you know Dr.
23 Roderick Mitchell, who is the individual who did the
24 first page of Deposition Exhibit Number 5, did that
25 report?

1 A. I do not know him.
2 Q. He's apparently an internist in Texas.
3 A. In emergency medicine as well, just like me.
4 Q. I was curious if you knew him.
5 A. I do not.
6 Q. Do you know if Dr. Mitchell has ever done
7 any work for Healthscreen?
8 A. I do not know anything about Dr. Mitchell.
9 Q. Okay. We are moving along. Let's go to
10 Deposition Exhibit Number 4, which is Mr. Larry
11 Drosche's records that you have.
12 A. Do you mind if we take another quick break
13 before we do that?
14 Q. Absolutely.
15 A. Thank you.
16 Q. Before you do that, before you come back,
17 same type of question. I think we already identified
18 these, but let's make sure we understand which ones
19 were part of your file and which ones have been
20 provided to you by Nix Patterson. But let's go ahead
21 and take a break. You can do that before we come back
22 on?
23 A. Okay. Sure.
24 - - -
25 (Off the record.)

1 - - -
2 BY MR. SETTER:
3 Q. Doctor, off the record we were talking a
4 little bit about some of the materials in Deposition
5 Exhibit Number 4. I just want to clarify it as to
6 what we have.
7 The materials that are part of your file
8 would include the first two pages, which is your
9 report, correct?
10 A. Yes.
11 Q. Then you have a radiological evaluation by
12 Dr. Levine?
13 A. Two pages, yes.
14 Q. And then we have a pulmonary function report
15 done on May 8th, 2001, and the first page is a summary
16 sheet?
17 A. Correct.
18 Q. The next two pages are dealing with the flow
19 volume loop?
20 A. Yes.
21 Q. Two more pages dealing with lung volumes.
22 I'm sorry.
23 A. Yes.
24 Q. And then two more pages dealing with DICO?
25 A. Correct.

1 Q. And then in addition -- I don't want to take
2 these out of the exhibit, but we talked about this off
3 the record -- we have one, two, three, four, five,
4 six, seven, eight, nine, ten, eleven, twelve pages all
5 the way down to the Red River Valley Radiological
6 Associates x-ray examination report, pulmonary
7 function test reports that are in one form or fashion
8 a duplication of either lung volumes or diffusion
9 capacity for Mr. Drosche?
10 A. Correct.
11 Q. And then at the very end of Deposition
12 Exhibit Number 4, we have x-ray examination reports
13 that seem to be four copies of the same thing, if I'm
14 correct?
15 A. Yes.
16 Q. From Dr. Steven Clifford?
17 A. Which is the result of a CT scan.
18 Q. Okay. Did you rely on anything from the CT
19 scan in reaching your opinion in your report?
20 A. No, I did not have that at the time I did my
21 report.
22 Q. Okay. As we sit here today, do you rely
23 upon that CT report for any reason?
24 A. No, it was not available to me.
25 Q. As you sit here today, according to the CT

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1 findings, the lungs are entirely clear, correct?
2 A. It was a normal CT scan.
3 Q. All right. Now for Mr. Drosche, if I
4 understand correctly, on physical examination, was he
5 essentially normal in terms of the physical
6 examination findings by Dr. McKenzie?
7 A. Yes, he was.
8 Q. All right. And we see Dr. Levine has the
9 1/0 with no pleural abnormalities, correct?
10 A. Correct.
11 Q. And then we may have an adverse ILO
12 examination that says he's normal, but we don't have
13 that for you today. That could change the
14 radiological evaluation, correct?
15 A. Correct.
16 Q. In other words, it would make it so you
17 wouldn't have an opinion about radiological issues,
18 correct?
19 A. Correct, if I had an official B-Read report
20 that was totally normal.
21 Q. Now, wouldn't the CT evaluation also help
22 you in that regard?
23 A. Yes.
24 Q. Doesn't that show it being in conflict with
25 Dr. Levine in terms of what Dr. Levine found?

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1 A. It was read as normal.
2 Q. Okay. And Dr. Levine found him abnormal and
3 Dr. Clifford on CT found him normal?
4 A. Correct.
5 Q. So we can't rely or you won't rely on that
6 information on the radiological basis to form opinions
7 about Mr. Drosche, correct?
8 A. Correct.
9 Q. All right. On pulmonary function, then we
10 find -- you find that they're within normal limits
11 with the exception of the diminished diffusion
12 coefficient?
13 A. Correct.
14 Q. He has no restriction; is that correct?
15 A. Correct.
16 Q. And he has no obstruction?
17 A. Correct.
18 Q. The only thing that we can say is he has
19 reduced diffusion capacity?
20 A. That is correct.
21 Q. Do you have an opinion as to why he has a
22 reduced diffusion capacity? And it's perfectly fine
23 if the answer is you don't have an opinion; you just
24 know he has reduced diffusion capacity.
25 A. At this time I do not. If you believe Dr.

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1 Levine's report that it was consistent with
2 asbestosis, then that could explain it.
3 Q. However, if you believe Dr. Clifford, then
4 that's not an issue in terms of the asbestos, correct?
5 A. If you believe that there is a totally
6 negative x-ray report, then it could be asbestos but
7 you just can't say that that's the cause of it. The
8 American Thoracic Society consensus paper does state
9 that you can see a diminished DlCO even due to
10 asbestos even with a completely normal chest x-ray.
11 However, I personally would not put myself out on a
12 limb to say this is clearly due to asbestosis if
13 that's the only abnormality I have.
14 Q. Doctor, could we possibly explain this
15 reduced diffusion capacity as a result of testing
16 methodology? Have you looked at that issue?
17 A. As a result of testing methodology?
18 Q. Yes.
19 A. Let me get to the DlCO page. The DlCO tests
20 according to this criteria appear to be reliable and
21 reproducible. Based on these numbers, I would say I
22 feel comfortable saying there is a decreased DlCO.
23 Q. Walk me through -- bear with me. Let's walk
24 through this a little bit. Healthscreen is using a
25 nitrogen washout lung volume test, correct?

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1 A. Correct.
2 Q. And as part of that test, the idea is to
3 washout the nitrogen in the lung with oxygen?
4 A. Correct.
5 Q. To do that, the technician basically fills
6 up the client or patient with O2 as part of the test?
7 A. Correct.
8 Q. In fact, you want to get to a level, and I
9 think we were talking about some of these graphs, if
10 you look at the lung volume, for example, for Mr.
11 Drosche, it says N2 of 0.4 percent. Are you with me
12 on that?
13 A. Yes.
14 Q. So that is telling the technician and
15 whoever printed the report at the point they are doing
16 this lung volume testing, they have Mr. Drosche with
17 99.6 percent O2 in his lung; is that right?
18 A. It says -- it says that there's 0.4 percent
19 N2. I cannot give you a hundred percent guarantee
20 that the rest is pure oxygen because --
21 Q. Isn't that the idea on the test?
22 A. It's what they're trying to do.
23 Q. They're trying to give him pure oxygen down
24 to the left that the N2 is basically washed out?
25 A. They're trying to do that, but in reality

1 the only way to truly give someone a hundred percent
2 oxygen is by putting them on a mechanical ventilator,
3 and we don't do that so there are other contaminants
4 that are in there.
5 Q. But the idea is to bring down his N2 level
6 to less than one or two percent?
7 A. Yes.
8 Q. And to fill him with oxygen for the
9 remainder to the extent that it can be done?
10 A. Yes.
11 Q. With the understanding that you may not
12 eliminate all of the other components in there,
13 whatever trace elements may be there, correct?
14 A. Correct.
15 Q. All right. So now we take Mr. Drosche and
16 we fill him up with ninety -- you would agree at least
17 ninety-eight percent oxygen?
18 A. I would say as much oxygen as we can get
19 into him.
20 Q. Okay. Would it be over ninety-five percent
21 at least?
22 A. To tell the truth, most studies have shown
23 that without a mechanical ventilator, it's hard to get
24 much higher than sixty percent oxygen without a super
25 tight seal. The rest would be ambient air.

1 Q. All right. So that would have some --
2 ambient air is mainly nitrogen, isn't it?
3 A. Yeah. They got most of it out, so....
4 Q. So, we now have him filled up with oxygen
5 and what else?
6 A. Oxygen, nitrogen, and whatever else might be
7 contaminants in the tank.
8 Q. But the nitrogen is only at 0.4 percent and
9 my point is the rest would be --
10 A. For the sake of argument, we'll say it's
11 oxygen.
12 Q. Okay. When we're doing this test and we
13 fill him up with oxygen, and whether it's sixty or
14 ninety-eight percent oxygen, the idea is to see how
15 much oxygen can displace the nitrogen?
16 A. Correct.
17 Q. And that's because normally most folks have
18 somewhere around twenty, twenty-one percent O2 in
19 their lungs, and one way to measure lung volume is to
20 replace that O2 -- replace the nitrogen, I should say,
21 with oxygen?
22 A. Right.
23 Q. It's part of this lung volume test?
24 A. Right.
25 Q. Do you know how long a time period you're

1 supposed to wait when you do one of these lung volume
2 trials before you do another trial?
3 A. I've read that before, but I've forgotten
4 the number.
5 Q. For the sake of argument, I'll state to you
6 that it sounds like the ATS requires fifteen minutes.
7 Does that sound reasonable?
8 A. Yes.
9 Q. The reason the ATS requires fifteen minutes
10 before you do another test is why?
11 A. To give time for the nitrogen to wash out.
12 Q. Really to give time for the --
13 A. For the ox --
14 Q. For the oxygen.
15 A. For the oxygen to wash out.
16 Q. Right. So you fill your lungs back up with
17 nitrogen again. And wouldn't it be true, Doctor, that
18 if you don't let the individual fill his lungs back up
19 with nitrogen and then you do a diffusion capacity
20 test, that having all that to O2 in your lungs will
21 decrease the diffusion capacity?
22 A. It certainly could.
23 Q. All right. Now, let's talk about Mr.
24 Droesh. On the lung volume second page that we have
25 here on the pulmonary function test, it starts with

1 TLC and has LVol Date. Are you with me on that one?
2 A. Yes.
3 Q. Do we have an LVol Time?
4 A. Yes.
5 Q. Let's go to the DICO test, okay. This is
6 the one that has the DICO at the top and the DICO time
7 at the bottom.
8 A. Yes.
9 Q. Can we put in order, at least from these
10 time stamps what happened first, second, third and
11 fourth? That's what I'm going to try to do.
12 A. Yes.
13 Q. Would you agree with me that for Mr.
14 Drosche, the first thing that was done is a lung
15 volume test at the hour and minute of 1648?
16 A. Yes.
17 Q. Then it looks to me, and see if you agree,
18 the second thing done was at 1651, three minutes
19 later, he was given a diffusion capacity test?
20 A. Yes.
21 Q. We didn't wait fifteen minutes, did we?
22 A. No.
23 Q. All right. Then the next thing that we did
24 is a lung volume test. No, I'm sorry, another
25 diffusion capacity test at 1658, correct?

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1 A. Correct.
2 Q. And then the fourth out of the four was
3 another lung volume test at 1704?
4 A. Correct.
5 Q. Doctor, here's where I'm going with this.
6 Would you agree that doing the first lung volume test
7 at 1648 would adversely affect the diffusion capacity
8 for Mr. Drosche when it was done in terms of the
9 diffusion capacity, first and second trials, within it
10 looks like ten minutes?
11 A. Both of them were done within ten minutes.
12 Q. Is that right?
13 A. Yes.
14 Q. You think that would have an affect on those
15 values?
16 A. It's possible.
17 Q. Well, did you discuss any of this with Dr.
18 Petrini?
19 A. No.
20 Q. Did you discuss this test with Dr. Petrini?
21 A. No.
22 Q. And if you look at the diffusion capacity
23 for trials one and two -- are you with me? The 23.7
24 and the 24.2?
25 A. Yes.

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1 Q. It seems like they get higher when we get
2 further away from that lung volume test?
3 A. Yes, they did.
4 Q. That would kind of indicate that now that
5 we're getting more nitrogen in Mr. Drosche's lungs,
6 we're getting a better diffusion; is that right,
7 Doctor?
8 A. Yeah, that could be explained that way.
9 Q. Would that possibly maybe be the reason that
10 we have a lower diffusion capacity for Mr. Drosche?
11 A. It's possible.
12 Q. Do you know what the Miller predicted values
13 would say about Mr. Drosche?
14 A. No, I do not.
15 Q. If I represented to you that if we used the
16 Miller predicted values, we would get a DlCO in the
17 eighty percentile, then he would not have an abnormal
18 diffusion capacity, correct?
19 A. I'll have to take your word for it.
20 Q. So we could be explaining his reduced
21 diffusion capacity because of a couple of reasons,
22 just to wrap this up for us. One could be because we
23 were doing the lung volume test and the diffusion
24 capacity test too closely together; is that right?
25 A. That's possible.

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1 Q. And two, we may have predicted values that
2 are too high for Mr. Drosche, and other predicted
3 values would show him normal, and the predicted values
4 being used show him abnormal?
5 A. Possibly.
6 Q. Therefore, he doesn't have a diffusion
7 capacity issue, it's just a matter of what predicted
8 values were being chosen by Dr. Petrini?
9 MS. BOONE: Object to form.
10 BY MR. SETTER:
11 Q. Isn't that right?
12 A. Possibly. I'd have to talk to Dr. Petrini
13 about it.
14 Q. Well, I understand. But if the Miller
15 predicted values show him normal and Dr. Petrini
16 showed him abnormal, it's just a function of predicted
17 values chosen, correct?
18 A. That would make sense.
19 Q. Okay. Doctor, I'd appreciate the
20 opportunity to talk to you about a couple of other
21 files, but I don't think we'll have time today and I
22 understand they're not trial cases, so I'll defer that
23 for some other time.
24 I'm going to let other counsel ask you some
25 questions. Just quickly I want to check some notes.

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1 A. Okay.
2 Q. Doctor, I notice you are making notes during
3 this deposition; is that correct?
4 A. Yes.
5 Q. Do you mind if I photocopy those today?
6 A. Sure.
7 Q. That way I hope you took the notes of the
8 items we're going to ask for?
9 A. Yes.
10 Q. If you don't mind, may I have those today?
11 A. You would like them now?
12 Q. Yes. We'll make a photocopy and mark it as
13 an exhibit. How's that?
14 A. All right.
15 Q. You agreed, I believe, on these three
16 individuals to find the work and medical history
17 forms, exam form, that's all one document, correct?
18 A. Yes.
19 Q. For the three individuals we talked about;
20 the quality assurance reports?
21 A. Yes.
22 Q. If they exist, unacceptable test forms?
23 A. Yes.
24 Q. And I believe the consent forms for these
25 three individuals?

1 A. Yes.
2 Q. And you'll also identify the location of the
3 test for the three individuals?
4 A. Yes.
5 Q. Based upon sign-in sheets?
6 A. Yes. And I'm to provide them to this office
7 here.
8 Q. Yes, to the court reporter. She'll give
9 you her card and if you'll just make photocopies and
10 send them to her. And if you want to charge me for
11 the photocopies, I'd be happy to pay you for that.
12 A. Okay. Thank you.
13 MR. SETTER: For the record, we're going to
14 go ahead and mark your notes as Deposition
15 Exhibit Number 8.
16 ---
17 (Whereupon, Exhibit 8 was marked.)
18 ---
19 BY MR. SETTER:
20 Q. All right. Doctor, we've copied Deposition
21 Exhibit Number 8. Is that a photocopy of your notes?
22 A. Yes, it is.
23 MR. SETTER: Thank you, sir. With the right
24 to come back and ask you further questions, I'm
25 going to pass the witness to expedite the process

1 if you don't mind. Thank you, Doctor, for your
2 time.
3 THE WITNESS: Very well, thank you.
4 MR. SETTER: Any counsel have any question
5 questions on the phone.
6 MS. PHIFER: You did such an outstanding
7 job, I can't think of a single one.
8 MR. SETTER: Oh, come on.
9 THE WITNESS: They were sleeping.
10 MS. PHIFER: Oh, not sleeping.
11 MR. ESCOVER: I don't have any questions
12 either.
13 MR. SETTER: No questions. If no one else
14 has any questions, Doctor, you have the right to
15 review this deposition and make corrections as
16 necessary as well as to sign it. If you would
17 like to do that, we can arrange for the court
18 reporter to send you a copy and then you can send
19 it back to her?
20 THE WITNESS: I would like to do that.
21 MR. SETTER: All right. Unless we have any
22 further questions, Doctor, we definitely
23 appreciate the time that you spent with us today
24 and it was my pleasure.
25 THE WITNESS: Thank you.

1 ---
2 (Witness excused.)
3 (The deposition was concluded at 1:45 p.m.)
4 ---
5 (Whereupon, Exhibits 9-11 were marked when
6 provided to the court reporter.)
7 ---
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1 CERTIFICATE
2 STATE OF MISSISSIPPI
3 COUNTY OF HARRISON
4 I, Lisa Hood Brown, Freelance Court Reporter
5 and Notary Public, duly commissioned for the County
6 of Harrison, State of Mississippi, do hereby certify:
7 That on the 10th day of May, 2003, there
8 appeared before me JEFFREY H. BASS, M.D., who was
9 sworn and examined to tell the truth, and that the
10 preceding one hundred seventy-two (172) typewritten
11 pages contain a full, true and correct copy of my
12 stenotype notes and/or electronic tape recording of
13 the testimony of JEFFREY H. BASS, M.D.
14 That the witness has chosen to reserve
15 reading and signing of the deposition.
16 That I am not related to or in anywise
17 associated with any of the parties to this cause of
18 action, or their counsel, and that I am not
19 financially interested in the same;
20 IN WITNESS WHEREOF, I have hereunto set my
21 hand, this 19th day of May, 2003.
22
23
24 Lisa Hood Brown, CSR No. 1166
Notary Public, State of Mississippi,
25 County of Harrison. My commission
expires 2-6-06.

1 ERRATA SHEET
2 STATE OF MISSISSIPPI
3 COUNTY OF ____________
4 I, JEFFREY H. BASS, M.D., the undersigned
5 Deponent, having read the foregoing deposition, pages
6 numbered 6 through 172, find the same to be a true and
7 correct transcription of the proceedings taken at the
8 time and place indicated therein, except as follows,
9 (if any):
10 PAGE LINE WHERE IT READS: SHOULD READ:
11 ____ ____ ____________________ _____________
12 ____ ____ ____________________ _____________
13 ____ ____ ____________________ _____________
14 ____ ____ ____________________ _____________
15 ____ ____ ____________________ _____________
16 ____ ____ ____________________ _____________
17 ____ ____ ____________________ _____________
18 ____ ____ ____________________ _____________
19 ____ ____ ____________________ _____________
20

____
21 JEFFREY H. BASS, M.D.
22 Sworn to and subscribed
by me, this _____ day of
23 ____________, A.D., 2003.
24 ____________________________________
Notary Public, State of Mississippi,
25 County of _________________________.
My commission expires: