Exhibit 599

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NORTH CAROLINA
SOUTHERN DIVISION

IN RE: CAMP LEJEUNE WATER LITIGATION	)	No. 7:23-CV-897

VIDEO DEPOSITION OF DUNCAN JOHNSTONE, MD, produced, sworn and examined on June 20, 2025, between the hours of 9:00 in the morning and 5:00 in the afternoon of that day, taken at the United States Attorney's Office, 400 E. 9th Street, 5th Floor, before Stacy L. Decker, a Certified Court Reporter, Certified Shorthand Reporter, in a certain cause now pending before the United States District Court for the Eastern District of North Carolina, RE Camp Lejeune Water Litigation.

Job No. MDLG7403787

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I N D E X

EXHIBITS

EXHIBITS (Continued)

* * *

IT IS HEREBY STIPULATED AND AGREED by and between counsel for the Plaintiff and counsel for the Defendants that this deposition may be taken in shorthand by Stacy L. Decker, CCR, a Certified Court Reporter, and Notary Public, and afterwards transcribed into typewriting; and the signature of the witness is expressly reserved.

* * *

VIDEO TECHNICIAN: We are now on the record. Today's date is June 20th, 2025, and the time is 9:14. This is the video-recorded deposition of Dr. Duncan Johnstone in the matter of Camp Lejeune Water Litigation vs. USA, Case 7:23-cv-897.

Will the attorneys please state their name and affiliation for the record.

MR. BU: Nathan Bu for the United States.

MR. MANDELL: Mark Mandell for the Plaintiffs Litigation Group, Plaintiffs Law Group.

MS. JOHNSON: Camille Johnson for the United States.

MR. RUZICKA: Ted Ruzicka for the PLG.

VIDEO TECHNICIAN: And will the court reporter please swear in the witness.

DUNCAN JOHNSTONE, MD,

of lawful age, having been first duly sworn to tell the truth, the whole truth, and nothing but the truth, testified as follows:

EXAMINATION

BY MR. MANDELL:

Q. Dr. Johnstone, my name is Mark Mandell, and I'm a representative as a lawyer of the Plaintiff Litigation Group in this case, these cases. I will be asking you some questions today.

What I would -- all I would ask you is that, if you don't understand one of my questions, either all or part of a question, that you just let me know, and I'll do my best to rephrase the question. Okay?

A. Will do.

Q. All right. Also, if you don't tell me that you don't understand one of my questions, I'm going to assume that you do. Fair enough?

A. Fair.

Q. Okay. And the only other thing I

would say as a preliminary comment is that I do not mean any disrespect to you by any of the questions that I ask, and I hope you understand that. I, like you, am just making an effort to do the best job I can at what I'm doing. You understand?

A. Understood.

Q. Great. Would you agree with me, Doctor, that in your role here today it's important that you be an objective scientist witness?

A. Of course.

Q. An objective physician witness?

A. Of course.

Q. Why is that important, sir?

A. I guess it's a credo of how I approach medicine, science, and life.

Q. Okay. Why? Why is that a credo that you state you follow as we approach my questioning and your answers?

A. I believe in facts, I believe in science, I believe in examining data and trying to do the best I can to help people while also following evidence and best practice.

Q. Would you agree that you and your testimony today must be fair, honest, and as accurate as possible?

A. Yes.

Q. All right. Would you agree that your testimony today should not be influenced by any bias for the defense?

A. Yes.

Q. Would you agree that your testimony today should not be influenced by your being an advocate espousing a position as to relying on objective scientific and medical fact; would you agree with that?

A. I'll have to have you repeat.

Q. Sure. Would you agree that you should not be an advocate for the defense today?

A. Yes.

Q. Okay. Would you agree that the opinions -- any opinions you express today should be based as much as is possible on objective scientific and medical fact?

A. Yes.

Q. Would you agree you should not intentionally misstate any facts?

A. Yes.
Q. Would you agree you should not intentionally stretch or overstate facts or opinions solely so they would fit defense arguments or claims?
A. Yes.
Q. All right. Would you agree you should not provide opinions outside of your expertise as if they were within your expertise?
A. Yes.
Q. All right. In terms of your approach to your work in this case, have you been part of any coordinated effort with other defense experts to be sure you all were on the same page as to opinions expressed?
A. No.
MR. BU: I'm going to object to form. Sorry.
Q. (By Mr. Mandell) Go ahead, Doctor. If you answered it, I didn't hear it. I'm sorry.
A. No.
Q. Okay. So just so we're clear, you have not been part of any coordinated effort

with other defense experts identified in this case and disclosed to plan a coordinated defense, is that true, to be sure you're on the same page?

A. Yes.

Q. Okay. Have you had any contacts, discussions, email exchange, text exchange, meetings, anything along those lines, with other defense experts in this case?

MR. BU: I'm going to object to form.

Dr. Johnstone, you can answer the question. But your conversations with DOJ attorneys or other DOJ experts are privileged and protected under CMO 17.

MR. MANDELL: And, Nathan, I agree with part of that, disagree with part of that. When we get to a point that anything of substance is disclosed, I'm more than happy to discuss that with you on the record.

Q. (By Mr. Mandell) But for this -- this particular point, this particular question, Dr. Johnstone, my question is have you had any contacts, discussions, exchanges, emails, texts, meetings of any kind with other defense -- with people you know to be other

defense experts in these cases?
MR. BU: Same objection. Same instruction.
A. Yes.
Q. (By Mr. Mandell) All right. How many? How many times -- strike that.
How many different defense experts have you had those kinds of contacts, discussions, or exchanges with, sir?
A. To the best of my recollection right now, maybe four. Maybe three.
Q. All right. Could you identify the three or four experts that you have in mind, sir, that you have had contacts, discussions, or exchanges by email, text, or otherwise with?
MR. BU: So similar instruction, Dr. Johnstone. You can answer that, but the substance of your conversations with those experts are protected.
MR. MANDELL: And I -- I have the same reaction to that. And I assume we'll get to that sooner than later.
Q. (By Mr. Mandell) Go ahead, Dr. Johnstone. Who have you had contact with who

you know to be, and knew to be at the time of contact, another defense expert in this case or these cases?

A. I don't know any of them personally. There was a medical oncologist I believe from the University of Chicago, a human geneticist from the University of North Carolina, and a care planner.

Q. Sorry. The first word you said was -- I didn't get -- before planner, what was the word, sir?

A. Care, c-a-r-e.

Q. You mean a life care planner?

A. Yeah.

Q. Okay. Thank you.

Now, the name of the medical oncologist from the University of Chicago, what is that person's name?

A. I don't recall. I didn't know any of them personally. And I don't remember their names right now.

Q. All right. Well, if I told you, by documentation, the medical oncologist from Chicago you talked to was named Walter Stadler, would that ring a bell to you, sir?

A. Yes, it does.
Q. Okay. Now, actually in your report, when you refer -- you do refer to Dr. Stadler in your report, at least one of your reports, if not both, true?
A. I believe that's the case. You could show me where in the report.
Q. All right. And I'm happy to do that, but do I really have to do that? Are you saying you don't remember mentioning Dr. Stadler in your reports?
A. I remember reading his report and probably referencing him.
Q. Okay. Is there any question in your mind that you referenced him in your report or reports?
A. You can show me where in my report. I'm not remembering putting in his specific name.
Q. Right. Okay. Well --
MR. MANDELL: Ted, could you, if you don't mind, produce Dr. Johnstone's reports, both in Mr. Mousser's case and also the report he did in Ms. Tukes' case, and we can mark them as Exhibits 1 and 2.

(Exhibits 1-2 were marked.)
MR. BU: Madam Court Reporter, which report is Exhibit 1 and which one is Exhibit 2?
THE DEPONENT: It looks like Mousser is one and Tukes is two.
Q. (By Mr. Mandell) You have both, Doctor, in front of you, or just one?
A. Both.
Q. Oh, okay. Good. Now, if you look at -- which one is Exhibit 1?
A. Mousser.
Q. Mousser, okay. Doctor, if you look at Exhibits 1 and 2, Exhibit 1 being your report concerning Mr. Mousser, and Exhibit 2 is your report concerning Ms. Tukes, you'll see that next to each paragraph there is a number. Do you see that, sir?
A. Yes.
Q. Now, we did that in my office to make it easier to refer you to certain parts of your reports as we go through this deposition. So I may say if you look at Page 1, Paragraph 2, that's just for ease of reference. That's why we did that. Okay?

A. Understood.
Q. So take a look at Page 26, paragraph 68, of your report of Ms. Tukes.
MR. BU: I'm sorry, Mark, can we actually pause briefly. I think --
MR. MANDELL: I'm so sorry, Nathan. I didn't hear you.
MR. BU: I'm sorry. I have two Mousser reports.
MR. MANDELL: Okay. All right.
MR. BU: Thank you, Mark. You can go ahead.
MR. MANDELL: Thank you, Nathan.
Q. (By Mr. Mandell) Doctor, are you on Page 26, paragraph 68, of the Tukes report?
A. Yes.
Q. And do you mention in paragraph 68 Dr. Stadler?
A. Yes.
Q. I'm sorry. I didn't hear you.
A. Yes.
Q. Okay. So we've cleared that up, right? You've mentioned Dr. Stadler in your report on Ms. Tukes in this case, correct?
A. Correct.

Q. All right. Now, you state in your report, paragraph 68 of Ms. Tukes' report, that you have also read the expert opinion of Dr. Stadler, correct?

A. Correct.

Q. You don't mention in your report you actually spoke with Dr. Stadler, do you?

A. I don't think so, no.

Q. Why not? Why not just say that I had a conversation or was part of a conversation with Dr. Stadler as opposed to just saying I read his report?

A. My recollection is that the meeting was not very extensive and really had very little to do with what I'm -- what I'm writing in my report.

Q. All right. Then why did you meet or have a discussion with Dr. Stadler -- and there were other -- first of all, there were other experts in that contact you had with Dr. Stadler, correct?

MR. BU: So I'm going to object to form.

Again, Dr. Johnstone, the substance of your conversations with other experts are

protected.

MR. MANDELL: Okay. And so I disagree with that as a wholesale statement, and we'll talk about that. But my question was not what they said, Nathan. My question was there were other -- there was at least one other expert identified by the defense in this case in that conversation that Dr. Johnstone had with Dr. Stadler.

A. I think that's true, yes.

Q. (By Mr. Mandell) Do you remember who that other expert was who participated in that contact you had with Dr. Stadler?

A. That may have been the geneticist.

Q. Whose name right now you don't remember, correct?

A. Looking here it looks like it was Dr. Vance.

Q. Right. Now, you say that -- when you identified the geneticist a few minutes ago, you said it was a geneticist from the University of North Carolina. Do you recall saying that, sir?

A. I did.

Q. Okay. Are you sure that Dr. Vance

is from the University of North Carolina?
A. No.
Q. Okay. Then why say it?
A. I was trying to recollect the reference.
Q. All right. Is she from Indiana, sir?
A. I don't know, sir.
Q. Now, you mentioned that you never met Dr. Stadler before you had this conversation with him and at least one other expert, true?
A. Correct.
Q. Did you ever hear of him before you met and had that conversation?
A. No.
Q. My question is did you ever hear of him before? Did you know he existed in life, in the world, before you had that contact with him?
A. I replied no.
Q. Oh, okay. I didn't hear you. I'm sorry. I'm sorry.
All right. You had no idea of his background, his training, or his practice or

his involvement in other lawsuits as a witness; is that true?

A. True.

Q. Okay. So -- and maybe you're on mute, but -- it looks like you just said yes, but I couldn't hear the word. Did you -- is your answer to that, yes, you didn't know anything --

A. I replied true.

Q. Thank you. I definitely heard you just now.

All right. Now, just so I understand, with Dr. Stadler, a person you never met, knew, heard of, didn't know his name, had no contact with him, didn't know his training, his background, what did you call him in your report? How did you identify him in your report? It's at paragraph 68. If you remember, fine, but it's in paragraph 68.

A. Dr. Stadler.

Q. Yeah. Actually you called him in your report, paragraph 68, Dr. Walt Stadler. Is that true?

A. Yes.

Q. All right. So is it fair to

assume -- or do you know his actual name is Dr. Walter Stadler?

A. I -- that's probably true.

Q. All right. So Walt would be a nickname for Dr. Stadler, his first name?

A. Probably, yes.

Q. Okay. So in this report that you were expressing your viewpoints, opinions, based on your work, why use a nickname to describe somebody you've never met or heard about before in your entire life?

A. Trying to recollect why I used that name. And it may have been that I looked at old invites from DOJ, saw the name and put it in as written, as such.

Q. Okay. So you described Dr. Stadler as a medical oncologist, sir?

A. Yes.

Q. Okay. Now, the other person that you described as being a participant in this conversation you had with Dr. Stadler, you say it was a human geneticist named Dr. Vance, correct?

A. Yes.

Q. All right. Isn't it true, sir,

that Dr. Vance was not part of that particular conversation, but a life care planner, Dr. Shahnasarian, participated in that conversation with you and Dr. Stadler; isn't that true?

A. That's very possible.

Q. All right. Now, do you remember the date on which you had this contact with the two other experts who are defense experts in this case?

A. No.

Q. I'm happy to show you -- strike that.

Dr. Shahnasarian, who was the life care planner who you participated with in that conversation, have you ever seen his report or reports on -- one on Ms. Tukes, one on Mr. Mousser?

A. In part.

Q. Okay. And the part you saw was what part, sir?

A. Some preliminary drafts.

Q. Okay. Part of -- do you remember, with reference to Dr. Shahnasarian's report, he had a section of the report that was

narrative that explained his conversation with you and Dr. Stadler and his interpretation of the medical records and other such items.

Do you recall that there was a body of his report that was one part of his report?

A. I don't think I ever saw that, no.

Q. All right. Do you recall that there was an appendix to his report that included life care plan tables?

A. I think so.

Q. Did you see that?

A. I think that's what I saw, but I would need to have it shown to help recollect my memory.

Q. Okay. Fair enough.

MR. MANDELL: Ted, would you please produce Dr. Shahnasarian's reports, plural, one as to Mr. Mousser, one as to Ms. Tukes, and they would be marked as Exhibits 3 and 4. And I assume Ms. Mousser would be three and Ms. Tukes four in the same sequence as Dr. Johnstone's.

(Exhibits 3-4 were marked.)

MR. RUZICKA: Yes. I'm handing doctor

Exhibit 3, which is the Mousser report, and Exhibit 4, which is the Tukes report.

Q. (By Mr. Mandell) So, Doctor, take -- if you would, take either one, so let's say Exhibit 3, Mr. Mousser's report, if you would. And take a look at -- in Mr. Mousser's report, take a look at Page 45.

Actually take a look at the table of contents -- take a look at the table of contents first of Dr. Shahnasarian's report for Mr. Mousser. It's page number 1, at the very beginning. It says contents at the top.

A. All right.

Q. All right. Look down close to the bottom, corresponding to Page 45, can you read what the entry is in the table of contents for this report?

A. I think I'm on a different page from you. The table of contents just has five entries with page numbers.

Q. All right. For Mr. -- the very first page on the outside says "Rehabilitation Evaluation of Frank Wayne Mousser" and at the bottom "Michael Shahnasarian, Ph.D., April 8th, 2025." Do you see that?

A. Yes.
Q. Okay. So the first page after that, what do you have?
A. It says Page 45, "Financial Information From Clinical Interview."
Q. Okay, fair enough. Fair enough. What I was asking you was -- there is a full report, and in the table of contents it actually refers to Page 45.
All right. So you're on Page 45 now, Dr. Johnstone?
A. Yes.
Q. All right. Towards the top do you see the bold black title of the section on that page?
A. Yes.
Q. All right. And what does it say sir?
A. "Consultation with disease experts, Dr. Walter Stadler, medical oncologist, and Dr. Duncan Johnstone, nephrologist."
Q. Now, in the very beginning of that four-paragraph section, it indicates that you met or had a conversation with Dr. Stadler and

Dr. Shahnasarian on what date?
A. On March 5.
Q. Of what year?
A. 2025.
Q. All right. So just a few months ago, correct?
A. Yes.
Q. True?
A. True.
Q. And this was -- do you recall the format? Was it in person, was it a telephone call, was it a Zoom?
A. It was remote. Either Zoom or Teams.
Q. Okay. So if Dr. Shahnasarian described your contact as a telephone call, he's wrong?
A. I don't recall ever having a telephone call with Dr. Shahnasarian.
Q. Now, do you see where Dr. Shahnasarian, as he described in that heading, indicates it was you, him, and Dr. Stadler on that -- in that consultation, Zoom or Teams?
A. Yes.
Q. Okay. So no Dr. Vance in that

conversation, right?
A. True.
Q. Now, if you would, take the Tukes exhibit, Number 4, and look at Page 19 if you would, please. Are you there?
A. Yes.
Q. Do you see the heading, bold black, about halfway down the page, that reflects that meeting?
A. Yes.
Q. What does it say?
A. "Consultations with disease experts: Dr. W. Stadler and Dr. D. Johnstone."
Q. And it says in the first sentence on March 5th, 2025, "Dr. Shahnasarian and Ms. Hilby had an opportunity to consult with Dr. Walter Stadler, medical oncologist, and Dr. Duncan Johnstone, nephrologist."
Did I read that accurately, sir?
A. Yes.
Q. So who is Ms. Hilby?
A. I don't remember.
Q. Okay. And it identifies you as a nephrologist, correct?
A. Correct.

Q. Now, if we can refer to that report, the one you have for Ms. Tukes, Exhibit 4, it indicates that you, Dr. Shahnasarian, and Ms. Hilby and Dr. Stadler -- one thing you did was you reviewed Ms. Tukes' treatment records according to Dr. Shahnasarian's report that was disclosed on April 8th of this year in this case, true?

A. What part are you referring to?

Q. Okay. If you look at the very first paragraph and the second sentence, it says, "The specialists reviewed Ms. Tukes' treatment records," at the beginning of that sentence, true?

A. So that -- I think that's referring to we had reviewed all of her available medical records.

Q. And we is who?

A. Me and Dr. Stadler.

Q. Okay. Now, is that a reference that you did it on this Zoom meeting or Teams meeting, or that you did it -- you did it before then and were bringing that knowledge into this discussion?

MR. BU: Again, Dr. Johnstone, I'll

instruct you, the substance of your communications with other experts are protected.

A. I --

Q. (By Mr. Mandell) Did you review the records -- I'm sorry. Go ahead.

A. I reviewed everything myself.

Q. Okay. Before you had this conversation?

A. Yes.

Q. And when you say everything, you said you reviewed all of Ms. Tukes' medical records. Did you also review all of Mr. Mousser's medical records before you had this conversation with Dr. Stadler, Dr. Shahnasarian, and Ms. Hilby?

A. If any records became available after that meeting, then I would have reviewed them and incorporated them into my final opinion. I had reviewed a great deal of medical records by that point.

Q. Do you know what medical records of Ms. Tukes and Mr. Mousser you reviewed prior to this March 5th conversation with Dr. Shahnasarian and Dr. Stadler and Ms. Hilby?

A. It was hundreds, if not a few thousands, of pages of medical records, including University of North Carolina, and her private nephrologist, and the records from DaVita Dialysis, followed by her transplant course. So at least four different institutions -- and the VA. So five different institutions with medical records.

Q. So you said you reviewed hundreds, if not thousands, of pages of Ms. Tukes' records before March 5th, 2025, true?

A. True.

Q. Same for Mr. Mousser, did you review hundreds, if not thousands, of pages of his records before March 5th, 2025?

A. No. His records were much less extensive.

Q. Okay. How would you approximate the number of those pages you read before March 5th, 2025?

A. I don't remember exactly how many I read before March 5th. It was a small number. And I think I read some after that.

Q. All right. What about Ms. Tukes, did you receive records concerning her

treatment and care and other items about her after March 5th, 2025, or did you receive everything you received concerning Ms. Tukes that's in your materials considered list before March 5th, 2025?

A. I may have received some things afterwards. I just can't recall the specific dates.

Q. All right. Do you recall what records you received after March 5th -- excuse me.

Do you recall what records and/or documents you received after March 5th, 2025, concerning Ms. Tukes, whether they're records, depositions, whatever?

A. It might have been her most updated records from the transplant clinic.

Q. All right. When you were describing the records of -- and other documents of Ms. Tukes that you had received before March 5th of this year, you mentioned four different institutions that you had received records from.

Can you do the same with Mr. Mousser's documentation you had reviewed

before this meeting on March 5th, 2025?

A. I think it was two institutions, the VA and one other. But I don't remember details.

Q. Okay.

MR. MANDELL: Now, Nathan, as to this conversation on March 5th, 2025, I do intend to ask questions about what Dr. Shahnasarian has in his two reports that have been marked Exhibits 3 and 4 that were disclosed publicly in this case so that I had an opportunity to read it, every lawyer in this case had an opportunity to read it, et cetera.

So I will tell you, and I'm more than happy to put it up and share the screen on this, if it's necessary, the Case Management Order 17, to the extent that it addresses conversations that do not have to be disclosed between retained testifying experts along with several other categories, if you look at the very first subparagraph and section, Paragraph 3, which would be 3-A, it actually reads defining what will be protected.

Any form of oral or written communications, correspondence, or work

product shared only between, and then it goes on. And in subparagraph VI, it says retained testifying experts.

Now, the word "only" is a critical part of that, because this information was not shared only between these experts, because Dr. Shahnasarian disclosed it and talked about what was said in his reports.

In addition, that would be expected, because if Dr. Shahnasarian is a life care planner as to Ms. Tukes, Dr. Johnstone signed off on his life care plan. And as to Mr. Mousser, at least by the life care plan table, Dr. Stadler participated in that.

So, you know, I intend to go through what Dr. Shahnasarian publicly in this case disclosed. It took it out of shared only between retained the experts. And I intend to ask Dr. Johnstone about what Dr. Shahnasarian said happened in that conversation on March 5th, 2025.

I would also add that, when Dr. Shahnasarian testifies, it is virtually certain that you and Department of Justice are going to bring out that Dr. Johnstone and Dr.

Stadler endorsed those tables since their name is on the tables, Dr. Johnstone for Tukes -- Ms. Tukes and Dr. Stadler for Mr. Mousser. And this narrative in Dr. Shahnasarian's report identifies their participation in those subjects.

So I don't -- I'm -- these conversations, that particular conversation on March 5th, as it has been revealed publicly in this case, was not shared only between the testifying or the retained experts.

So I'm happy to listen to your response. But if you won't let me do that, I can assure you we'll be back with Dr. Johnstone again for this -- what seems to be a pretty obvious exception to that general rule.

MR. BU: Thank you, Mark.

MR. MANDELL: What do you think?

MR. BU: Thank you, Mark. So just so that I understand your position, because the existence of the conversation on March 5th was disclosed in Shahnasarian's report, you're taking the position that the substance of the conversation is no longer between only retained experts?

MR. MANDELL: Yeah. It's -- yes. As a result, I know about it, and others in this case know about it. Anybody else who has read Dr. Shahnasarian's report knows about it.

MR. BU: Right. So I agree with you, the existence of the conversation is not protected, and everyone knows about it. I'm not sure that I agree the substance of the conversation, what they discussed, is no longer protected simply because it's referenced in Dr. Shahnasarian's report.

MR. MANDELL: Well, how is it solely shared between experts if I know about it? And I'm an attorney cross-examining one of the experts who is participating in this. How is that possibly shared only?

I'm just trying to be able to ask what is in Dr. Shahnasarian's report and Dr. Johnstone's reaction to it as it was publicly revealed.

MR. BU: Right.

MR. MANDELL: I mean, it wasn't plaintiffs or plaintiff's counsel who waived any confidentiality that might exist for that. It was your own expert. And he did it to

justify his opinions. So how can I not cross-examine one of the doctors that Dr. Shahnasarian said he's relying on for his life care plan when he's going to testify about the life care plan? He put it in his table of contents. How can I be precluded from asking questions about that? That seems grossly unfair.

MR. BU: So I think our position would still be the substance of the conversation is protected. The substance of the conversation was not disclosed in Dr. Shahnasarian's report.

MR. MANDELL: Nathan, are you -- and I mean this most respectfully. Are you looking at the report?

MR. BU: Yes, I am.

MR. MANDELL: The report actually does disclose the subject of the conversation.

MR. BU: Well, I think it just says for Ms. Tukes that Dr. Shahnasarian and Ms. Hilby had an opportunity to consult with Dr. Walter Stadler and Dr. Duncan Johnstone, but it doesn't say what was discussed during that consultation.

MR. MANDELL: Really? Let me read it -- I'll read it to you. I'll read part of it to you. Do you want to look at Mr. Mousser first on Page 45?

MR. BU: Sure.

MR. MANDELL: There are four paragraphs that describe the substance of that conversation. In Ms. Tukes', he does use the word opportunity on Page 19. It says, we had -- he and Ms. Hilby, that is Dr. Shahnasarian, had an opportunity to consult with Dr. Stadler and Dr. Johnstone. And then he goes through a number of paragraphs identifying what they talked about, including causation, including medical care and treatment, including Mr. Fryar's life care plan.

And for Mr. Mousser, he also talks about, that is, as Dr. Shahnasarian reveals, in addition to that, his prior employment in the automobile sales industry.

That isn't just saying I had the opportunity to talk to him. He's actually saying publicly what they talked about and what the different opinions were.

So I hope we don't spend too much time

on this, because it seems pretty clear. But as to this particular conversation with other defense experts, it's been publicly waived if there was any confidentiality.

MR. BU: Okay. I think I understand your position, Mark. I mean, right now, I would say DOJ's position is the same. I'd suggest you move on from this line, and maybe we can revisit it later this afternoon.

MR. MANDELL: Well, I'm going to ask the questions. If you object to it, I'll ask the Court for the ability to reconvene this deposition. And I will ask that we not have to pay for Dr. Johnstone's time when we do reconvene, because this is pretty obvious that this was waived.

Let me just ask you this: You have in front of you Dr. Shahnasarian's report disclosed April 8, 2025, for Mr. Mousser. And on Page 45, if I were to ask Dr. Johnstone any questions concerning anything in those four paragraphs, other than the fact that he -- there was a meeting and who was there, is it your testimony you're going to object and instruct Dr. Johnstone not to answer those

questions?

MR. BU: If you're asking about what was discussed on March 5th, then yes. You can ask Dr. Johnstone for his own opinions about those topics. But the conversation itself, we'll take the position it's protected.

MR. MANDELL: Do you know any attribution by Dr. Shahnasarian in this report, and in Ms. Tukes' report, as to what occurred in that conversation on March 5th, any attribution to Dr. Johnstone in terms of what he said, what his opinions were, you're going to instruct him not to answer?

MR. BU: Yes, I will.

MR. MANDELL: Okay. I'm sorry, Dr. Johnstone, but we will be back, at least I believe we'll be back.

Q. (By Mr. Mandell) Doctor, in your report, I don't see any of the -- either report, as to Mr. Mousser or Ms. Tukes, I don't see any reference by you as to what caused their cancers that were found in their kidney.

That's true, isn't it, that you don't mention that at all in your reports?

A. That's true.

Q. All right. And is it true that you will not be offering any expert opinions in this case concerning what caused Mr. Mousser's cancer, true?

A. True.

Q. You will not be offering any opinions in this case, at trial or in this deposition, as to what caused Ms. Tukes' cancers, true?

A. True.

Q. Now, at different places in your report on Ms. Tukes, you make reference, and you do this more than once, to the "small" size of the cancers that were removed from Ms. Tukes and the amount of allegedly functioning kidney tissue that was removed during those surgeries. Do you recall making those comments?

A. Yes.

Q. Have you ever -- is it your intention to say that Dr. McCarthy, Dr. Roc McCarthy, who performed the surgeries on Ms. Tukes, her cancer surgeries, is it your intention to testify that he committed medical

malpractice by doing those surgeries?

A. No.

Q. Medical negligence. Are you accusing him of medical negligence?

A. It's not my area of expertise, and I'm not testifying about that.

Q. Okay. Well, if it wasn't -- if it's not your area of expertise and you're not testifying about it, why did you -- and I'll go through your report with you if you want. Why did you mention numerous times how small the cancer was he took out, how much functioning tissue was taken out, and even put references to notes by health care professionals that they advocated waiting or every time you do surgery it makes the next surgery harder? Why make those mentions if you're not testifying about it and have no opinions about it?

A. I think I'm writing as a kidney doctor whose aim is always to protect someone's functional kidneys from disease loss.

Q. Okay. So --

MR. BU: I'm sorry, Mark. I am

getting an alert on my iPad, your Zoom account is being signed in on another device.

VIDEO TECHNICIAN: That was my phone being connected to it.

MR. BU: So allow or deny?

VIDEO TECHNICIAN: Just allow.

MR. BU: Sorry, Mark.

MR. MANDELL: Are you all set?

MR. BU: Yes. Thank you.

MR. MANDELL: Nothing nefarious here, trust me.

Q. (By Mr. Mandell) So, Doctor, let me see if I can try that question again.

I understand you were writing your reports as a nephrologist.

A. Correct.

Q. There's no question about that, right?

A. Correct.

Q. All right. And you've expressed your view that you like to spare patients with kidney cancer from having surgery or unnecessary surgery; that's true, also?

A. That's true. Again, it's -- I am not a urologic oncologist, so it's not my area

of expertise.

Q. So I -- so we understand that you're a nephrologist. And if someone doesn't need surgery, you would rather not see them have surgery. We agree on that, right? That's your viewpoint?

A. Yes.

Q. Why put it in your report that this doctor, this surgeon, Dr. McCarthy, who did a partial right nephrectomy and then two partial left nephrectomies at different times, and then a total right nephrectomy, and then a total left nephrectomy, why put it in your report that, well, I took out a lot of functioning kidney tissue and the cancers were small that he took out?

Why put that in there unless you are trying to create some kind of impression of criticism that these were small cancers and a lot of healthy tissue was taken out at the same time? Why say that if you weren't being an advocate?

A. That's what I saw in the medical record.

Q. Well, was there a lot of things --

were there a lot of things you saw in the medical record that you didn't put in your report?

A. I don't think so. I think I reviewed everything, took everything I could that was I thought most germane and put it in.

Q. Can we agree that, at every single surgery that I just mentioned that Dr. McCarthy did, part of the tissue removed was cancer, both -- well, certainly as to Ms. Tukes? Isn't that true?

A. Yes.

Q. Every surgery he did took out cancer, kidney cancer?

A. Yes.

Q. Are you aware of his explanation as to why he did the surgeries he did, either from his records or any other source of information, that revealed why he did the surgeries he did, each one?

A. No, I'm not.

Q. Do you know anything about his background, his training, his experience, his competence? Do you know anything about that, sir?

A. I do not.
Q. You have in your reports commented about whether or not, for example, Ms. Tukes -- well, strike that -- whether or not Mr. Mousser will need transplant surgery, right? You commented on that in Mr. Mousser -- in your report on Mr. Mousser --
A. I believe so.
Q. -- whether he will need transplant surgery?
A. I believe so. Can you -- can you direct me to the part you're referencing?
Q. I can. But is there really any question in your mind that you commented and said you don't think he's going to need transplant surgery?
A. I think it's extremely unlikely, yes.
Q. Okay. And you made a comment about whether Ms. Tukes would be a candidate for another kidney transplant in the future, right? And you said she'd be a -- in your mind you disagree with Dr. Cooper as to whether or not she might not be eligible or she might not be a good candidate. Do you

recall that?

A. That's partially correct.

Q. What's the part that's incorrect, sir?

A. My recollection is that he said she would not, not that she might not, but that she would not be a candidate for a transplant.

Q. And you disagree with that, right?

A. Correct.

Q. All right. Doctor, as to your comments about what Dr. McCarthy took out from the surgeries we just discussed, as to your comments about Mr. Mousser not needing transplant surgery, as to your comments about whether Ms. Tukes would be a candidate for surgery -- let me ask you this: You finished medical school in what year, 2001?

A. Yes.

Q. And then you began your residency and training, true?

A. True.

Q. Doctor, let me ask you this question: How many years have you been in practice as a practicing nephrologist after

training?
A. I think it's 18 now.
Q. 18. All right. So in those 18 years, have you ever done transplant surgery yourself as the person operating?
A. I am not a surgeon.
Q. So is the answer, no, you've never done transplant surgery?
A. Correct.
Q. All right. Have you ever done surgery on a kidney?
A. On a human kidney, no.
Q. Have you ever done surgery on any part of the body of the human, any body organ, since you've been in private practice for 18 years?
A. I've never been in private practice. I have performed surgeries during training.
Q. I'm saying after your training, sir. You've been in practice for 18 years after training, true?
A. Correct.
Q. All right. Now, during training you may have been involved in surgery, but

that's as part of either -- say a residency program, true?

A. Or fellowship, yes.

Q. All right. So in the 18 years that you've been in practice, out of training, have you ever done surgery on any body organ on any live person?

A. I've done procedures. Nothing I would consider to be a surgery.

Q. When there is surgery done on a kidney, which doctors do that, sir, by description of the type of doctor?

A. Most often a transplant surgeon.

Q. Right. How about a urologic oncologist, say, for example, for kidney cancer?

A. Sure. If it's cancer, absolutely.

Q. Isn't that a difference between urologists and nephrologists like yourself is that nephrologists don't do surgery and urologists do do surgery when it involves the kidney?

A. Yes.

Q. All right. Now, in addition to the fact that you have never in 18 years done

surgery on a kidney, a bladder, a ureter, or any other organ in any live human being, is it also true that you have never made the final decision as to what surgery would be done on a patient? Isn't that also true?

A. True.

Q. All right. If the person who had made that decision as to what surgery would be done on a patient would be the surgeon in conjunction with the patient, true?

A. Not necessarily, no.

Q. How is that untrue, sir?

A. So at transplant centers it's not a single surgeon making the decision. It's a committee comprised of surgeons and non-surgical nephrologists and psychologists and support staff.

Q. Okay. There is a transplant service, a kidney transplant service, at the Kansas University Medical Center where you practice now, true?

A. True.

Q. Have you ever -- have you ever seen the website that describes and identifies the categories of doctors who are on the

multidisciplinary team --

A. No.

Q. -- involving transplant surgery at Kansas University Medical Center, sir?

A. No.

Q. Are you aware that you're not listed as part of any multidisciplinary team involving transplant surgery at Kansas University Medical Center, although some nephrologists are?

A. That does not surprise me, no.

Q. Okay. Now, what you do is you refer patients or you may have referred patients in your 18 years in practice to surgeons if you think, well, a patient might be a candidate for surgery, but you defer that decision to the person who is doing the surgery and certainly to the patient who has a right to decide what surgery is done, true?

A. Are you referring to kidney transplant surgery or different surgeries?

Q. I'm referring to any surgery on a human body of a live person, any organ, in your 18 years. You refer them to surgeons so that they, along with the patient, can decide

does the surgery occur, what surgery it will be, true?

A. Not necessarily, no.

Q. Okay. So other than the multidisciplinary team involving transplant surgery that you're not affiliated with or on, how is that not true?

A. Again, I'm not affiliated at KU. The referral process doesn't -- for a kidney transplant doesn't go to a surgeon. It goes to the new transplant patient group, more than half of whom are kidney doctors.

And then at some institutions, including institutions where I've worked and trained, the referring physician can go for the listing meeting after the entire process is done. And I've been involved many times at those listing meetings in helping make decisions.

Q. Do you make the final decision as to what surgery is done, you yourself?

A. Again, I don't make the final decision. It's an entire group decision. Have I advocated one way or another, absolutely.

Q. Have you ever made the final decision with a patient as to what surgery is to be done on them, on any patient in your 18 years?

A. No.

Q. Okay. Now, Doctor, as to Dr. McCarthy and the surgery he did, did you ever communicate to anybody in the month of March of 2025 that the medical care and treatment Ms. Tukes had received up to the end of -- up through March 2025 was appropriate and reasonable?

MR. BU: So I'm going to --

Q. Did you ever communicate that to anybody?

MR. BU: Communications with DOJ attorneys and other experts are protected. But you can answer to the best of your ability.

Q. (By Mr. Mandell) Let me make it more specific. On March 5th, 2025, did you ever communicate to Dr. Shahnasarian and Dr. Stadler that you believed that the treatment and care that Ms. Tukes received up to March 5th, 2025, was appropriate and

reasonable?

MR. BU: So I'm going to make the same instruction. Your conversations with other experts are protected. You should not testify as to your -- the substance of your conversations with other experts.

MR. MANDELL: And, again, for the record I'm going to represent what is in Dr. Shahnasarian's report, that Dr. Stadler and Dr. Johnstone believe that the medical care and treatment Ms. Tukes had received up to and including March 5th, 2025, in their meeting, that all of that treatment and care was appropriate and reasonable. So I'm making that representation, so when we address this to the Court it's clear.

Q. (By Mr. Mandell) Now, are you aware, sir, that your name is not on the life care plan tables concerning -- that Dr. Shahnasarian has attached to his report as to Mr. Mousser; it's only Dr. Stadler's name who is on that?

A. I'm not aware.

Q. Okay. In your report on Mr. Mousser, did you advocate any future

treatment and care for Mr. Mousser as a result of the condition of his kidney?

A. I don't think so, no.

Q. All right. You didn't advocate any future treatment and care for Mr. Mousser in your report, because you don't believe any treatment and care will be needed at all for Mr. Mousser in the future concerning his kidney, true?

A. True.

Q. Now, did you -- have you ever seen Dr. Shahnasarian's life care plan tables for Mr. Mousser?

A. I don't think so, no.

Q. So if he and Dr. Stadler actually did identify future care needs for Mr. Mousser in the tables of the life care plan attached to Dr. Shahnasarian's report, you disagree with him, is that true, because you don't think any treatment and care will be necessary in the future, right?

A. I think I'd have to see the report.

Q. Well, you just said you don't believe any treatment and care would be

necessary for Mr. Mousser in the future concerning his kidneys, and that's why you didn't put anything about that in your report, right?

A. Based on his current level of kidney function and future risks of kidney disease, all things being equal.

Q. What does that mean, all things being equal?

A. New things can always happen to people. You could have excellent kidney function right now, sir, but next week could come down with a horrible illness that would change the likelihood that you need future dialysis or kidney care. But based on all the information for --

Q. All right -- I'm sorry. Go ahead.

A. Based on all the information for Mr. Mousser, his kidney function and likelihood of being on dialysis are good enough that he doesn't need specific treatment for his kidneys.

Q. Did you ever see the life care plan tables -- did you ever see a report produced by an expert identified by the

plaintiffs in these cases named Michael Fryar, who is a life care planner concerning Ms. Tukes and/or Mr. Mousser?

A. I have a recollection of seeing it for Ms. Tukes. I can't specifically recollect seeing one for Mr. Mousser.

Q. Was there anything in Mr. Fryar's -- by the way, the records you saw, was it a life care plan prepared?

A. If we're talking about Ms. Tukes, I think it was. This was months ago, and it would have been a brief review.

Q. Was there anything in that life care plan that you associate with Mr. Fryar that you agreed with as to the future for Ms. Tukes?

A. I don't have specific recollection.

(Off the stenographic record.)

Q. Dr. Johnstone?

A. Yes.

Q. Doctor, when you -- you had mentioned you also had contact with a geneticist. And it was clarified that you had contact -- actually let me strike that. Let

me just go back for one second.

In your invoices, that is, the description of the work you've done in this case that was provided to me by Mr. Bu, on March 5th, 2025, the entry for that bill reads "Group call discussing life care plans, Tukes and Mousser."

Is there any reason why you didn't identify that you had that conversation with Dr. Shahnasarian and Dr. Stadler on March 5th, 2025, in your description of the work done?

A. I'm not understanding. What did I not identify?

Q. Who the participants were and that they included Dr. Shahnasarian and Dr. Stadler in that March 5th, 2025, billing statement that you prepared, or that was prepared for you?

A. The billing statements are me quickly entering what I've done. I -- it's not a -- it's not an exact process. It's me trying to make sure I'm not overbilling and that I'm accounting accurately and fairly for my time. That's all it's really meant for.

Q. Earlier when we were talking --

when I was asking you about that meeting with Dr. Shahnasarian and Dr. Stadler, one comment you made about it was that it was brief, it was -- or words to that effect. Do you recall that?

A. Yeah, I don't -- I don't remember a lot of substantial new information in that call.

Q. No. I just asked you, do you recall describing it, that is, that contact with Dr. Shahnasarian and Dr. Stadler as brief or very short, or words to that effect, in this deposition?

A. It wasn't -- it wasn't a five-minute call. But it was not a highly substantive call in my recollection. So, no, I don't think it was brief.

Q. All right. In your billing for that date as to that group call discussing life plans of Tukes and Mousser, you attribute one hour. Is that accurate?

A. If I put it on there, it was a one-hour call.

Q. So, Doctor, in your billing statements for the date March 10th, so five

days after that contact with Dr. Shahnasarian and Dr. Stadler, the entry is "Group call with geneticist." That was March 10th. Does that sound about right to you as to when that contact with the geneticist, Dr. Vance, was?

A. Off the top of my head, I can't recall. But if that's the billing statement, then, yes, it would be accurate.

Q. All right. And the amount of time that was attributed to that group call with geneticist was 10 minutes. Is that accurate?

A. Again, if that's what I attributed, it's accurate.

Q. Did you have any other contact with Dr. Vance of any kind other than a 10-minute group call with her on March 10th, 2025?

A. Not that I recall, no.

Q. Do you recall any of the discussion that occurred on March 10th, 2025, with the geneticist?

MR. BU: So Dr. Johnstone, the substance of your conversations with DOJ experts are protected. You should not disclose of substance of those conversations.

You can answer to the best of your ability.

Q. (By Mr. Mandell) Yeah. My question is do you recall any of the content that occurred in that group call on March 10th, 2025 --

A. At least some of it.

Q. -- with the geneticist?

A. At least some of it, yes.

Q. And -- all right. What was it -- what was discussed that you recall?

MR. BU: Again, Dr. Johnstone, the substance of your communications with other DOJ experts are protected. I'm going to instruct you not to answer.

Q. (By Mr. Mandell) Who was on that call, sir, in addition to the geneticist, Dr. Vance, on March 10, 2025?

A. Probably a few members of the Department of Justice.

Q. Doctor, going back to the March 5th Zoom or Teams meeting that you discussed that included Dr. Shahnasarian and Dr. Stadler, was there anyone else involved in that meeting or discussion?

A. Probably a few members of the

Department of Justice. I don't remember who exactly were on those calls.

Q. Now, on your billing statement for May 29th, that is, the one that -- your billing statement for May 29th, it says, "Questions with expert and DOJ."

What expert, sir, May 29th?

MR. BU: So, Dr. Johnstone, if that meeting is related to your reports on Tukes and Mousser, you may answer. If it's related to your other work for DOJ, I'm going to instruct you not to respond.

A. I don't think it was related to Tukes and Mousser.

Q. (By Mr. Mandell) Do you remember who the expert is that is identified "Questions with expert and DOJ"?

MR. BU: Same instruction, Dr. Johnstone.

A. Yeah, I don't.

Q. (By Mr. Mandell) All right. How many other cases are you working on involving -- strike that.

How many other cases, projects, or -- yeah. How many other cases and/or projects

are you working on with the Department of Justice as a defense consultant and/or expert in addition to the Camp Lejeune water contamination cases, including Ms. Tukes and Mr. Mousser? How many other cases are you working with DOJ on?

MR. BU: Object to form. You can answer.

A. None.

Q. (By Mr. Mandell) What other work are you doing with DOJ that would have led you to have an entry in your billing "Questions with expert and DOJ" on May 29th?

MR. BU: I'm going to instruct you not to answer that question to the extent it gets into your work beyond the Tukes and the Mousser reports.

MR. MANDELL: Is it beyond the water contamination cases involving Camp Lejeune in addition to Ms. Tukes and Mr. Mousser, Nathan?

MR. BU: I'm sorry. You're asking me?

MR. MANDELL: Yeah. I'm just asking you for a clarification on what you've said. The implication could be that Dr. Johnstone is working on other matters with DOJ, which he

has denied. And you keep saying, if it's beyond Ms. Tukes and Mr. Mousser, he shouldn't answer and you're instructing him not to answer.

So I'm asking, are you instructing him not to answer a question the answer of which would involve any aspect of the Camp Lejeune water contamination cases that you and I are lawyers on --

MR. BU: So I --

MR. MANDELL: -- generally.

MR. BU: I'm sorry.

MR. MANDELL: No. Go ahead. I'm done.

MR. BU: I'm instructing him not to the get into the substance of other work, yes. But the Camp Lejeune water litigation that he may be doing for DOJ, that is not related to the reports in Tukes and Mousser.

MR. MANDELL: If it involves Camp Lejeune, why is that not relevant? He did reports on Mr. Mousser and Ms. Tukes, but that doesn't mean he's limited to questions concerning his work and the Camp Lejeune water contamination cases. So why?

MR. BU: I'm trying to think about how to answer this without giving it away. But he can be working as a consulting expert on other issues. He can be working on settlement issues. Those are still protected.

MR. MANDELL: So you're not going to let him answer that question; is that true?

MR. BU: About who the expert was on this other May call?

MR. MANDELL: Yeah. No. In terms of what other work he's doing with DOJ in the Camp Lejeune water contamination cases.

MR. BU: That is generally true with one exception. I think the billing records do reflect he is doing work on EO settlement, which naturally is related to settlement. That's been disclosed. And so you should be aware that he is working with DOJ on that aspect, or has worked with DOJ on that aspect.

MR. MANDELL: And I'd just ask you -- for the EO settlement. I see. Okay. I didn't hear that word.

So you're saying that -- and this is in Dr. Johnstone's billing that he was involved with the EO settlements, true?

That's what you're referring to?
MR. BU: Is that again to me?
MR. MANDELL: Yeah. I'm just saying --
MR. BU: Yes, that's what I'm referring to. I think there is an early bill that refers to EO settlement.
Q. (By Mr. Mandell) All right. I'm going to ask you about that, Doctor. But before I do, when I asked you who the expert was that you talked about -- that you talked to on May 29th, you said you don't recall, just a few minutes ago; is that true?
A. True.
Q. All right. Now, it's June 20th now. We're talking about three weeks ago. And you don't remember who the expert is that you spoke to so that you had an entry here "Questions with expert and DOJ"?
A. I don't remember the name.
Q. You honestly -- do you remember what kind of expert, what subject matter expert it was?
MR. BU: I'm going to instruct you not to answer, Dr. Johnstone.

Q. (By Mr. Mandell) Was it by Zoom, Teams, call, in person?

A. Zoom call.

Q. Doctor, what was your involvement with the EO settlement concerning the Camp Lejeune water contamination cases so that on December 5th and December 19th of 2024 there are entries for December 5th, preparing talk for the EO group about settlements, and a December 19th, EO navy group presentation and questions? What did you do?

MR. BU: So, Dr. Johnstone, the substance of your communications with DOJ or with the navy about settlement are protected. I'm going to instruct you not to answer to the extent your response would include the substance of those communications.

Q. (By Mr. Mandell) What did you do, Doctor?

MR. BU: Same instruction.

Q. (By Mr. Mandell) Did you do PowerPoints? Did you go to meetings? Did you make a presentation to people about the settlements? What did you do?

MR. BU: You can describe the manner

of the communications, but the substance of the communications are protected, and you should not disclose the substance of those communications.

A. Both were either Zoom or Team calls, and both had presentations by me followed by questions from the group.

Q. (By Mr. Mandell) Doctor, you mentioned in your billing of October 10th that you had a call with DOJ. You identified the people, including Mr. Bu. And then you say after that, you say then sending slide decks. Do you remember doing that?

A. I don't remember which slide decks, but I've shared a couple, sure.

Q. Now, yesterday I received from Mr. Bu, or within last day or two, three slide decks that were the slide decks you presented and then a reference on October 10th, 2024.

Were those slide decks in any way involved in the EO settlement work you did in these cases?

A. I think so.

MR. BU: Same instruction. The substance of your communications with DOJ,

DON, are protected.

MR. MANDELL: So are you instructing him not to answer?

MR. BU: Yes.

MR. MANDELL: Okay.

Q. (By Mr. Mandell) Did you have contact, Doctor, with any other experts other than Dr. Shahnasarian, Dr. Stadler, Dr. Vance, and this expert who is unknown that you can't remember who it was that you talked to on May 29th?

A. I don't think so, no.

Q. Anyone else?

Did you ever contact any of Ms. Tukes' treating doctors?

A. No.

Q. Did you ever contact any of Mr. Mousser's treating doctors?

A. No.

Q. Now, why would you have a conversation with Dr. Shahnasarian and Dr. Stadler?

A. I was asked to join a call by the DOJ group.

Q. What was the purpose of the call?

MR. BU: I'm going to object to form. The substance of your communications with DOJ attorneys and other experts are protected. You should not disclose the substance of those communications.

Q. (By Mr. Mandell) So are you able to answer that question, Doctor, what was the purpose of your being involved in those -- in that contact with Dr. Shahnasarian and Dr. Stadler?

A. Discussions of the Tukes and Mousser case.

Q. Doctor, what was the purpose of your talking with Dr. Vance for 10 minutes on March 10th?

MR. BU: Same instruction. The substance of your communications with DOJ experts are protected. You should not disclose the substance of those communications.

Q. (By Mr. Mandell) Can you answer the question, Doctor, with that instruction?

A. Other than I was asked to join the call, and I answered some questions about kidney disease. That's -- that's the full

extent of my recollection.

Q. What was the purpose of your conversation with an expert on May 29th, the unknown expert?

MR. BU: Same instruction as before.

Q. (By Mr. Mandell) Are you able to answer that question, sir?

A. I haven't even --

Q. What was the purpose of that May 29th contact?

A. Yeah, I'm not able to answer that question, I guess.

Q. He didn't tell you not to answer that question. He just objected to the form in which I presented it. That's different.

What was the purpose of that contact with an expert on May 29th, sir?

MR. BU: To be clear I am instructing you that the substance of your communications with DOJ experts are protected and you should not disclose the substance of those communications.

Q. (By Mr. Mandell) Doctor, when you were hired -- when you were hired to work on these cases, it was as a result of contact you

had with a company called Versed; is that true?

A. Yes.

Q. And that's an expert witness finder service out of Pennsylvania?

A. Yes.

Q. Do you know how they got your name?

A. I think I've done some work with them in prior years.

Q. Okay. Now, you say you think you did. Is there any question in your mind whether you did work with Versed in prior years, or Versed in prior years?

A. I haven't done a great deal of expert consulting, but I believe that they were the third party in a few cases that I've done in the past, and they reached out again.

Q. When you say the third party, you mean they were the vendor that found you as an expert and presented you to some attorneys; is that what you're saying?

A. Yes.

Q. Now, when you were approached by Versed and when you were hired to work on this

case, would it be fair to say that you were hired as an individual to look at records, to bring to bear honestly and with -- and ethically your opinions as a nephrologist on the issues in Ms. Tukes' and Mr. Mousser's case; is that a fair statement?

A. Sure. Yes.

Q. Okay. Are you working on any other cases other than Ms. Tukes' and Mousser's case or have you worked on any other cases in the Camp Lejeune water contamination cases in addition to the Tukes and Mousser?

MR. BU: Object to form. You can answer.

A. I'm working with the DOJ. If they ask me for a meeting or for a review of records, I will try my best to make time on my schedule.

Q. (By Mr. Mandell) Has that happened to this point in any water contamination case involving Camp Lejeune other than Ms. Tukes' case and Mr. Mousser's case?

MR. BU: Object to form. You can answer.

A. Generalizations, yes. No specific other cases.

Q. (By Mr. Mandell) What do you mean generalizations, yes?

A. General talks about kidney disease with regard to Camp Lejeune. It's been quite general.

Q. My question to you is, you were hired as an individual based on -- for you to provide, based on your training, your experience, your practice, your viewpoints on issues as to specific cases, Ms. Tukes and Mr. Mousser, right?

A. Right.

Q. Did you need to talk to Dr. Vance, Dr. Stadler, Dr. Shahnasarian and/or the unknown expert on May 29th? Did you need to talk to them for you to be able to write the reports you wrote in this case and to identify the opinions that you would provide in this deposition and at trial as set forth in those reports?

A. I don't think so, no.

Q. Is there any aspect of any of the conversations, any of those communications

with Dr. Stadler, Dr. Shahnasarian, Dr. Vance, and/or the unknown expert of the May 29th, is there any aspect of any of those conversations that found their way into your report so that it became your opinion as opposed to you just brought to bear what you knew based on your experiences as a physician up to the time your report was filed on April 8th?

A. I don't think so. Can you give me a specific example?

Q. Okay. So your answer is nothing you learned or heard from Shahnasarian, Stadler, Vance, or the unknown expert on May 29th, none of that has -- serves as a foundation for your opinions that you will give in this case as a nephrologist? That's true?

A. True.

Q. Okay.

VIDEO TECHNICIAN: Counsel, I need to change the video, so if we could take a break when you get a second.

MR. MANDELL: Sure. I mean, do we need to take a break or can we just wait while you change the video?

VIDEO TECHNICIAN: It will take a minute to change the video, so we should just take a break here. I'll put us off the record at 10:47.

(Recess.)

VIDEO TECHNICIAN: We are back on the record at 10:53.

Q. (By Mr. Mandell) Dr. Johnstone, could you turn to Page 23 of your report in Ms. Tukes' case and what we have identified as paragraph number 56. And let me know when you're there, sir.

A. Sure.

Q. All right. Now, do you see about halfway down, a little more than halfway down in that paragraph, there's a sentence that starts, "She also met with a genetic counselor on November 26, 2018"?

A. Uh-huh. Yes.

Q. Do you see that?

A. Yes.

Q. All right. Now, the genetic counselor she met with, was that Ms. Katie Garbarini?

A. That sounds like the correct name,

but I -- I think so.

Q. Okay. And in your paragraph number 56, concerning that encounter on November 26, 2018, can you read that sentence into the record verbally, sir?

A. Beginning with she also met?

Q. Correct.

A. "She also met with a genetic counselor on 11/26/2018 after the initial Invitae results whose recommendations included a discussion that the 30 gene test is not perfect in ruling out hereditary renal papillary cancer."

Q. So do you -- how do you know that information that you just read in that sentence?

A. From a review of a huge amount of records in the CORA database that included her records from UNC.

Q. Now, I'm going to show you -- this is a letter dated November 26, 2018, to Ms. Tukes from Katie Garbarini. Do you see that, sir?

A. Yeah.

Q. Okay.

MR. MANDELL: Now, there is a folder for the UNC genetics record. And if you would provide that to Mr. Bu and Dr. Johnstone, Court Reporter, please.

(Exhibit 5 was marked.)

MR. RUZICKA: I'm marking Exhibit 5 which is a UNC health record for Ms. Tukes.

MR. MANDELL: Specifically the letter from Ms. Garbarini November 26, 2018, please. And just let me know when that's done.

MR. RUZICKA: Sorry. Do you want me to just pull out that specific letter from the --

MR. MANDELL: Yeah. It's -- actually you can do the whole thing, Ted. Just mark the whole thing.

MR. RUZICKA: All right. I marked the whole UNC record as Exhibit --

MR. MANDELL: As Exhibit 5?

MR. RUZICKA: Yes.

Q. (By Mr. Mandell) Now, Dr. Johnstone, could you please -- in that exhibit is this letter that's on the screen. It's dated November 26, 2018. Do you see that, sir?

A. Just so I can bring it up as a paper copy, do you know what page it is in this?

Q. Page 29, sir, of that packet.

MR. BU: So, Mark, just so you're aware, I think the pages may be out of order, but I want to say what you're referring to is Bates stamped 1553 Tukes ending in 441.

MR. MANDELL: Correct, it is.

MR. BU: So, Dr. Johnstone, this will be toward the end of the packet. And there will be a number in bold on the bottom right-hand corner. You're looking for 441.

THE DEPONENT: I don't see 441.

MR. BU: You have to keep going back.

Q. (By Mr. Mandell) Let's do this, Doctor, to save time. Can you see it on the screen that we've shared?

A. Yes.

Q. Fine. Look at the fourth paragraph -- the third paragraph down. It starts, "Based on your personal history of multiple primary renal cancers." Do you see that?

A. Uh-huh.

Q. Yes?
A. Yes.
Q. Okay. So in this letter, November 26, 2018, Ms. Garbarini, who is the genetic counselor at UNC, wrote to Ms. Tukes, and in that paragraph, if you'll look halfway into the paragraph, she uses language that is what you put in your report, "since the current test is not perfect." Do you see that?
A. Yes.
Q. All right. And they're referring to genetic testing that was done that did not reveal a known pathogenic mutation in any of the genes tested, true?
A. That's true.
Q. Now, what you've put in your report, that the 30 gene test is not perfect in ruling out hereditary renal papillary cancer, that addresses the -- what you just read that is the first part of the sentence in the third paragraph on November 26, 2018, that is, since the current test is not perfect, right?
A. All right.

Q. Why did you leave out the rest of that sentence and not put it in your report, and the rest of that -- the whole sentence reads, "Since the current test is not perfect, it is possible that there may be a mutation that current testing cannot detect," and then the sentence ends, "but that chance is small." Do you see that?

A. And that's true, yes.

Q. Why didn't you put in there -- since you did put in the current test is not perfect, why didn't you also put in there the rest of that sentence that says that the chance that there may be a mutation that current testing cannot detect is small? Why did you leave that out, that it was a small chance only?

A. I also left out the sentence after that.

Q. Doctor, I'm asking why you left that out. If you weren't being an advocate for the defense, why did you leave out that it was only a small chance that there could be a mutation that the 30 gene panel didn't test?

A. I'm not trying to be an advocate

for the defense. I'm trying to look over her record and decide do we have an absolute certain idea of what is going on.

Q. Doctor, you put in your report that the current test was not perfect?

A. True.

Q. And you -- and as you said it's not perfect in ruling out hereditary renal papillary cancer. What were you trying to convey by saying that, that the test is not perfect in ruling out hereditary renal papillary cancer?

A. Because clinically my understanding from the literature is that multiple, small, slow-growing papillary or clear cell cancers make one think of a human hereditary papillary cancer syndrome. That's what I think she had.

Q. Why would you -- right. Doctor, you've already said you're not testifying about the cause of any of the cancer that Ms. Tukes had. You testified to that under oath a few minutes ago, right?

A. It's not my area of expertise, yes.

Q. Right. But if you're trying to raise the specter of a hereditary renal papillary cancer and you were trying to be accurate and honest, why would you not say that in the same sentence the genetic counselor said but that's a small chance? If you were really trying to be honest and accurate, why wouldn't you add that -- why would you cut that sentence in half?

A. I guess I'm trying to support my hypothesis that I think this probably was a hereditary papillary cancer syndrome. I am a nephrologist. I'm not -- I'm not the urologic oncologist involved in the case.

Q. Right. So you, based on your training, it's pure speculation, true, what you just said?

A. Okay, that's fair.

Q. Okay. Now, did you leave it out because you disagreed it was only a small chance and you rejected the genetic counselor's communication, or did you leave it out because you wanted anybody reading this report to think, oh, there was an underlying undiagnosed hereditary renal papillary cancer?

Did you leave it out deliberately?

A. I left it out as part of an argument based on my belief of her medical record. So I'm not trying to deliberately or nefariously do anything that you're suggesting.

Q. But there's no question you left it out, that is, that it was only a small chance?

A. Yeah, I grant that it's small.

Q. All right. Now, you -- in the beginning of this conversation, you said, well, I didn't put in the next sentence, too. So do you want to read the next sentence into the record that you were referring to that you also left that out?

A. I think you've just changed the document. "It is also possible that the cancer diagnoses in your family are due to a mutation in a different gene or genes or perhaps due to a combination of genetic and environmental factors."

Q. In your report you make a comment in the very next sentence about the gene test not being perfect that claims that UNC offered

Ms. Tukes a full genome testing and the NC genes study and she declined enrolling. Do you see that in your report on Page 23 and Paragraph 56?

A. Yes.

Q. What evidence do you have so that you would say in your report that Ms. Tukes declined enrolling in the NC gene study? You actually put that in the report. First let me ask you --

A. That was in one of her medical records.

Q. Why would you put in the report that she declined to participate in the NC gene study if you weren't trying to make her look bad?

A. I'm trying to say that there is, based on her clinical presentation, a reasonable chance that she has a hereditary cancer. We haven't proven it at all. But there are other tests that could have been done and weren't.

Q. Doctor, you say you saw it in a medical record she declined enrolling in the NC gene study?

A. Yes.

Q. Isn't it a fact that no medical record says she declined to participate in this study; all it indicates in one record is that she -- there was no participation by her in the study without saying why that participation didn't occur, yet you attribute it to she declined enrolling? Why did you say she declined enrolling if it's nowhere in the records that that was her declination for whatever reason?

A. Because my recollection of the record is that it says we offered her enrollment and she declined.

Q. Okay. Well -- the record will speak for itself. That's fine.

Now, Doctor, in the North Carolina records look at -- in that same record, the same letter that's on the screen, November 26, 2018, you keep saying that there's -- it's speculative you admit on your part, but you keep saying there's a chance that it could be this hereditary predisposition to renal cancer. Take a look at the fifth paragraph in that letter with the bold heading "Cancer

Screening." Do you see that?

A. Yes.

Q. All right. Now, that starts out talking about this normal result is reassuring, and it's referring to the 30 gene panel result that did not find any association between genetics and Ms. Tukes' cancer, right? That's what that's talking about the normal results are?

A. Correct.

MR. BU: Objection, foundation. Sorry. You can answer.

Q. (By Mr. Mandell) Now, that sentence -- the first sentence reads, under "Cancer Screening," "This normal result is reassuring. It indicates that you do not likely have well understood hereditary predisposition to renal cancer."

Do you see that?

A. Yes.

Q. So the genetic counselor, November 26, 2018, tells Ms. Tukes that she does not likely have a hereditary predisposition to renal cancer, right?

MR. BU: Objection, foundation. You

can answer.

A. At that time that was the counselor's advice and conclusion.

Q. (By Mr. Mandell) Right. And she recommends testing be done. It says, "We recommend that you consider to follow the cancer management and screening guidelines provided by your team."

Now, in that packet there is a letter after that that is from Julianne Daniel, a genetic counselor, and Jonathan Berg, the medical geneticist dated 9/13/22. Take a look at that, sir. We're going to put it up on the screen as well.

MR. BU: Mark, do you have a Bates stamp or Bates number?

MR. MANDELL: Yeah. It's 435.

MR. BU: I think it will be the second to last page of your packet.

Q. (By Mr. Mandell) It's on the screen now, Doctor. And it talks -- if you look towards the bottom of the letter to Ms. Tukes, it says, "Recently we received another update from the lab. They have now downgraded the PMS2 gene VUS to likely

benign."

And then do you see underneath that, it says, "This is good news and confirms the initial suspicion that these are natural variation among people and have nothing to do with cancer risk," correct?

A. Correct.

Q. Doctor, are you familiar with the subspecialty of nephrology called nephro-oncology?

A. Yes.

Q. What is nephro-oncology, Dr. Johnstone?

A. One of the major parts of that field is the number of different kidney disease -- kidney diseases that can arise from treatments of cancer.

Q. And is it a fair statement, Doctor, that you are not a nephro-oncologist?

A. True.

Q. Excuse me. You're not -- yeah. You are not a nephro-oncologist?

A. Again, true.

Q. Okay. And, in fact, there is a cancer center at Kansas University Medical

Center called the Genitourinary Cancer Center? Are you aware of that center, sir?

A. Yes.

Q. And that center has nine categories of kidney cancer specialists that are identified on the center -- the cancer center's website. Have you ever seen that, sir?

A. No. I've never looked at it.

Q. All right. The nine categories of kidney cancer specialists that are listed at the Kansas University Cancer -- Medical Center Cancer, Genitourinary Cancer Center, are medical oncologists, radiation oncologists, surgical oncologists, cytopathologists, urologists, radiologists, anesthesiologists, nurses, and mid-level providers. Are you aware of that?

A. Again, I haven't looked at the website.

Q. Are you aware that no nephrologists are listed as part of the team of doctors at the Genitourinary Cancer Center as involved with kidney cancer or kidney cancer specialists?

A. That doesn't mean we're not involved. We would be involved as a consultant from their group.

Q. All right. Not you, though?

A. Sure.

Q. True?

A. Sure, me, if I'm requested to see one of their patients as a consultant.

Q. Doctor, do you consider yourself an oncologist?

A. No.

Q. All right. Doctor, what's a transplant nephrologist?

A. A nephrologist who has additional training and certification in taking care of kidney transplants.

Q. Are you a transplant nephrologist, Dr. Johnstone?

A. No.

Q. Now, there are transplant nephrologists at Kansas University Medical Center, true?

A. True.

Q. All right. And transplant nephrologists, among other things they do,

they do an evaluation pre-transplant, they get patients waitlisted for transplants, they do living donor evaluations, they do post-transplant management, they collaborate with the transplant team, and they do research and develop innovations. Are those all fair statements, sir?

A. Yes.

Q. By the way, when did you first become aware of -- by the way, are you aware as you sit here now that Mr. Mousser had a recurrence of his cancer?

A. I don't know any details about it. That's about as much as I can say.

Q. Doctor, when did you first -- well, strike that.

Do you know whether or not Mr. Mousser has had a recurrence of his cancer? I know you say you don't know any details about it. Do you even know that detail, that he had a recurrence of his cancer?

A. I have heard, but it was not described as kidney cancer. It was described as bladder and that's all I --

Q. When you say you've heard, who have you heard that from?

MR. BU: So, Dr. Johnstone, your conversations with DOJ attorneys and other experts are protected. You should not disclose the substance of those communications.

Q. (By Mr. Mandell) Did you hear from any other source other than a DOJ attorney?

A. I -- probably not.

Q. Okay. Now, did you ever review any records, medical records, that address Mr. Mousser having a recurrence of his cancer?

A. No. None were available to me at the time.

Q. At what time, sir?

A. The time I was --

Q. Up till today have you ever looked at any medical records that addressed Mr. Mousser's recurrence of cancer?

MR. BU: Dr. Johnstone, you need to wait for Mr. Mandell to finish his question before you respond. You can respond.

MR. MANDELL: Thank you.

A. My opinion was based on all the records I had at the time the opinion was finished. I haven't seen anything on Mr. Mousser since that.

Q. (By Mr. Mandell) And your opinion was filed and finished -- you signed off electronically I think April 7th, maybe April 8th, and it was filed in this case and we received a copy of it on April 8th. Does that sound consistent with your memory?

A. That sounds right.

Q. Yeah. At the very back of the report, it actually says when you signed off on it and when it was filed also in the report, it says that.

Doctor, are you aware that on March 5th -- strike that.

On March 5th, 2025, on -- in the Mousser report by Dr. Shahnasarian at Page 45, it actually states in that report by Dr. Shahnasarian we reviewed Mr. Mousser's comorbidities unrelated to his UTUC and also discussed his recent diagnosis of bladder cancer."

Is that true or not true?

MR. BU: Same instruction, Dr. Johnstone. The substance of your communications with other DOJ experts are protected. I'm going to instruct you not to disclose the substance of those communications.

Q. (By Mr. Mandell) Dr. Johnstone, are you answering the question or no?

A. I am certain that I haven't received or looked at any information about a recurrence of cancer for Mr. Mousser.

Q. Doctor, do you see in Dr. Shahnasarian's report where he says we also discussed his recent diagnosis of bladder cancer on Page 45? Do you see that?

A. Yes.

Q. All right. If that's true that on March 5th you discussed with Dr. Stadler and Dr. Shahnasarian Mr. Mousser's recent diagnosis of bladder cancer, why wouldn't you include that in your report, that fact, that he had a recurrence of cancer?

A. My report is based on kidney disease, which is my area of expertise. And knowing no details about his bladder cancer

recurrence, it doesn't influence his kidney disease staging or projected outcomes with regard to kidney disease.

Q. Doctor, what do you consider -- do you know that it was diagnosed as a recurrence of the cancer that was found in his kidney years before?

A. I don't.

Q. All right. Doctor, there is a section of your report called "Relevant Clinical History" for Mr. Frank Mousser, true?

A. All right. Let's go to that part, so I can find out what you mean.

Q. Doctor, don't you know that in both of your reports for Ms. Tukes and Mr. Mousser there is a section that the title is "Relevant Clinical History"?

A. Sure.

Q. For Mr. Mousser it's for him, and for Ms. Tukes it's for her?

A. Yes.

Q. You don't think that Mr. Mousser's having a recurrence of the cancer that was found in his kidney, it was upper tract urothelial carcinoma, you don't think the fact

he had a recurrence lower down in the urinary system of that cancer is pertinent relevant clinical history for him?

A. You're saying kidney cancer. Again, it's my understanding that it is not kidney cancer. It was described as bladder cancer. I knew no more details about that bladder cancer. And bladder cancer, per se, does not have a direct bearing on his kidney disease.

Q. Doctor, look at Page 23 of your report for Mr. Mousser. When you get there tell me.

A. All right.

Q. Look at paragraph 53 on Page 23.

A. I'm there.

Q. Paragraph 53, the very last sentence, you discuss the pathology of the kidney that was removed due to cancer in Mr. Mousser. Please read that into the record.

A. "Pathology of the resected kidney confirmed high-grade noninvasive papillary renal carcinoma with negative margins and negative lymph nodes."

Q. Right. And you just mentioned I keep saying -- or I mentioned that it was kidney cancer. In that sentence in your report, paragraph 53 on Page 23, you say that pathology of the resected kidney confirmed high-grade noninvasive papillary renal carcinoma with negative margins and negative lymph nodes.

Renal carcinoma means kidney cancer, doesn't it?

A. Yes. This isn't referring to the recurrence that we're talking about.

Q. But, Doctor, the recurrence was simply, that renal cancer, some of the cells moved down the renal -- down the urinary tract to the bladder, and that's why it was called a recurrence and not a metastasis, true?

A. I don't know that at all.

Q. Because you haven't looked at any of the records for that, right?

A. I never saw those records, true.

Q. Did you -- when you found out -- assuming it's true what Dr. Shahnasarian says, it was as early as March 5th, 2025, did you ask anybody to see those records?

A. I didn't think -- again, it was described as urothelial carcinoma. I didn't think it was relevant to his current kidney disease.

Q. Then why did you put in your report on Page 23 that it was renal carcinoma per pathology, which is kidney cancer?

A. You're describing something different. It was described to me as urothelial carcinoma.

Q. Right. Was it described as a metastasis, or was it described as a recurrence to you?

A. I don't recall, sir.

Q. There's a big difference, isn't there?

A. Between recurrence and metastasis?

Q. Yes.

A. I don't think there's a big difference, but I'll defer that question to a medical oncologist.

Q. So your answer as to why you didn't include Mr. Mousser's recurrence of his upper tract urothelial cancer anywhere in your report is because you didn't think it was

relevant; is that your testimony?

A. I was finishing my report based on all the information I had at that time. And at that time it wouldn't have -- all right.

Q. No, go ahead. Go ahead. At that time, you mean before you filed your report on April 8th?

A. It would not have influenced his kidney function or the projection for progression of kidney disease over time.

Q. Okay. Doctor, in your resume you have a section that you call "Honors," true?

A. True.

Q. And you list what you obviously considered to be honors that you have received over time in that section, right? It starts on Page 2 of your resume, goes to Page 3 --

A. True.

Q. -- right? All right.

MR. MANDELL: Ted, can you take out Dr. Johnstone's resume, and let's mark that as the next exhibit. I guess that would be six, sir.

MR. RUZICKA: Yes. I'm marking the CV from May 2024 as Exhibit 6.

(Exhibit 6 was marked.)

Q. (By Mr. Mandell) Do you have that in front of you, Doctor?

A. Yes.

Q. Okay, good. What is it that you -- and listed -- strike that.

What was the criteria you used for you to put something in the honors section of your CV so that you would put it there? What do you mean by honors is my question?

A. Most of these are awards. A few others having a Faculty of 1000 article is just considered an honor. Being nominated in Nephrotic Syndrome Specialists is just considered an honor. So it's a professional honor.

Q. Right. You say the -- you referred to the Faculty of 1000 recommended article that you have listed in your resume with a link to the article --

A. Uh-huh.

Q. -- that you got in January of 2013. You said that is considered an honor, right?

A. Yes.

Q. By whom?
A. Professional colleagues.
Q. Okay. Well, let me ask you a few questions about that. The Faculty of 1000 recommended article --
A. All right.
Q. -- what is the Faculty of 1000, sir?
A. A group of scientists who look through the medical and scientific literature to decide which papers should be of particular interest, and they try to highlight those because there are just so many other articles written.
Q. Why is it Faculty of 1000? What does the 1000 refer to?
A. The number of people involved in the judging and selection process of notable articles.
Q. Yeah. All right. So the articles that you -- you've had one article that you put the link there for and Faculty of 1000, right?
A. Yes.
Q. And the article is titled APOL1,

"Null Alleles From a Rural Village in Indiana Do Not Correlate With Glomerulosclerosis." Is that true?

A. Yes.

Q. Okay. So let me just ask you a few questions about the -- what you call the honor of Faculty of 1000 to the extent you put it in your resume as an honor. Does Faculty of 1000 require that an article be peer reviewed prior to publishing it?

A. I don't think they publish it. I don't know all of the criteria they use to choose an article that they recommend or nominate.

Q. Okay. Doctor --

A. That article was peer reviewed.

Q. Isn't it a fact -- by the way, who peer reviewed your article prior to its publication?

A. I can't possibly know that. It's anonymous by design.

Q. Okay. There's not -- okay. Well, we'll talk about that in a second.

Isn't it a fact that Faculty 1000 does not peer review any article before it's

published? Isn't that a fact?

A. They're not the publisher. I think there's a point of confusion here.

Q. Have you ever been to their website, Doctor, Faculty of 1000? Have you ever Googled or researched them to see if indeed your article was peer reviewed before it was published or that they peer review or anybody does the Faculty 1000 article before it's peer reviewed? Have you ever checked that out, Doctor?

MR. BU: Objection, form. You can answer.

A. Again, I think you're misunderstanding the peer review process with that honor.

Q. (By Mr. Mandell) Doctor, isn't it true that the only peer review done of a Faculty 1000 article is actually done after it's published?

A. Again, by design.

Q. Yes, it is by design.

A. It's not the peer review process. They aren't the publishers. They aren't the peer reviewers.

Q. Doctor, have you ever participated yourself in a Faculty 1000 article as a peer reviewer?

A. No, I'm not a member.

Q. Doctor, are you aware that the Faculty 1000 website states peer review occurs after publication? Are you aware of that?

A. Again, it has to. That doesn't surprise me.

Q. All right. Doctor, the New England Journal of Medicine, does it peer review articles before they're published?

A. Again, sir, you're mixing up peer review for publication with a group of scientists who, as I said, comb the medical and scientific literature for articles to highlight them. So I think you're very confused.

Q. Yes. Thank you. Doctor, does the New England Journal of Medicine peer review articles before it is published in the New England Journal of Medicine?

A. As part of their process, absolutely. That is the process.

Q. Doctor, how many -- you say you

don't know how many people peer reviewed your article; is that true?

A. And I can't know who they were. That's true.

Q. Well, Doctor, how come we know who they were, it was a woman named Christine Clayton, who posted on the internet that she reviewed your article after it was published? Do you know who Ms. Christine Clayton is?

A. I don't. You're saying that you can find -- not someone who read the article, but the actual reviewer for the journal in which it was published? Those are two very different things.

Q. You can get three different grades, so to speak, for an article that is published through F-1000, Faculty 1000, right? You can get three stars, which is the best; you can get two stars, which is middle; and you can get one star, which is the opposite of three, by that gradation. Are you aware of that?

A. I'm not aware of that.

Q. Are you aware that when Ms. Clayton reviewed your article she graded

you with one star, not two, not three, on that article?

A. Again, I'm not aware of that.

Q. Are you aware that, to have an article published as part of Faculty 1000, there is a --

A. It's not published as part of it. Again, that's an error, sir. It is published as part of the peer review process by a medical or scientific journal.

MR. BU: Dr. Johnstone, you do need to let -- I'm sorry, Mark.

You do need to let Mr. Mandell finish his question before you respond.

THE DEPONENT: I'm sorry.

Q. (By Mr. Mandell) Doctor, are you aware that Faculty 1000 has what is called article processing fees for all articles, meaning that the person -- someone has to pay to have an article published after submission with Faculty 1000?

A. I'm not aware of that. And that was not true at whatever year that was. It was simply a nomination.

Q. All right. So your testimony

under oath is you did not pay that fee so that your article could be published?

A. Yes, that's correct. I paid nothing and did not even know until you're telling me today that they have become a publisher. My understanding is that it was a type of professional journal club, like a book club, for scientists and doctors.

Q. Doctor, in your report on Ms. Tukes on Page 24, paragraph number 60 --

A. All right.

Q. -- you cite Dr. Jayaram, who is Ms. Tukes' medical oncologist, his notes from June 16, 2022, office visit. Do you see that in the last sentence of that paragraph number 60? Do you see that Page 24?

Look at the last sentence. Do you see where it refers to Dr. Jayaram's notes from June 16, '22, visit?

A. Yes.

Q. All right. And you say that that included a discussion of recurrent kidney cancer with Dr. Rose from UNC Urologic Oncology. And you say that note documents, "With low-grade papillary cell" -- "clear

cell, unlikely to metastasize, no adjuvant therapy, only surveillance," right?

A. Yes.

Q. Now, this was on June 16, 2022, which is before Ms. Tukes had her left kidney entirely removed, right?

A. Correct.

Q. All right. Why did you put this into your report that Dr. Jayaram had a note that identifies Dr. Rose from UNC and that no adjuvant therapy, only surveillance would be recommended? Why did you put that in this report if not to be critical of Dr. McCarthy for doing surgery to remove kidney cancer?

A. My personal opinion is -- is critical. My professional expertise is not in the area of urologic oncology.

Q. Right. When you say your personal opinion is critical, what do you mean, critical?

A. As a kidney doctor, I would have advocated to try to save and preserve her kidney function.

Q. Did you read Dr. Jayaram's deposition, sir? It was on your materials

considered list. That is Ms. Tukes' treating medical oncologist. Did you read his deposition?

A. I don't think I did.

Q. All right.

MR. MANDELL: Ted, could you bring up, please, Dr. Jayaram's deposition, and we'll mark that as the next exhibit, please. Do you see it, Ted?

MR. RUZICKA: Yes. I'm marking as Exhibit 7 the deposition transcript of Dr. Jayaram.

(Exhibit 7 was marked.)

Q. (By Mr. Mandell) Could you let me know when you have it?

A. Yes, I've got it.

Q. Okay. Look at Page 59 of Dr. Jayaram's deposition, which you would have seen, 59 through 63, if you had read it, sir. But take a look at it, okay?

A. All right.

Q. Look at Page 59, line 10. It just identifies the conversation. It was about that June 16th, 2022, visit between Dr. Jayaram and Ms. Tukes. Do you see that?

A. Yes.

Q. All right. Turn to Page 63 of Dr. Jayaram's deposition and look at line 3, which addresses what he was referring to about adjuvant therapy and why that would not be done or should not be done. Do you see in the question, it says, from the DOJ attorney, and when you reference, quote, at this point she would not consider, meaning Dr. Rose, any sort of adjuvant therapy.

I first want to ask you, what is adjuvant therapy.

And Dr. Jayaram answers what adjuvant therapy is. He says adjuvant therapy is after surgery we would consider things like chemotherapy. And then he continues, and in kidney cancer we don't give a regular thought of chemotherapy. That, you know, kind of cytotoxic. So in this case there's oral chemotherapies and there's immunotherapy that we may give to try and prevent recurrences or spread to other areas of the kidney cancer, so they didn't recommend any -- doing any adjuvant therapy.

And then the next question by the

DOJ attorney is, And so, again, that's a great clarifying point. When it says she would not consider, you're referring to the doctor at UNC and not Ms. Tukes, correct?

And the answer was, so yeah, Dr. Jayaram said. The doctor would not consider doing that for Ms. Tukes. Yeah.

So, first, did I read that correctly, sir?

A. Yes.

Q. And what Dr. Jayaram explained about not doing chemotherapy is it would be toxic to Ms. Tukes' kidneys, true, and that's why it wouldn't be done?

A. That's not really what it says.

Q. He doesn't say on Page 63 that we don't -- in a kidney cancer we don't give regular thought of chemotherapy. That, you know, kind of cytotoxic. Doesn't he testify to that under oath on Page 63?

A. And then he goes on to say there are oral chemotherapies and immunotherapies that we may try to give.

Q. And then he says, so they didn't recommend doing any adjuvant therapy, right?

A. Right.
Q. And the reason he didn't -- he agreed with not recommending adjuvant chemotherapy is because it's cytotoxic. Did you know that?
A. Again, that's not the reason that they're not recommending it. They're not recommending it because it wasn't indicated in her condition.
Q. You've never talked to him, right --
A. No.
Q. -- in addition to not reading his deposition, true?
A. I've never spoken to him.
Q. By the way, in both -- in Ms. Tukes' and Mr. Mousser's reports by you, you repeat language, almost verbatim, that Ms. Tukes and/or Mr. Mousser, whoever's report it was, is seeking judgment against the USA on the basis that contaminated water from Camp Lejeune caused kidney cancer which resulted in bilateral nephrectomy, the need for dialysis, and eventually led to kidney transplant.
Now, that is from Ms. Tukes'

report. But that similar language is in Mr. Mousser's report. Why say it at all and why repeat it in both reports?

A. I'm trying to remember writing that section. And I think I was going back into the initial legal filings and trying to put accurately at that very part of my report the reasons that they had stated for starting this suit. So I think I'm taking it from the records of their suits.

Q. Doctor, when you were hired to work on the case, these cases -- by the way, do you know what I mean by the word equipoise?

A. Sure.

Q. All right. What does equipoise mean to you, sir?

A. Balance between two competing possibilities, favoring neither.

Q. All right. Are you -- have you ever read the statute which enabled these lawsuits on the Camp Lejeune water contamination cases that is the Camp Lejeune Justice Act? Have you ever read any part of that, sir?

A. No.

Q. Have you ever read anything at all that talks about the standards to be applied as part of what the Marines have to prove individually to be successful in their cases in terms of what standards have to be met?

MR. BU: Object to form. You can answer.

A. No.

Q. (By Mr. Mandell) Are you aware of any of that information as you sit here today in this deposition?

A. When you -- can you -- can you be more specific about what information?

Q. Yeah. Are you aware as you sit here today as to what congressional -- United States Congress law in the Camp Lejeune Justice Act requires as the standard to prove causation in this case by the plaintiffs?

MR. BU: Object to form. You can answer.

A. No.

Q. (By Mr. Mandell) When you were hired in this case, it came, as we talked about briefly before, through an expert finder service called Versed; is that true?

A. Yes.
Q. Were you vetted at all by Versed and/or the DOJ prior to your hiring to your knowledge?
A. Probably.
Q. I think one of your references indicates that you had references that you sent. Did you do that, sir?
A. I don't remember exactly what references, but I would have given them something, yes.
Q. All right. On September 19th in your billing records it indicates that you were sending references. Does that help you with your memory as to who the references were?
A. I'll be honest, I don't know if those are professional references or what we would call references of literature, so papers to read.
Q. The very first billing item in any of your bills was September 19th. It was actually before you were hired, true?
A. I don't recall. I'll take your word for it.

Q. Fine. And it says you referred to a conversation with DOJ attorneys by name and other team members, and then it says then coordinating schedules and sending references. You're saying that could have been references to the literature as opposed to job references since you hadn't been hired yet?

A. No. If this is before I was hired, then it was probably peer references or potentially my work in prior cases.

Q. The next billing item, which it spans 11 days from September 16th to September 27th said efforts to get DOJ clearance, discuss with Dennis Murphy at Versed, with security specialist, including Stephanie Jackson, including an FOIA request to the DHS, eventually escalated to Nathan Bu.

And you said that took an hour. Are you aware that that's in your billing statement, sir?

A. That rings a bell, yes.

Q. All right. It says discussed with Dennis Murphy at Versed these efforts to get DOJ clearance. Who is Dennis Murphy from Versed?

A. I think he was my point of contact, again, at Versed.

Q. Are you aware that he was the chief revenue officer at Versed?

A. No.

Q. Are you aware that he's the head of sales at Versed?

A. No.

Q. All right. If that's indeed accurate, why would you talk to the chief revenue officer at Versed about getting security clearance?

A. He was the person emailing me about involvement in the DOJ case. I was trying to get on the CORA server so I could start to help review all these records, and it's a secure, very difficult process. So when I failed, I was reaching out to everyone in my email for help.

Q. Dr. Johnstone, are you aware that at least as of February 26th, '25, DOJ sought a revised total contract funding from Versed of up to $749,000 and change?

A. That's the first I've heard of it.

Q. Your fee in this case is $850 an

hour for your time; is that true?
A. Partially true.
Q. What's untrue?
A. So my understanding is that Versed is charging the DOJ. My contract is directly with Versed.
Q. You pronounce it Versed?
A. Either is okay. I don't know how it's pronounced.
Q. All right. Me too. Me too. All right. So the -- are you paid by DOJ or by Versed, or Versed?
A. I'm paid by Versed.
Q. And are you paid $850 an hour?
A. No.
Q. So does Versed get a piece?
A. Yes.
Q. Of -- of what you charge?
A. Yes.
Q. -- or of the 850? How much?
A. I make 500.
Q. How much have you been paid to date, sir?
A. I don't know offhand. My guess would be between 20 and 35,000.

Q. Well, the time that you have spent on this case, if it's tabulated up and it's at $850 an hour, that amount is still well over $80,000, true?

A. I don't know that. I haven't tabulated it.

Q. Now, in your reports, both Mr. Mousser's and Ms. Tukes', the first 22 pages of each report is 100 percent identical, true?

A. That's true.

Q. All right. And you have spent over 100 hours on the case --

A. Again, I haven't tabulated it.

Q. -- for these two cases?

A. I haven't tabulated, but that's possible.

Q. So in Mr. Mousser's report -- which is 26 pages long, true?

A. Yes.

Q. -- there are only four pages -- less than four pages that deal specifically with Mr. Mousser out of this 24-page report, right?

A. Right.

Q. So for all the time you've spent in this case and all the money that you and Versed have been paid in this case, as to Mr. Mousser, you've got a four-page, as to Mr. Mousser, report with the balance being the first 22 pages which is identical to the introductory part of Ms. Tukes' report, correct?

A. That's true.

Q. And for Ms. Tukes you've got a 31-page report that, just as Mr. Mousser's, the section on her begins at Page 23, because the first 22 pages are the same introduction that Mr. Mousser had, so you've got eight pages concerning specifically Ms. Tukes out of the 31-page report, right?

A. Correct.

Q. So for all the billing entries you have for all the time you've spent on this case, the great majority of your reports is a general introduction that is verbatim, including typographical mistakes verbatim, in both reports, right?

A. If you choose to characterize it that way.

Q. Doctor, according to your billing statements, your efforts to get clearance went through September 27th. And on September 27th you started, according to your billing statements, writing your general background report and on that day spent two hours, true?

A. I can't recall how much time, but I'm certain, if I wrote that in the billing report, that's how many hours I spent.

MR. MANDELL: All right. Ted, could you get the Dr. Johnstone's invoices and have them marked as the next exhibit, please.

(Exhibit 8 was marked.)

MR. RUZICKA: I've marked as Exhibit 8 Dr. Johnstone's billing records.

Q. (By Mr. Mandell) So take a look, Doctor, at the first page of the billing records that is the time you spent in September.

A. All right.

Q. And look -- you see 9/16 to 9/27, trying to get security clearance, eventually escalated to Mr. Bu?

A. Uh-huh. Yes.

Q. On September 27th, it says writing

general background report for two hours, right?

A. Right.

Q. Next entry, September 29th, writing general background report, one hour and 15 minutes, correct?

A. Correct.

Q. September 30th, same, general writing, general background report, that time 30 minutes --

A. Also correct.

Q. -- right?

All right. The next month, October -- reflecting October, you've got work on CKD, chronic kidney disease, overview, work on introduction, work on introduction again, CKD overview, for the dates October 4, 29, and 30, right?

A. Right.

Q. So the next month it says November 27th, writing for 170 minutes, true?

A. Yes.

Q. And, again, that refers to the overview, right?

A. Yes.

Q. All right. The next month, December, it talks about you preparing for the EO group about settlements, a presentation, and then you gave it on December 19th to the EO Navy group on EO settlements, true?

A. Yes.

Q. And then on the last two dates of December the 30th and 31st, you spent writing intro overview, writing and editing, for 270 minutes, right?

A. Yes.

Q. And that continues, your writing on this overview, in January and February, beginning of February, correct?

A. Somewhere in here part of this writing and editing is the beginning of incorporating all the clinical information into the reports. I don't know where it begins, but it's the same amount of time.

Q. Right. Doctor, look at February 5th, 2025. It says you wrote for six hours, from 8:00 a.m. to 2:00 p.m., on February 5th, correct?

A. Correct.

Q. And then at 5:00 p.m., it says

review Tukes for 30 minutes, right?

A. Yes.

Q. Correct? Okay.

So you were -- became an expert in this case in late September, and the very first mention in any bill by you of any review you did of any records in this case, whether it's medical records of Ms. Tukes or Mr. Mousser, whether it's depositions, whether it's any reports, the very first mention that you did any work on this case, other than to write your introduction, was at 5:00 p.m. on February 5th, 2025? Months after you were hired, months after you started writing this introduction, is the very first mention of any review by you of anything specific to either Mr. Mousser or Ms. Tukes, true?

MR. BU: Object to form. You can answer, Dr. Johnstone.

A. Yeah, I think that 5:00 p.m. was actually a review of progress with the DOJ as a Zoom or Teams call. I had been -- when I say writing, a lot of that is also going into the CORA records and, again, paging through a large -- a large database. It's all part of

the writing process. Neither Versed nor DOJ requires that I say exactly what I'm doing from one minute to the next. So I'm accounting for total time.

Q. So when you say writing general background report, you don't mean writing general background report alone; you mean that you're reviewing depositions, medical records, et cetera; is that your testimony?

A. Well, if I say writing general background report, it means exactly that. But the entry -- the entry on February 5th just says writing, and that's --

Q. And then it says, after that, review Tukes; it has the word review?

A. And I think that was a review of my status on a Zoom or Teams call. It wasn't the start of reviewing the Tukes record.

Q. Doctor, on February 23rd, '25, does it not indicate that for three hours and 20 minutes, from 12:00 to 3:20 p.m., review of plaintiff statements?

A. It does.

Q. So why not just say writing if by that you mean review of documents?

A. I -- can you be a little more specific what you're getting at.

Q. What I'm getting at, Doctor, is that there is no reference in any of your billing from September through the beginning of February that you reviewed any documents; that all you did was write this generic introduction that's 22 pages long that you didn't look at any medical records of Ms. Tukes or Mr. Mousser or any depositions or anything else; all you did was say you were writing this review, the introduction. That's my point.

A. Well, I don't remember what --

Q. And yet when you did review something, you said you reviewed something, like plaintiff statements.

A. I don't remember --

MR. BU: Object to form. I'm not sure there's a question pending.

Q. (By Mr. Mandell) Yeah. The question is on March 2nd, 2025, take a look at that bill, Doctor.

A. March 2nd?

Q. 2nd.

A. All right.

Q. You don't say writing, you don't say writing introduction. You actually say what you're reviewing, Invitae test report, deposition of Dr. Thomas, deposition of -- you call her Gabaran, but you meant Garbarini I'm sure.

So when you reviewed something, you identified you reviewed it and what it was, true?

A. Sometimes these notes have more detail than others. It's not an exact accounting.

Q. And your testimony under oath in this deposition is, prior to March 2nd every time you wrote writing general background report, you meant you were also reviewing medical records, depositions, expert reports, et cetera?

A. I haven't said --

Q. Is that your testimony?

A. I haven't said that, either, no.

Q. Well, when I asked you is there any mention at all from September 27th until February 5th where it says review Tukes, was

there any reference in your bills you reviewed anything concerning this case, you said, well, when I say writing reports -- and then I'm not even sure what you said after that.

So the question is, when before, say, February 23rd, review plaintiff statements, do you indicate in this billing record that you reviewed any documents concerning these two cases?

A. It was difficult to get into the CORA database. I don't remember the date I started. It could have been December. It could have been January. Once I started reviewing that, I was focused first on Tukes, and I was trying to again go through a very large database as quickly as I could.

Q. Doctor, on April 14th you have an entry, signing -- April 10th you have review of life plan documents trying to sign and then on April 14th signing life plans. What life plans did you sign, plural?

A. That probably refers to the Tukes and Mousser life care plans from Dr. Shahnasarian.

Q. Yeah. Are you aware that Dr. --

the only name identified with Mr. Mousser's life plan table is Dr. Stadler, not you, in terms of the name on the plan?

A. I'm not aware of that, no.

Q. It does indicate you contributed, but the doctor whose name is on the plan, like yours is for Ms. Tukes, is Dr. Stadler. You're not aware of that? Is my telling you that the first time that you know that?

A. Yes.

Q. All right. May 21st, your billing record indicates a mock deposition of three hours. Where were you? Was that in person or virtual?

A. Virtual.

Q. Had you ever participated in a mock deposition before on any case, including this one, before May 21st?

A. No.

Q. Were you questioned during that as if it was a lawyer like me doing it?

MR. BU: So to the extent your response would require you to disclose conversations with DOJ attorneys, I'm going to instruct you not to respond. If you can't

respond, you should let Mr. Mandell know.

A. I'm not sure how I can respond to your question. I'm sorry.

Q. (By Mr. Mandell) Do you know who organized that mock deposition, whether it was DOJ or Versed or both?

A. Probably DOJ.

Q. Were there any other experts -- defense experts present during your mock deposition?

A. I don't think so, no.

Q. Do you know anything about Versed as an organization, Dr. Johnstone?

A. I don't.

Q. Do you know that they sponsor the Philadelphia Association of Defense Counsel?

A. I did not know that.

Q. Do you know that they sponsor the spring and fall meetings of the Connecticut Defense Lawyers Association?

A. No.

Q. No?

A. No.

Q. Do you know if the experts you've talked to about this case, Dr. Shahnasarian,

Dr. Stadler, Dr. Vance, and the unknown expert, whether they were obtained by DOJ through Versed?

A. I don't know.

Q. Do you know how many experts in this case who are the defense came from Versed out of Pennsylvania?

A. I don't know.

Q. Your material considered list, did you review all of the documents that are identified on that list?

A. Can you show me what you're referring to?

Q. Sure, of course.

MR. MANDELL: Ted, could you please get the material considered list for Mr. Mousser's case and Ms. Tukes' case and have them marked as the next two exhibits, please.

(Exhibits 9-10 were marked.)

MR. RUZICKA: I'm marking as Deposition Exhibit 9 the materials considered list for Mr. Mousser.

MR. MANDELL: Is Ms. Tukes' materials considered list Number 10, Ted?

MR. RUZICKA: Yes. I'm marking the materials considered list for Ms. Tukes as Exhibit 10 and handing that to the doctor.

Q. (By Mr. Mandell) Do you have it, Doctor?

A. Yes, all set.

Q. Who prepared this document, the materials considered list, Exhibit 9 and Exhibit 10?

A. I don't know.

Q. Did you review -- by the way, the materials considered list totals 45 pages long; is that true?

A. Yes.

Q. Is that true?

A. Yes.

Q. Okay. In fact, it's so long there had to be a table of contents indicating what documents were on what pages, true?

A. True.

Q. And there are expert reports that are listed on Pages 2 and 3? Page 2 are the PLG, the plaintiffs' experts. And Page 2 -- excuse me, Page 3 are the DOJ experts.

A. All right.

Q. Correct? Did you review all these expert reports, sir, on Pages 2 and 3?

A. No. I think I reviewed some of them.

Q. All right. Which ones did you review? Which of these expert reports that are on the list of materials you considered, in fact, did you review?

A. So I -- to the best of my memory, I looked at a report either from Bird or Mallon. Again, I'm not remembering exactly. Definitely from Matthew Cooper. Yes for Dr. Allen. Yes for Dr. Cooper again.

Q. When you say yes again, you're talking about in the Tukes case for Dr. Allen and Dr. Cooper again?

A. And Cooper for the Mousser case, also.

Q. Yes. Right. Okay. Anything else? Any of these reports additional you looked at plaintiffs on Page 2?

A. Again, I think I looked at parts of some of these reports. And if I was reading it through and nothing jumped out, I would have just kept going to the next one.

Q. So --
A. I think --
Q. The reports -- I'm sorry. Go ahead.
A. I think I read part of a report also from Mallon for Tukes, also.
Q. And is it a fair statement that the rest of these reports on Page 2 from the plaintiffs' experts you did not review, or you might have started reviewing but none of it registered to you so you didn't rely on it or put any of it in your report; is that true?
A. Or, at most, I put a small part, because I wouldn't have thought that it was critical to what I was seeing elsewhere in the record and trying to write.
Q. Can you remember any of these reports that you might have taken a small part and mentioned?
A. I'd have to go back to -- to the writing process. I'm really not remembering.
Q. How about the DOJ experts' reports, did you review any of those? Page 3.
A. Dr. Stadler and Dr. Vance and then -- I reviewed parts of other reports. If it

was toxicology reports, it was -- it was dense reading, the toxicology. So I think I reviewed a few of the other ones, but I don't recall details right now.

Q. Did you review Dr. Shahnasarian's reports?

A. I don't think they were completed by the time I was submitting mine, so no.

Q. Did you review any of the depositions that you have listed on page -- as part of this materials considered list?

A. I think I reviewed --

Q. Did you review Dr. Bove's depositions?

A. That name doesn't ring a bell.

Q. Savitz?

A. I'm sorry. It's not ringing a bell.

Q. Did you review any of the depositions that were Mr. Mousser's case?

A. I mean, I know I reviewed a few of the depositions, and I wasn't finding new information in them compared to the actual medical records from CORA. So I was just going through them as fast as I could to find

something that was different than the medical record.

Q. Is there any part --

A. And I don't think there was.

Q. Okay. Sorry. Is there any part of anything you read in any of the depositions that you were provided that are on your materials considered list that serve as any basis for any of your opinions in this case?

A. There are a lot of any's there. I don't think so. Can you give me an example?

Q. On Page 6, Doctor, on your materials considered list, there's a section "Other Articles and Literature." Did you read any of that?

A. I think I read part of Number 10.

Q. That's the National Research Council 2009?

A. Yes.

Q. It's 339 pages. What part did you read?

A. Sir, I'm not going to remember.

Q. Do you remember anything you read in it?

A. Trying to assess levels of a few

different compounds at different parts on the base.

Q. Doctor, on Pages 7 to Page 45, it's a category "Other Documents Produced in This Litigation." And it's just a series of Bates stamped numbers. Do you know what's in -- if you needed to find a record, would you actually know how to find a record on Pages 7 through 45?

A. This is the first time I've seen this compendium, so no.

Q. Now, there is also 363 pages of a chronology on Mr. Mousser and Ms. Tukes that was prepared by an organization called LMI, Litigation Management, Inc. Did you review those chronologies?

A. Doesn't ring a bell at all, no.

Q. All right. Well, in the very beginning of both of your reports, you say on Page 1 of both reports that -- the very first thing you say actually is, "I have reviewed primary and summary documents for Mr. Frank Mousser," and you say the same for Ms. Tukes. What summary documents?

A. There were a few documents at

first before I got into the CORA database in something called Box. And they were extractions of a complete medical record, so I was reading medical record documents. It just wasn't the complete list.

Q. Doctor, your reports that have been marked as Exhibits 1 and 2, did you use artificial intelligence to prepare any part of either report?

A. No.

Q. So the 22-page introduction was entirely in your words?

A. Entirely.

Q. All right. Have you ever used that introduction, that 22 pages, in any other presentation you've ever given?

A. I mean, I've used some of the slides and some of the general concepts in many talks, because I give presentations about chronic kidney disease and some other subjects. So in that regard, it's -- it's really just another hopefully fairly comprehensive overview of chronic kidney disease.

Q. The analogy to the coffee maker

that you have --
A. Yes.
Q. -- on Page 5?
A. Yes.
Q. -- is that original to you?
A. It is. I think other people like it and have used it, but it was my own.
Q. Your reports, did anyone help you draft them, any part of them?
A. I don't have any assistants, so no.
Q. Okay. Are they, the reports, a -- do they include all of the opinions that you have on this case that you would testify to at trial?
A. I certainly think so. Can you tell me what you mean?
Q. Is there anything -- is there anything, as you sit here now, understanding this is -- this may be my only time to ask you questions about your reports, is there anything you want to change that's in your reports or add to, add to them, as you sit here now, sir?
A. If new information on the clinical

status of either patient comes to light, I'd be happy to look at that. I haven't seen it and hadn't seen it at the time of these reports. So with regard to these, no, they stand alone.

Q. Okay. So my question to you is as you sit here now, not what may happen in the future. But as you sit here now, as I have this opportunity to ask you questions, is there anything you would add to either Ms. Mousser or Ms. Tukes' report or subtract from it, either way?

A. No.

Q. Okay.

A. I wish I could edit some of the grammatical errors that I see in the reports.

Q. Yeah, okay. So you understand I didn't mean that, right? I meant content.

Is there anything you would change at all about these two reports, or are these reports a full, comprehensive, and accurate recitation of your opinions in this case?

A. Yes.

MR. BU: Wait for Mr. Mandell to finish his question, Dr. Johnstone.

THE DEPONENT: Okay. I'm sorry.

VIDEO TECHNICIAN: And, Mr. Mandell, I need to change the video again.

MR. MANDELL: Okay. It's 1:30, guys. I'm happy to keep going or I'll do whatever you want to do.

VIDEO TECHNICIAN: Let's go off the record at 12:29.

(Recess.)

VIDEO TECHNICIAN: We are back on the record at 1:04.

(Exhibits 11-12 was marked.)

Q. (By Mr. Mandell) I have asked to have marked as Exhibits 11 and 12 the LMI summaries, 11 for Mr. Mousser, 12 for Ms. Tukes.

Doctor, have you ever seen Exhibits 11 and 12 before?

A. I can't tell in this form. It's definitely possible. This might have been one of the things that I reviewed.

Q. Well, Exhibit 11, which is Mr. Mousser's LMI summary report, is 281 pages, true, if you look at the bottom --

A. It feels about that size. Yes,

281.

Q. And Exhibit 12, Ms. Tukes, is 82 pages. And these are summaries that are represented to be summaries of the medical records in the case or at least some of the medical records in the case, true?

A. Again, I -- I'm not 100 percent sure what's in these. Some of it looks somewhat familiar.

Q. Can you testify under oath whether you looked at Exhibits 11 and 12 or you did not as part of your work in the case?

A. Again, nothing that was named an LMI summary. So the format looks somewhat similar to things that I recall reviewing. I think that's about as much detail as I can -- as I can give you is that nothing was ever called an LMI summary, but this has a similar format.

Q. Okay. Do you see at the bottom left-hand corner of Exhibits 11 and 12 it says prepared by Litigation Management, Inc.?

A. Yes.

Q. Is it your testimony -- well, strike that.

What is your testimony as to -- as it relates to the medical records for Ms. Tukes and Mr. Mousser, whether you looked at the original medical records -- and I don't mean the ones that are in the hospital; I mean the actual medical records -- or you didn't look at the medical records and you looked at these summaries prepared by Litigation Management, Inc., or you looked at both, these LMI records, summaries of Ms. Tukes' and Mr. Mousser's records, and you also looked at the medical records as well? Which is it?

A. So it's going to be mostly both. I know I looked at actual medical records. This format looks similar to some of the documents I looked at, but it was never labeled as an LMI summary. It was just a --

Q. Okay.

A. -- a format of a document that I looked at.

Q. Before you -- well, did you rely -- strike that.

Are any of the entries in your reports, Exhibits 1 and 2 for Mr. Mousser and Ms. Tukes, do any of those entries come from

what you read in the summaries that are Exhibit 11 and 12 of those records?

A. My memory is -- I think I had access to some of these summaries first when I wasn't able to get into the CORA database. Once I got into everything, I think I remember seeing that everything was in there, and there were some additional materials. But I was basing everything, not on someone else's summary, but trying to write down what I was learning from the medical record.

Q. Okay. Well, if you --

MR. BU: Sorry, Mark, one second. There's some whirring going on outside. Does that interfere with the sound or is it okay?

VIDEO TECHNICIAN: It's okay. You can hear it in the background, but it's not overwhelming.

MR. BU: Okay. Sorry, Mark.

MR. MANDELL: No, that's okay, Nathan. I can't hear it at all if that makes a difference, but...

Q. (By Mr. Mandell) Doctor, if you -- I think you just testified that your opinions emanate from your review of the

actual medical records, not from any summaries, like in Exhibit 11 and 12, and that you didn't rely on those summaries, Exhibits 11 and 12, for any of the notations in your reports or as a basis for any of your opinions that you will testify to today or at trial. Is that accurate?

A. That's very fair, yes.

Q. Okay. So I guess what I would ask you then is, as you -- why would you read the summaries, Exhibit 11 and 12, at all if you were just going to read the medical records and rely on those?

A. So, again, I'm not sure I read these in their formats. I read something that has a similar, you know, date and then something in chart note. But I had access to a collection of summary notes that look a little like this format using something called Box before I finally got full access to the CORA system that has the entire medical record.

Q. About when did that happen? When did you get access to CORA?

A. I think it was December, right

around the holidays.

Q. So after you got access to the CORA website or repository, did you look at any summaries, whether you knew them to be LMI summaries or not, that were Exhibits 11 and 12, or did you only look at the medical records themselves?

A. I think once I got access to CORA, I was just looking at CORA. I had notes on everything, so I was just going back and forth and trying to -- like I've done before when I've been involved in trying to render an expert opinion, just go through as much of the medical record I can and as quickly as I can.

Q. Doctor, is it your testimony that every fact that you cite in your report that serves as a basis for your opinions in this case, to the extent that it would be in the medical records, did not come from any summary such as Exhibits 11 and 12, but only came from your reviewing the actual medical records?

A. I certainly think that's the case. And when I was reading the summaries in this format, I wasn't even aware it was a third party. It was just -- it was just a first

dive into the medical record.

Q. Yeah, okay. I'm not really asking if you knew it was a third party. I'm asking you, if I were to show you the records -- the summaries in Exhibits 11 and 12 and show you that, as they relate to the medical records and comments you put in your reports and that your comments came from the summaries and not from the medical records, would you dispute that?

A. Probably, yes.

Q. Okay. So take a look at Page 23 of your report --

A. On which --

Q. -- on Ms. Tukes.

A. All right.

Q. Ms. Tukes. And look at Paragraph 55, sir.

A. All right.

Q. Now, you say that in April a note from UNC pathology for a second opinion concurred with a diagnosis of renal cell carcinoma. Do you see that in the last sentence of Paragraph 55?

A. Yes.

Q. Now, in fact, and I'm happy to show you the medical records, that note from UNC pathology was on May 24th, 2018, not in April.

And if you look at the LMI chronology for Ms. Tukes, you will see on April 26, 2018, which is on Page twenty -- starts on Page 27 of 82 pages, Bates stamped 308, you will see several notations for that date, including the pathology report on Page 28 and page -- the surgical pathology report is on Page 28, do you see that, Bates stamped 309?

A. I'm on Page 28, pathology report.

Q. And do you see the date, 4/26/18?

A. Yes.

Q. Now, if you look at the actual pathology report itself --

MR. RUZICKA: Mark, we can't hear you.

MR. MANDELL: Yeah, I was off. I was on mute for a second.

Q. (By Mr. Mandell) Doctor, is it your testimony that your reference to the note from UNC pathology for a second opinion did not come from the summary Page 309 of Exhibit

Number 12? Is that your testimony under oath today? You think this actually came from a medical record and not from this summary, Page 309?

A. Again, as I've testified about the order in which I saw something like these summaries before I got into CORA, because CORA took a while to get into, I may have written down dates and findings. And if the actual date was a month later, I might not have cared. I would have just seen, oh, okay, this is that biopsy report, yeah, here we go.

Q. Okay. So you might not have cared and might have left the inaccurate date in there because it was only a month, it didn't matter?

A. I definitely could have. I don't remember.

Q. As opposed to you read the summaries and not the medical records, and that's why this would be an inaccurate date?

A. If I had access to both, I probably read both.

Q. So if there are any other inconsistencies between the LMI, or the

summaries in Exhibits 11 and 12, and the actual medical records, it wouldn't be that you only read the LMI or the summaries in 11 and 12 and not the medical record s? It just would be, well, they're close, so it didn't make a difference?

A. I hope there are very few discrepancies. And I read -- again, I'm not familiar with the term LMI until today. So I read something that has a format like this. And then a month or two later I had access to the CORA database and was able to start getting into that record. And then after that, I just used that.

Q. Okay. By the way, LMI, do you know anything about that organization?

A. Nothing.

Q. Do you know that -- the three -- actually three or four of the top level people who run LMI are actually members of what is called the Defense Research Institute?

A. I don't know anything about LMI.

MR. BU: Make sure you speak up, Dr. Johnstone.

A. I know nothing about the

organization.

Q. (By Mr. Mandell) Doctor, would you agree that, as to how long Ms. Tukes' kidney transplant will last, that you can only speculate as to that subject matter and that you put that in your report?

A. That's true.

Q. And would you agree that, as to any predictions by you as to when Ms. Tukes' transplant might fail, would be quite speculative for you to do that and that you put that in your report?

A. I think that's true for all predictions of future health. And it's equally true for Ms. Tukes.

Q. So the answer to the question is, yes, that if you were to offer any opinions at all about predictions on when Ms. Tukes' transplant might fail, that would be quite speculative for you to do and that you put that in your report?

A. And I think I used the word speculative, yes.

Q. In fact, you used the words quite speculative on Page 31 in Paragraph 82 of your

report. Isn't that true?

A. I'll look at Page 31.

Q. Okay. Let's do that, sir. Paragraph 82. Look at the first sentence in Paragraph 82. Does it not say any predictions for when her transplant might fail and require her to return to dialysis are also quite speculative?

A. Right. That's in relation to Dr. Cooper's assertion that her transplant will fail and she will need to return to dialysis.

Q. Yes. I'm asking you about your opinion, not Dr. Cooper's opinion, at this point.

Now, what you wrote on Page 31 in Paragraph 82 would be any prediction that you would make about when her transplant might fail and when she might be required to return to dialysis would be quite speculative if you were to say when for either of those, and that's what you put in your report on Paragraph 82 on Page 31, true?

A. And I think this is in my section of the document that's in response to Dr. Cooper's report.

Q. No, it actually isn't, Doctor. It's in your conclusion section of your report that begins at the bottom of Page 30. Isn't that correct?

A. You're right. Just following the part where I'm talking about Dr. Cooper's assertions.

Q. What does that mean, just following? The fact that it comes after it but close to it means it's part of it; is that what you're saying?

A. I can look back to try to reread my response to the report of Dr. Cooper.

Q. Doctor, don't you say in your conclusion, summarizing all of what you're saying in your report, that any prediction that you would make as to when her transplant might fail and when she would be required to return to dialysis, if you were to do that it would be based on it being quite speculative --

A. Yes.

Q. -- an opinion on your part, right?

A. Yes.

Q. That's what you said. And then

you said, in addition, that it is far too speculative, in that same paragraph. You say it is far too speculative to say she would never be a good candidate for repeat transplant surgery, right?

A. That's also true.

Q. And then you say, It is also quite speculative to predict her transplant will fail in 13 years at the median time cited by Dr. Cooper, and then you go on to explain why, right?

A. Yes.

Q. By the way -- so what you're saying is that for you to give an opinion as to how long a kidney transplant Ms. Tukes has will last, as to when it might fail and when she might have to go back on dialysis, that would be an opinion by you that would be based on speculation, even quite speculative, and that's what you put in your report, true?

A. In part.

Q. Okay. In part, true, or you put it -- what do you mean by in part?

A. The speculation is in part true but is based on data from transplant outcomes

nationwide and what factors predict early transplant failure and what aspects of her current clinical status are more reassuring than the average transplant.

Q. And, Doctor, what I'm asking you is about Ms. Tukes. You have put in your report that, as to her, any opinion that you put -- that you would provide as to those subjects I mentioned, how long her kidney is going to last, any prediction as to when the transplant might fail, when I say the kidney, I mean the kidney transplant will last, when it might fail and will it last 13 years or 10 to 12 to 15 years, that you could only speculate about those opinions as to her, true?

A. Yes. And it's an attempt at getting speculation based on the prediction models we have for average transplant duration, the things I cite from Harry Herron, for example.

Q. Right. But what you're saying as to Ms. Tukes is there's no way to know when she'll need dialysis -- to you, there's no way for you to know, it's your opinion, when her

kidney is going to -- how long the transplant will fast, when it will fail, when she has to go back on dialysis, that as to her, where these prediction models may exist that you referred to, as to her and her condition, it would be basic speculation on your part, quite speculative, for you to give any opinion on that, right?

A. For me and for others, yes.

Q. And whether she would be a good candidate for another kidney transplant in the future or not, that -- you're saying she, in your mind, Page 29, paragraph 77, of your report, she may be a good candidate. That's your opinion, right?

A. Yes, that's my opinion.

Q. She may be or she may not be?

A. That's true.

Q. You're uncertain what her condition will be like in the future and whether or not she might be a candidate for a second transplant. You say that on Page 29, paragraph 77, if you want to look at that. Isn't that true?

A. That is true.

Q. And that -- in Dr. Shahnasarian's life care plan tables, as to hemodialysis, and I'm happy to show you that if you want, which is on Page 6 of 10 of her -- of his appendix to Ms. Tukes' report, there's a -- it says, no, that it -- per Dr. Stadler and Johnstone, whether there will be a need for hemodialysis in the future is contingent on the success or failure of the current transplanted kidney and whether Ms. Tukes is a candidate for future kidney transplant.

So in those life care plan tables that deal with hemodialysis, as you've just talked about on these other subjects, there's no way -- your opinion is there's no way for you to know, so it would be just pure speculation on your part to say -- to give any answer to those questions, right? That's what you put in your report?

MR. BU: Object to form. You can answer.

A. That's not quite what I put in my report. Yes, it's speculation at an individual level, but there are reasons to be optimistic for Ms. Tukes -- Mrs. Tukes. I'm

sorry.

Q. But it's speculation for you to think -- or in your mind it's speculation for you to assign any date or time period or range of periods, because, according to you, there's no way to know that, and, therefore, it's speculative, right?

A. So the time period assigned was I believe from Dr. Cooper's report. And what I have said in these sections are that we have predictions for the average duration a transplant works, and since she has already made it at least past six months, and I believe up to a year, with excellent transplant kidney function, no episodes of rejection, no severe viral or other infections due to her immunosuppression, that -- and she had no delayed graft function, which is the critical part early on in a transplant, that her expected duration for a working transplant should, on average, be much better than the average for the whole country, because she's already made it past the most risky year.

And kind of similarly --

Q. And I'm going to ask you -- go

ahead.

A. -- with all the other predictions when you're saying will she be a candidate for a future transplant, is that purely speculative, am I just speculating. And no. I'm saying that a second transplant requires that you be at that time in good health. And most people who get their first transplant do so for more common reasons of kidney disease like diabetes and cardiovascular disease, and they end up being much less likely to be healthy enough for a second transplant.

But because of the mechanism of her kidney disease, where her kidneys were just surgically moved, she has had not diabetes, she has not had severe cardiovascular disease. So it's more likely than not that she is going to be healthier than the average person of her age if she were to need a second transplant. So it's -- it's still speculative but she has a number of good prognostic features.

Q. All right. And, therefore, it's possible she might live -- or her transplant might last longer than the average, but for

you to say that she likely would, that would be speculation on your part? That's what you put in this report, right?

A. Yes.

Q. All right. Now, I'm going to ask you some questions about how long -- that literature you talked about kidneys and how long they last and et cetera. But you said Ms. Tukes has not had diabetes. Are you certain of that? You say you looked at all her medical records. Are you certain that she has not ever had and/or does not have now diabetes?

A. Does she have it now after having had a transplant? I don't know. There's something called post-transplant diabetes. She did not prior to her transplant.

Q. Are you certain?

A. I did not see it in her records.

Q. By the way, when you talk about diabetes, are you saying either type one or type two diabetes? You're not saying only type one or only type two as a negative risk factor 'you're talking about either type one or two, right?

A. Sure, you can include both.
Q. Well, I'm not asking you if we can. I'm saying do you --
A. I do.
Q. -- include both?
A. I do.
Q. Okay. Now, in terms of how many years Ms. Tukes is expected to survive, that's something upon which you think, it's your opinion, that we can only speculate, and you put that in your report at page 26, paragraph 71, true?
A. True.
Q. Yes, no?
A. True.
Q. I didn't hear you if you said a word. You said true?
A. Yes.
Q. Okay. And then, also, as to any negative impacts to her life expectancy, at this point in your mind are just speculative if somebody were to mention what negative impacts might exist or will exist in the future, it's your opinion, and you put it Page 31, paragraph 81, of your report, that would

be speculative, true?

A. Yeah, I'm optimistic, but that's still speculation.

Q. Yeah. And in terms of what the quality of her life will be in the future, it's your opinion that for -- what the quality of life would be in her future for as long as she lives, your opinion is we can only speculate about that, and you put that in your report at Page 26, paragraph 71, true?

A. True. I think that's true for all of us.

Q. Yeah. Now, in terms of whether or not Ms. Tukes in the future will need future care in assisted living, in your mind any opinion about that that you might express would be quite speculative, true?

A. Also true, but optimistic at this point.

Q. And when you say but optimistic at this point, you're saying that's what you hope happens, that's what -- there might be some evidence that things now in your mind are good, but it's still speculation in your mind for you to give an opinion as to that subject

matter? That's what you're saying?

A. That's true for all of us and all people in the future, yes.

Q. Okay. By the way, you have said, and I'll ask you a few questions about that in a few minutes, but as to Mr. Tukes and his -- Mr. Mousser and his ability to work or not --

A. All right.

Q. -- your opinion is the fact that he has one kidney in and of itself doesn't mean by some national statistics or writings that having one kidney would mean you can't work in the capacity he was working in in the auto industry?

A. Correct.

Q. You know that you have expressed that opinion in your report, sir?

A. Correct.

Q. All right. And yet you also say you're uncertain why he had to stop work or he did stop work after he had his kidney surgery, true? That you're not certain as -- you're uncertain as to why he chose to stop work or he stopped work, and you express that in Page 24, paragraph 57, of your report, right?

A. So yes. There were documents in his medical record that he felt under great stress as a result of that. And the stress is real. I'm not discounting that. But having one kidney per se doesn't prevent people from living a full life and an enjoyable productive life.

Q. You're not talking about all people, are you? You're talking about some people. Some people with one kidney will act differently than other people. Some may be more disabled. Some may have greater psychological reactions. Some may have additional physical reactions. Some may have comorbidities. You have to look at the individual to be able to say, well, this would prevent them from working. It wouldn't. You can't just take a global estimate and apply that to everybody; isn't that true?

A. I think there's parts of that I agree with and a fair amount that I don't agree with.

Q. Doctor, when you make an assessment as to one individual, whether that person because of what has happened to them --

let's say they had to have a kidney removed and they have chronic kidney disease in the other kidney, take that person. Now, you could say, well, you can survive on one kidney and flourish. Your kidney -- chronic kidney disease in your opinion, Dr. Johnstone, isn't so bad, so having one kidney functioning, you can work, you can play, you can have a quality of life. So you could say that, and that is your opinion in this case about Mr. Mousser, correct?

A. Correct.

Q. Yeah. But you have to look at Mr. Mousser, not some person in another state who may have enrolled in some study and they may have different health issues than Mr. Mousser. You have to look at Mr. Mousser and his comorbidities, his medical condition, his psychiatric condition, and look at him and say he can or he cannot work, true, for it to be accurate?

A. There's still a lot of that that I simply do not agree with.

Q. What don't you agree with, Doctor? You think you can apply national statistics to

every person, every single individual who has one kidney?

A. As a doctor I'm sometimes asked to sign documents so that people can go on disability, and I'm very comfortable doing that. I have patients coming to see me because they have only one kidney. Those patients ask what does this mean for me. And I tell them and write in their medical record that you're not allowed to play rugby, you're not allowed to go sky diving or do anything that would threaten that other kidney.

But that, you know, you're 40 or 45 years old and you've only just learned that you've had one kidney, keep enjoying your life. So I'm in this clinical situation, and I give advice to people who find they only have one kidney.

Q. Do you give that advice to every person who comes to you who has only one kidney no matter what their condition is otherwise?

A. I would not sign disability forms saying someone was unable to work only for the reason of having one kidney.

Q. Right. But you have to look at the person, if you have that form in front of you, and say what effect having one kidney has had on them, and, for example, psychiatrically, and you also have to look at what other comorbidities they have. You just can't say, because you have one kidney you can work and I'm not signing disability. You can't do that across the board, can you?

A. If it's a psychiatric disease problem, then they should be asking and getting disability from their psychiatrist, not from a kidney doctor.

Q. That's your answer? I asked you can you apply that which you said you would tell a patient with one kidney, which is go ahead and enjoy your life, no reason you can't work, no reason you can't play, you would say that to everybody who comes to you with one kidney regardless of their overall condition or comorbidities?

A. Yes. Can you be -- can you give me an example of something otherwise?

Q. Yeah, Mr. Mousser. Have you read the psychiatric records?

A. I haven't and shouldn't because I'm not a psychiatrist.

Q. Right. Okay.

A. And, again, that's a separate reason for disability that is not related to having a single kidney.

Q. So, Dr. Johnstone, let's assume you have a patient that has one kidney who has been diagnosed with adjustment disorder, depression, psychiatric issues. You're saying you wouldn't want to know what their medical records say from the psychiatrist because you're a nephrologist, is that what you're testifying to, for your own patients?

A. In almost all cases, that medical record would actually be closed to me.

Q. Got it. Okay.

A. Even if we're sharing a patient, I can't access a patient's psychiatric records.

Q. No, but you could ask the patient can I see your records. You would get permission from the patient and a signed HIPAA form and then you'd contact the psychiatrist's office and say your client, our mutual client, our patient, has agreed. And you're saying,

no, you're not going to do that because you're a nephrologist, not a psychiatrist?

A. No. In your example, if I thought there was something important for care of him as a kidney disease patient, I would and have reached out to psychiatrists. But do I have the right to jump into his record, no, I don't.

Q. But nobody said that, Doctor. We're talking about finding out. The point is that you need to look at each person to be able to give an honest and accurate opinion as to whether or not they can work or whether or not their life has been adversely affected; isn't that true?

A. I think the way you're phrasing it is very fair.

Q. And you say but the cause of his decreased functional capacity for work and life activity is not related to having a single remaining left kidney?

A. Correct.

Q. Now, first, doesn't that depend on the condition of the single remaining kidney?

A. Yes.

Q. Doesn't that depend on what other medical and/or psychiatric problems the person has that they're receiving treatment for from other doctors?

A. Again, I'm focusing on the kidney. So if the question is the remaining kidney function, I look at the values that correspond to that kidney function. If he happens to be on a medication, and there are a couple in psychiatry that can be toxic to the kidney, then that's a conversation I definitely want to have with him and his treating psychiatrist.

If it's a question of just single kidney and the creatinine is fairly low, then it's a good functioning single kidney, and that's true for him.

Q. I know that's your opinion. I plan to ask you about that in a few minutes. But, Doctor, you don't just treat a kidney; you're treating a patient that has that kidney, true?

A. That's true.

Q. And to treat that patient and that kidney properly, you need to know whether that

person's heart is okay, whether their brain is okay, whether their liver is okay. You need to know the condition, physically and psychiatrically, of that patient for you to be able to do your job well, true?

A. Yes.

Q. Because the kidney does not live in isolation; it lives within a human being, true?

A. True.

Q. Yeah. Now, do you know why Mr. Mousser quit work or was unable to work? From any of his medical records, do you know?

A. No.

Q. Do you know what he's testified to in his deposition -- strike that.

Did you read his deposition?

A. I think so, but I can't recall lots of detail.

Q. Can you recall any detail from Mr. Mousser's deposition?

A. Discussions about getting tested for gross hematuria. I don't think I have --

Q. Do you know how many times he -- do you know how many times he sat for a

deposition, whether it was once, twice, three, four times?

A. I don't.

Q. Do you have any idea how many times he sat for a deposition?

A. No.

Q. Okay. Now, are you aware of any determinations by the Veterans Administration after they considered evidence, medical records, and thought about it, do you know what their determination was as to whether or not, after Mr. Mousser's nephrectomy, nephroureterectomy, whether he was able to work or not?

A. I don't know.

Q. Have you read any documentation from the Veterans Administration as to a decision they made about him in terms of whether he was entitled to disability benefits or not?

A. No.

Q. All right. Are you aware that the Veterans Administration reached out to a vocational rehab expert who did a vocational rehab examination and report and then

supplemented it with a second report? Are you aware that happened --

A. No. Again --

Q. -- that expert being -- go ahead. I'm sorry.

A. Nothing from those VA records, no.

Q. All right.

MR. MANDELL: Ted, could you get the Veterans Administration decision. It's number 32. It's on the list as 32. It would be Exhibit 13.

MR. RUZICKA: Yes. I'm marking the VA decision April 8, 2024, as Exhibit 13.

(Exhibit 13 was marked.)

A. All right.

Q. (By Mr. Mandell) Okay. All right, Doctor. Turn to, if you would, please, the third page of that packet, please. Does it identify at the top there Department of Veterans Affairs?

A. Page 3 says Appeal to the Board of Veterans Appeals.

Q. The third page of that packet, sir?

A. Says Appeal to the Board of

Veterans Appeals.

Q. Okay. I'm going to share a screen, Doctor, and show you what I'm talking about from that exhibit.

All right. So can you see on the screen?

A. No, sir.

Q. Okay. Well, it's coming. Do you see it now?

A. All right.

Q. It's dated April 8, 2024, Mr. Mousser --

A. Yes.

Q. -- from the VA? We've made a decision on your VA benefits. Do you see that?

A. Yes.

Q. All right. Let's go to the third page. Do you see on the page on the screen now, it's Bates stamped 25855, VBA.

A. All right.

Q. Do you see it says, Decision, Evaluation number one of insomnia with depressive disorder chronic ongoing, paren, previously rated as mood disorder due to

general medical condition with major depressive episodes, closed paren, which is currently 70 percent disabling is continued.

Number two, entitled to individual unemployability is granted effective October 21st, 2023.

Do you see where I read that, sir?

A. Yes.

Q. Yes?

A. Yes.

Q. Okay. I can't hear you, but I think you said yes?

A. Yes. I'm not sure why it's not going through.

Q. Okay. Let's go to the next page. Do you see where it says Evidence on the next page, Bates stamped 25856?

A. Yes.

Q. And it's got six categories of information, right?

A. Yes.

Q. Including the very first one which is referred to as the employability evaluation, January 26, 2024. Did you see any of those six documents or categories of

documents that are listed under evidence ever?

A. If I saw them I would not have felt they were critical for deciding what his kidney function and future chance of progressive kidney disease was.

Q. What about for his ability to work, which you said it shouldn't be a problem based on one kidney?

A. Again, if he had --

Q. Would it be relevant to that?

A. -- other reasons for not working that are legitimate, that's fine. But I was -- I was focusing, as I should, on his kidney function and future kidney disease.

Q. Doctor, are you aware, from looking at Mr. Mousser's records, or from any source, that it was only after Mr. Mousser had his right kidney removed that he began to have the issues that have prevented him from working? Are you aware of that?

A. No.

Q. Okay. So look at the next page which says Entitlement to Individual Unemployability. And do you see where in that first paragraph -- could you read that into

the record, please, sir.

A. Reasons for decision?

Q. No. Entitlement to individual employability, number two.

A. Entitlement to individual unemployability is granted from October 21, 2023, because you are unable to secure or follow a substantially gainful occupation as a result of your service-connected neoplasm of kidney, urothelial cancer, status post right kidney removal and ureter removal with left kidney chronic kidney disease. Recurrent cystitis of the bladder with hematuria, now also claimed as overactive bladder with nocturia. Insomnia with depressive disorder, chronic ongoing. Tinnitus.

Q. Right. So according to the VA Mr. Mousser was granted entitlement to individual unemployability for a number of reasons. One reason is as a result of his cancer of his kidney and the fact he had to have his kidney and ureter removed, true?

A. True in part.

Q. What's not true about it, sir?

A. Is this decision based on opinions

from his VA kidney doctor, or is it entirely based on opinions from his VA psychiatrist. And if it's the latter, I am not qualified to talk about psychiatry, and the reasons underlying are part of his mental health disorder.

Q. Doctor, the VA decision that you just read into the record attributes, in part, Mr. Mousser's inability to work to the fact that he had kidney cancer in his right kidney and he had to have it removed, and his ureter removed. And there are other reasons that you read, also, but that was part of it. Isn't that written there in that decision?

A. It is written.

Q. Okay. And then the next paragraph, doesn't the first sentence from the VA read, VA examination showed that your service-connected disability impacts your ability to function in an occupational environment?

A. Yes.

Q. Doesn't it say that?

A. Yes.

Q. Let's go to the next page, please.

And if you look at the next page, which is Bates stamped 25858, doesn't it say in the first -- the second paragraph on that page, Basic eligibility for dependence educational assistance is granted as the evidence shows you currently have a totally disabled service-connected disability or disabilities permanent in nature.

Doesn't it say that?

A. Yes.

Q. And is it your opinion, without your having the benefit of any of the information that the VA based this decision on, that they're wrong, that somehow you're right, that nothing about his kidney and the removal of his kidney means he might not be able to work or shouldn't work? Are you saying they're wrong?

A. No, not at all. Someone can have an entirely service connected mental health condition. And, if so, the VA has done the very appropriate thing of giving them service connect -- full service benefits for that mental health condition.

Q. Now, Doctor, are you aware when --

you say, well, it depends who read this, you know, was it a psychiatrist, and you said I'm not qualified to deal with psychiatry issues.

Are you aware that the doctors who have indicated Mr. Mousser's kidney condition impacted his ability to work where Dr. Douglas Jenkins on December 15, 2020, Dr. Hameed, both internal medicine doctors, on May 5th, 2021, Dr. Anthony Martinez -- excuse me, family nurse practitioner Anthony Martinez on November 12th, '21, Melissa Lebron, a family nurse practitioner October 5, '22, and Harry Croft, who is a psychiatrist, also -- all of them, all five of them indicated that Mr. Mousser's kidney condition impacted his ability to work. Are you aware of that?

A. I'm not aware of that. And I am not hearing about a kidney doctor.

Q. Right. Doctor, do you know who Kelly Sakala is, please?

A. No.

Q. So she's a vocational rehab expert that the VA asked in January 26, '24, she did -- as a result of their asking, VA commissioned an evaluation, and she did an

evaluation and issued a report on January 26, '24. You've never seen that report, have you?

A. No.

MR. MANDELL: Ted, could you mark as exhibits Kelly Sakala's report and her supplemental report, please.

(Exhibits 14-15 were marked.)

MR. RUZICKA: I'm marking as Deposition Exhibit 14 the report dated January 26, 2024, and the -- I'm marking as Exhibit 15 the supplemental report dated February 7th, 2025.

MR. MANDELL: So that's Exhibits 14 and 15.

Q. Dr. Johnstone --

MR. BU: Sorry. Could you hold on one second?

MR. MANDELL: Oh, of course. Of course.

MR. BU: All right. Go ahead.

Q. (By Mr. Mandell) I'm showing you the conclusion of Ms. Sakala's vocational rehab report dated January 26, '24. And do you see on her signature line is there on this page, Page 27 of the report, Bates stamped

8599.

So let's look at this conclusion. All right. Number one, Mr. Mousser is unable to perform his past relevant work as an automobile salesperson or sales manager on a sustained full-time competitive basis.

Did I read that correctly?

A. Yes.

Q. All right. Were you even aware of that finding until I just showed it to you?

A. I mean, I think I read it in the medical record.

Q. You read that Kelly Sakala did an evaluation January 26, 2024, asked by the VA to do it, vocational rehab expert?

A. No.

Q. And that finding, number one, you read about that in the medical record, sir; is that your testimony?

A. No. Again, no.

Q. So number two reads, Mr. Mousser is unable to work due to the residuals of his severe service-connected emotional and physical condition.

Did you know about that until you

just saw it?

A. This is the first time I'm reading this report.

Q. All right. Read number three, will you, please?

A. Mr. Mousser is unable to perform any sedentary, light, medium, heavy, or very heavy work existing in the local or national economy on a sustained full-time regular competitive basis due to the residuals of his service-connected impairments.

Q. You can read four and five to yourself, and I want to ask you if you have any disagreement with Kelly Sakala's -- Ms. Sakala's report findings as they exist on Page 27.

A. I haven't read her report.

Q. I'm asking if you have any disagreement with her findings based on what you did read since you've given the opinion that he should be able to work with one kidney.

A. My opinion is still the same. One kidney, per se, does not prevent someone from working or living a productive life.

Q. Right. But this isn't an issue of one kidney, per se, Doctor. It's an issue of a person, a human being named Frank Mousser. And, in addition to his loss of his kidney and his chronic kidney disease in the other kidney, has other issues that may and do affect him. This is a disability determination, not of a kidney, but of a person, true?

A. True.

Q. Isn't that true?

A. Yes.

Q. All right. Are you aware that Ms. Sakala issued a supplement to this opinion in which she renewed her opinion and -- reaffirmed her opinion that Mr. Mousser is not employable? Are you aware of that, sir?

A. No.

Q. Okay. All right. And the second time she gave -- did her renewed report as an expert for the plaintiffs in this case where the first time it was purely at the request of the VA. Are you aware of that?

A. No.

Q. Doctor, you're not a toxicologist

are you?

A. No.

Q. Not an epidemiologist?

A. No.

Q. Not an occupational medicine MD?

A. No.

Q. Now, in your report there's absolutely no mention strike that.

You mentioned in your reports for both Ms. Tukes and Mr. Mousser factors such as -- that are risk factors for kidney cancer, true?

A. Yes.

Q. You mentioned, as to Mr. Mousser, smoking, which I'll talk to you about in a few minutes.

You mentioned hypertension for Ms. Tukes, true?

A. True.

Q. You mentioned obesity I think for Mr. Mousser, true?

A. Yes.

Q. You mentioned Mr. Mousser's peripheral arterial disease, his cerebrovascular disease that all preexisted.

Diabetes.

You mentioned a number of risk factors for kidney cancer in your report, right?

A. And some of those are listed as risk factors for length of life and quality of life.

Q. I'm asking you the question, Doctor, and I'm happy to modify it to add what you said. But you don't -- you mentioned a number of other issues --

A. All right.

Q. -- without giving an opinion on causation, which you've said you're not doing in this case, but you've mentioned a lot of other issues that are risk factors for kidney cancer or urothelial cancer of the upper tract in the kidney.

But one thing you don't mention at all, other than to say Mr. Mousser and Ms. Tukes are claiming that toxins in the water at Camp Lejeune have caused their cancer, you don't mention toxins at all or their exposure to toxins at all as a risk factor for the cause of their kidney cancer

and urothelial upper tract cancer; isn't that true?

A. I think that's true.

Q. Yeah. The concept and facts of the toxic exposures Ms. Tukes had and Mr. Mousser had at Camp Lejeune are absent from your report, right?

A. Because, as you point out, I'm not a toxicologist or an epidemiologist, yes.

Q. Well, because maybe you only mentioned those things that aren't related to what the plaintiffs are claiming in this lawsuit as the cause of their kidney cancer and you're being an advocate; is that a possibility, Doctor?

A. I think I'm mentioning things that I'm familiar with. I am very unfamiliar with the field of toxicology and don't feel myself qualified to be going through toxicologic reports and trying to judge the degree of causation.

Q. Yeah. But, Doctor, you've given -- you've alluded to things in your report that you have said you're not giving any opinions on because you're not expert in the

area, but you still mention them in your report -- let me withdraw that.

Doctor, do you know how many national and international organizations have said that the chemical TCE causes kidney cancer? Are you aware of how many different organizations nationally and internationally have said that?

A. No, I don't.

Q. And do you know what exposure levels have been identified as to when you could say that TCE is harmful to human health generally and specifically in causing kidney cancer? Do you have any knowledge of that at all, sir?

A. The only knowledge I've gleaned is in the few reports I've read. But I'm not able to judge how much exposure someone has had or whether it's mostly, partly, or not causal. It's just not my field.

Q. And your answers would be the same for PCE, vinyl chloride, and benzene, in kidney cancer; is that true? You just don't know?

A. Benzene at least is in the medical

literature that I've read and know a little bit better. For the others it's not a field that's been part of my training, so, no, I don't -- I don't -- I don't know.

Q. Doctor, in your report you actually make this comment: My clinical area of expertise is glomerular disease, but I have never placed limits on who I will see in the clinic.

And you said that on Page 2. I think it's the fifth paragraph of your report. And I guess my question to you is what do you mean by you've never placed limits on who you will see in your clinic?

A. I don't have a specialty clinic only for glomerular disease. And if someone calls -- this was true in Philadelphia, it was true in Pittsburgh, and it's true at Kansas. If someone calls the kidney office and says I have this question about my kidneys, and one of the nurses or administrators reaches out to me and says will you try to see this patient, this is a strange question, I always say, yes, I'll do my best.

Q. Doctor, in Kansas do you work at

three Fresenius dialysis centers?
A. I am currently at two of them.
Q. Two of them. Did you work at three until recently?
A. No.
Q. All right. Well, how long -- you've been in Kansas since when, what year?
A. About two years.
Q. Two years. And the Fresenius dialysis centers, are they affiliated -- are they part of the Kansas University Medical Center?
A. Those two are joint ventures with KU. They're not part of the University of Kansas per se.
Q. Are they for-profit businesses?
A. Fresenius is, yes.
Q. And you're -- in attending -- what are the names of those Fresenius centers?
A. Fresenius Parallel and Fresenius Lenexa.
Q. What about Fresenius Rainbow? You've never worked there as attending nephrologist?
A. No.

Q. Okay. If you've never worked at Fresenius Rainbow, why is it on your resume that you've worked there since May of 2023 to the present? It's on Page 2 of your resume, the last non-academic appointment.

A. I can go there if needed. I am not part of the rotation. Other colleagues in my group go to -- go to Rainbow. As the clinical director, I can be called to fill in for someone in an emergency at any time. I've never had to.

Q. So take a look at your resume. It's been marked as an exhibit.

A. Six.

Q. Take a look at Page 2, sir. Do you see the very last item under non-academic appointments, May 23 to the present, FMC Rainbow, Parallel, and Lenexa, attending nephrologist, right?

A. Yes.

Q. Why would you put Rainbow on your resume, and you're saying you're an attending nephrologist there, if you've never been there?

A. Like I said, as the clinical

director I can be called there. I'm privileged there to work if anyone can't. I haven't had to. Other colleagues have covered that particular facility every month.

Q. So your testimony is you have a clinical director who has never been there?

A. I'm the clinical director of KU Nephrology. And -- and, yes, I've never been to the Fresenius Rainbow site.

Q. And yet you put it on your resume as a qualification?

A. It's a place where I am certified to work if needed as part of our medical group.

Q. How much time per week do you spend at the -- either at or dealing with issues concerning the Fresenius medical centers, whether it's Rainbow, Parallel, or Lenexa? How much time per week?

A. So one of us in our group covers each facility as a solo practitioner for that month. In the past year I was at both Parallel and Lenexa for three months. And during those months I probably put in 40 to 50-ish, maybe 60 hours of work, within the

month.

Q. All right. So that's 120 to 180 hours in three months approximately?

A. It's only for the months where I'm taking the responsibility.

Q. Yeah, yeah, for those three months. Right? But I just multiplied three times 40 to 60 hours per month --

A. You mean for the year, yes.

Q. Well, those three months. You say for three months you were there 40 to 60 hours a month. That's 180 hours for those three months, right?

A. Over the course of the year, yes.

Q. Yeah, sure. So how does that work that you're the clinical director of Kansas University Medical Center and you can dedicate 100 hours -- 180 hours out of, what, three months a year? How do you do that? How do you be medical -- the director of nephrology at Kansas University Medical Center and spend that much time at a for-profit entity?

A. I'm confused by your question.

Q. Fresenius is a for-profit, right?

A. Yes.

Q. You spent 180 hours there in a year, right?

A. Seeing dialysis patients, yes.

Q. Right. But you're not at Kansas University Medical Center working there seeing patients there, being the head of your division there. How is it you can spend 180 hours for moonlighting at a for-profit dialysis center?

A. It's not moonlighting.

Q. By the way, in your resume do you claim that you -- and I might confess I've never seen this in a resume before -- that you actually scored 761 on your nephrology recertification exam in 2017?

A. Yes.

Q. And you made a point of indicating that was one of the top four scores in the nation I guess in 2017; is that what your reference is?

A. Yes.

Q. All right. Why would you put in your resume that you received one of the top four scores in the nation in your nephrology recertification exam in 2017? Why would you

put that in there?

A. It's a point of pride. What's --

Q. Yeah. How do you find out? Those results aren't confidential?

A. They sent out a distribution of scores across the country. So it looks like a huge graph with bars that create a bell curve. And there's a small bar at the end for people who scored more than 760. And there were only four people in the country who had done that. And I knew my score. So I don't know if the other three scored higher than me, but mine must have been one of the top four scores that year.

Q. All right. I don't need to get into it --

A. I don't think I need to be ashamed of putting it.

Q. Doctor, please don't read anything into the question. I'm just asking why you would put that in a resume.

The other times you've listed your scores for board certification, not quite as high, right?

A. The internal medicine score uses a

different range. I think the top score for that is 300. So 271 is still a good score. It's nothing to sneeze at. It wasn't one of the top four in the country. So, yes, I'm only boasting about the thing that I'm kind of proud of.

Q. Yep, got it. Would you agree, Doctor, that the kidneys are a vital organ in a human body?

A. Sure.

Q. And, in fact, in your first 22 pages you spend several pages talking about how critically important the kidneys are in the human body, true?

A. True.

Q. You talk about how keeping blood in all the cells in our bodies in a stable balance of salts and water is a function of the kidneys and it's a very important function, true?

A. True.

Q. Can people live without a functioning kidney?

A. If they're on dialysis, yes.

Q. But then they effectively have a

functioning kidney replacement. I'm saying if there's no organ in the body and no way to satisfy the function of the kidneys, will people die every time?

A. Yes.

Q. It's that important, right?

A. Yes.

Q. Kidneys not only regulate the balance between salts and water, but they regulate and stabilize water and electrolyte concentrations in our blood, right?

A. Yes.

Q. Kidneys filter out toxins at the rate of -- I think you wrote 45 gallons of urinary filtrate each day, true?

A. That's how much filtrate is made, yes.

Q. And it isn't just getting rid of toxins, stabilizing salt, water, making sure the electrolyte balance is there; they're critically important to the brain and to -- and, frankly, every part of our body? I mean, kidneys are ultimately important organs in our body, true?

A. True.

Q. They are not vestigial organs; they're critical to our life and death, true?
A. True.
Q. So if something happens -- and by the way, of course, we have two kidneys so that, among other things, we have insurance if we lose one, right?
A. Exactly, yes.
Q. And the danger of losing one kidney, say Mr. Mousser or Ms. Tukes, because of kidney cancer, is that if something goes wrong with the remaining kidney, they don't have that insurance kidney left, true?
A. True.
Q. And in Ms. Tukes' case, that is a classic example of that. She lost her right kidney due to cancer, and then she lost her left kidney due to cancer; and to stay alive she had to go on dialysis until she got a transplant in the year 2024, true?
A. I think true. There were a lot of parts of that question.
Q. Is there any part of that question you disagree with?
A. She made a choice for when she

needed to have those surgeries, but ultimately the -- the result was that she lost both kidneys.

Q. Are you aware on the Kansas University Medical Center website that it says the common treatment, or words to that effect, for kidney cancer is surgery? Are you aware that your own employer puts that out on its website?

A. I haven't read their website, but I'm sure it's true.

Q. Yeah. By the way, dialysis -- Ms. Tukes was on dialysis for how long, sir, about nine months or so, maybe a year?

A. Yeah, close to a year. Not quite.

Q. And you work in dialysis -- well, you're the medical director or the clinical director of dialysis centers. You've -- you're well familiar with --

A. Not quite.

Q. You're well familiar with, on the one hand, it keeps people alive, and, on the other hand, it's like a living hell being in dialysis; would you agree with that?

A. It can be. Some people tolerate

it very well, but it can be a very hard treatment.

Q. In fact, you've cited a doctor -- a nurse practitioner who said that she actually mentioned to Ms. Tukes maybe you don't want surgery even if you have cancer because the dialysis is potentially worse than the cancer. Are you familiar with that note that you referenced in your report?

A. I think that was one of the University of North Carolina urologists, yes.

Q. So briefly would you describe the harm -- potential harm and harm caused to patients like Ms. Tukes who are on dialysis, sir?

A. Potential harm -- I mean, it's keeping them alive.

Q. Yes, I understand the positive. I'm talking about the negatives of dialysis. The harsh reality of dialysis.

A. So dialysis has a number of side effects and a number of risks every treatment. The risks vary with someone's underlying conditions and the side effects vary from patient to patient. Some are quite common,

some are rare. Overall most people on dialysis at some point experience symptoms because of their treatment, and it can be --

Q. What's the worst side effect you attribute to dialysis? For a patient like Ms. Tukes, what's the worst side effects?

A. Severe muscle cramping can be incredibly painful. The itching that some dialysis patients experience can be severe, debilitating. Most dialysis patients feel wiped out after a treatment, on average, for national surveys, from about an hour and a half to 10 hours. And depression is not uncommon.

Q. Do you know -- you had mentioned in your report that Ms. Tukes had hemodialysis at DaVita?

A. Yes.

Q. During the time she was on dialysis, did she ever have peritoneal dialysis?

A. I think that was her original plan, but she decided to never go through with it.

Q. Did she have hemodialysis at any

location other than DaVita?

A. She started in the hospital.

Q. Okay. You've read all her medical records you say. Did she have -- other than starting at the hospital, yes or no, did she have hemodialysis at any location other than at DaVita?

A. I think she was at two different DaVita units. She was at one and then transferred to another at which point her dialysis care was transferred to a different dialysis doctor.

Q. Doctor, you read all the records. Are you unaware that she had dialysis at home? Is my telling you that the first time you knew that?

A. Yes. I thought she didn't like peritoneal dialysis and turned it down.

Q. So would it surprise you to learn that indeed she did have dialysis at home?

A. Yes.

Q. Yeah. Okay. Would you agree that Mr. Mousser's right kidney had to be removed due to the UTUC high-grade cancer, or do you question that, too?

A. I don't question that.

Q. You don't mention anything in your report at all about the issue as to whether or not his kidney should have been removed or should not have been removed. That's why I asked you the question, Doctor.

But -- let me ask you this. Mr. Mousser has chronic kidney disease; is that true?

A. Yes.

Q. And when you lose a kidney like he did, when his right kidney was removed, you lose 50 percent of the nephrons, the tubules, in your body, true?

A. Yes.

Q. And the remaining kidney, depending on its condition, can actually work harder and produce, at least for a period of time, more than 50 percent of the kidney function, true?

A. Yes. True.

Q. There's a phenomenon called hyperfiltration that helps explain how a single kidney can do that, right?

A. Yes. And hypertrophy. Both

occur.

Q. Neither one can go on generally indefinitely. It can work for a time, but eventually the kidney just can't keep going indefinitely, one kidney, under hyperfiltration or hypertrophy, true?

A. Folks who are born with one kidney and who are hyperfiltering the other kidney have a 20 or 30 percent risk of a condition called secondary FSGS in the other -- in their single kidney at about 40 years of age.

Q. Okay. So --

A. But it takes a while. It takes a couple decades.

Q. Was Ms. Tukes born with one kidney?

A. No.

Q. Was Mr. Mousser born with one kidney?

A. No.

Q. Okay. So your opinion, if I could summarize it, about the potential need by Mr. Mousser for a kidney transplant in the future, as Dr. Cooper has expressed his conclusion about, your opinion is, well,

Mr. Mousser has a good prognosis, that his kidney is in excellent condition, his left kidney, and it's functioning so well that you would actually offer him the opportunity and, to quote you, to graduate from kidney clinic, right?

A. Yes.

Q. That's your opinion in this case?

A. Yes.

Q. That any kidney dysfunction in his left kidney is mild, and any negative impact from his having a single kidney, as to his quality of life, any negative impacts are negligible. You put that in your report, too, right?

A. Yes.

Q. All right. Now, how would you describe to your knowledge, your understanding based on your review allegedly of all of Mr. Mousser's medical records, how would you describe the impact that his having lost his kidney the way he did, what effect that has had on Mr. Mousser, the person? How would you express that, sir?

MR. BU: Object to form. You can

answer.

A. So I'm -- as the kidney doctor reviewing his case, I'm not going to be looking into his mental health or psychiatric records. I'm just looking at his kidney function starting with the contention from Dr. Cooper that, with a creatinine of, it was either 1.6 or 1.9, he had a high risk of either ending up on dialysis or needing a transplant in about 10 years --

Q. Is it your testimony under oath that's what Dr. Cooper said?

A. -- and it's not true with one kidney.

Q. Right. Doctor, let me ask you my question again. You've read Mr. Mousser's medical records. Did you selectively choose not to read his psychiatric records, first of all? You just put them to the side and said I'm not going to look at those because I'm not a psychiatrist? Is that what you did?

A. Sort of not germane. In a way none of my business.

Q. You're here getting paid $850 an hour to give an opinion that it's harmful to

Mr. Mousser's case, and you're saying it's not your business to look at all of his medical records but to selectively choose which specialties you're going to avoid; is that your testimony?

A. With respect, sir, I can spend hours and hours and hours reading parts of medical records that aren't important for me to talk about someone's kidneys. But I try to focus on his kidneys, kidney function, and future risk of progressive kidney disease, because that's the area that I'm being asked to render an opinion as an expert on.

So if there's a large part of the medical record that's not germane to that question, then for the sake of saving time and money for the government, I should skip that part and go to the core question.

Q. Okay. So you just answered my question. Thank you.

Doctor, you have put in your report, and you've just said it's your opinion, that any negative impacts for Mr. Mousser having a single kidney as to his quality of life, any of those negative impacts

are negligible. And what you're saying is they're negligible to you because you've put aside a whole category of documents and chosen not to look at them to save the government money. That's not being an advocate, Doctor?

A. I don't think I should be doing this just to make money for myself. And I'm trying to serve an expert role and that's as a kidney doctor.

Q. Right. How could you possibly say that Mr. -- any negative impacts from Mr. Mousser having a single kidney are negligible when you haven't -- as to his quality of life are negligible when you have selectively decided you're only going to look at those records that deal with the physical condition of his kidney, his remaining kidney, and not whether or not the impact of his losing his right kidney, what impact that was?

A. So that question --

COURT REPORTER: I'm sorry. Could you start your answer over.

A. The question -- so I can think of two different ways to approach it. One is that if I had a mole on my nose and felt it

was so disfiguring that I couldn't work and couldn't function, those are real feelings. It could be that a nose doctor would think that there's a treatment and there's something that could be done for that.

This is similar. You only have one kidney. I know that there are people who live their entire lives with a kidney. I know that people who receive a transplant by definition have only one kidney.

So in and of itself, either being born with one kidney or getting a transplant single kidney doesn't confer the inability to work and enjoy life. If that's happening with him, it's something else. And that something else is not the purview of a kidney doctor.

Q. Got it. Does it matter, Doctor, in your opinion how a person loses a kidney, in other words, why they lose a kidney, in terms of the effect on them?

A. So I can best speak to the effect on kidney function. If you're asking about the effects on their mental health, I think I should defer that to a mental health expert.

Q. Well, Doctor, your -- your opinion

on the excellence in condition and function of Mr. Mousser's left kidney, his remaining kidney, what -- you referred to test results before that serve as a basis for you coming to that conclusion. What test results are you talking about?

A. Well, it was a combination of creatinine and -- urine albumin and creatinine ratios, best as I can recall.

Q. Now, would you agree with me that -- the GFR is a glomerular filtration rate; is that true?

A. Yes.

Q. And the -- that filtration rate measures the volume of fluids and what's in there, how -- the volume that the glomeruli actually filter during a given period of time; is that true?

A. Yes.

Q. All right. And that involves getting rid of toxins, reabsorbing things like salt that the body may need and things that would be healthy to the body, true?

A. Yes.

Q. So the assessment of the -- I'm

going to call it GFR just so I don't have to keep repeating the words.

But the assessment of GFR is fundamental to clinical practice, public health, and well-being of all American citizens. Do you agree with that?

A. Sure.

Q. Okay. And what happened in -- and there are different ways to assess and identify the GFR, the glomerular filtration rate, true?

A. Yes.

Q. And the weight you're relying on for your opinion, like you said, are creatinine and the albumin-creatinine ratio, right, in the urine?

A. One of those has to do with the GFR and the other doesn't.

Q. The creatinine has to do with the GFR?

A. Yes.

Q. All right. Now, there are other ways to measure the GFR, and that is to actually measure the GFR and not just estimate it, true?

A. True.

Q. And the -- if you measure the GFR, there are different ways to do that, that would be the gold standard in terms of accuracy as to the status of the kidney vis-a-vis chronic kidney disease, as compared to estimating the GFR by using creatinine, true?

A. True.

Q. All right. Now, not everybody uses actual measurements of GFR to find the actual GFR, even though it's the most accurate way to do it, because it takes time and it has expense to it, true?

A. And risk, yes.

Q. All right. So the cheaper dirty and quicker way of creatinine to indirectly assess GFR, that is, estimate GFR, is more widely used than a direct measurement of GFR, true?

A. Yes.

Q. And you talk about the risks, but there are countries like Sweden and other countries that have basically institutionalized measuring GFR because it's

more accurate than estimating GFR, which is what creatinine does, true?

A. No.

Q. Okay. So Sweden hasn't done that?

A. Not to my knowledge, no.

Q. All right. Now, the danger -- or excuse me.

What causes creatinine to be less accurate than a measurement of GFR is that it is influenced and can be highly influenced and the creatinine changes, even daily, depending on a number of variables, true?

A. It can, yes.

Q. Now, creatinine is called an endogenous chemical, because we actually produce it in our body when our muscles break down because it's a by-product of that, true?

A. Yes.

Q. Right. And the problem with using creatinine to be an accurate measurement of what GFR actually is is it can be highly influenced by age, true?

A. True.

Q. Sex, meaning gender, true?

A. To some degree.

Q. Muscle mass, true?
A. Absolutely.
Q. Body composition, true?
A. Not sure how that differs from muscle mass, but I think you're getting at the same thing.
Q. Severe chronic illness, if that exists, true?
A. Yes.
Q. Diet and nutritional habits can affect creatinine and the level of creatinine, true?
A. Yes.
Q. I mean, if you and I were to go out and have dinner and have big steaks, our creatinine would increase, true?
A. In a single day, highly unlikely.
Q. All right. Okay. Does red meat increase creatinine?
A. In a single day?
Q. I didn't say a single day. Does red meat increase creatinine?
A. No more so than in equal amounts of chicken or fish.
Q. Do tubular secretions increase

creatinine?

A. They would decrease it.

Q. Does protein intake affect the level of creatinine?

A. Yes.

Q. Would you agree there are many other factors that actually influence creatinine levels at any given time since a blood test is a snapshot at a given point in time; isn't that true?

A. Yes.

Q. All right. And would you agree that using serum creatinine to estimate GFR often leads to misclassification of patients or potentially puts patients at risk for inappropriate clinical decisions; do you agree with that?

A. It can.

Q. So possible solutions are they have developed now Cystatin C that is an alternative that is less highly influenced by those same things than creatinine, and the recommendations are, well, if you're going to use it, use it together, if you're going to do an indirect estimation and not just

creatinine, true?

A. Yes. If you're going to do it, do both. It doesn't need to be --

Q. And, again, the most accurate way to assess, we talked about a direct measurement, is actually not using an endogenous chemical, but using what's called exogenous chemical that then is, say, injected into our bodies and that -- whether it's Atehexal, inulin, or others, actually have the ability to accurately, not reasonably or not approximate, but actually accurately determine the GFR, true?

A. True.

VIDEO TECHNICIAN: Counsel, I need to switch the video when you get a chance.

MR. MANDELL: Sure. How much time are we at?

VIDEO TECHNICIAN: Well, we're 28 minutes over where I was supposed to be.

MR. MANDELL: No, no. I'm saying total time out of seven hours, where are we?

VIDEO TECHNICIAN: Over five hours.

MR. MANDELL: And you're not counting lunch in there, right?

VIDEO TECHNICIAN: Yeah, can we go off the record so she doesn't have to type this up?

MR. MANDELL: 100 percent we can go off the record.

VIDEO TECHNICIAN: Off the record at 2:53.

(Recess.)

VIDEO TECHNICIAN: We are back on the record at 3:03.

Q. (By Mr. Mandell) Dr. Johnstone, would our creatinine levels -- by the way, because creatinine levels don't directly measure GFR, when it's an assessment of what GFR is using creatinine, before the letters "GFR," there's a small "e" to indicate it's an estimate; it's not an actual measurement, true?

A. Yes.

Q. All right. Is creatinine used at all to determine whether or not a kidney is worthy of being donated?

A. Yes.

Q. Are you sure?

A. Yes.

Q. Are you sure that -- okay.

Doctor, by the way, your reports, both of them, Exhibits 1 and 2, have the University of Kansas Medical Center logo on the top left-hand page of each page, top left-hand corner of each page.

A. Right.

Q. Are the opinions expressed in your reports for Ms. Tukes and Mr. Mousser, are they your opinions --

A. Yes.

Q. -- or are they opinions that have been endorsed by the University of Kansas Medical Center, or anyone else there, other than you?

A. Entirely my own.

Q. Okay. Now, if you look at your report on Page 25 of the Tukes' report, paragraph 65, I'm going to share screen and put it up on the screen, Doctor.

So look at paragraph 65, the last full paragraph on Page 25. Do you see that starts, Ms. Tukes underwent kidney transplantation on April 23rd, '24, at East Carolina University, right?

A. Yes.

Q. Okay. And then at the bottom of that paragraph, you talk about, three days after transplantation, she was discharged with a creatinine of 7.43, which improved to 4.12 by the end of the week, which improved to 1.32 by May 6th, and reached best creatinine values of 0.96 to 0.97 in July and August of 2024. You say these results meet all, quote, best expectations, right?

A. Yes.

Q. All right. Let's go to the next page, paragraph 66. When you were -- saw the records, then see that on November 18, 2024, also after the kidney transplant, there's a note from a Dr. McLawhorn that reported a kidney -- a creatinine value that week of 1.15, and the baseline was 0.9 to 1.1. So there's been an increase of the creatinine as of November 18th to 1.15, right?

A. Correct.

Q. But then you make the comment, in a kidney transplantation, creatinine values cannot be translated accurately into an estimated GFR to calculate the stage of

chronic kidney disease as is done for native kidneys. Do you see that?

A. Yes.

Q. Okay. So -- and then you go on to say, but a creatinine of 1.15 in six months post-transplant is considered superb; not just good, but superb, right?

A. Yes.

Q. So why use creatinine values after transplantation to say they had best values and why use a creatinine value of 1.15 at six months to say it's superb if in a kidney transplant patient creatinine values can't be translated accurately into an estimated GFR to calculate the stage of chronic kidney disease? If you can't use it, why do you use it?

A. So two different things in that question. The first is, in the transplant literature, does a given creatinine value for a kidney transplant accurately predict the GFR for that kidney transplant. And the answer is no. And that's a known thing about kidney transplants. So that's why I wrote that part.

That doesn't mean the creatinine is useless. It still gives you a good

baseline and a good approximation. And if someone with a kidney transplant has a falling creatinine, then their transplant is kicking in and working well. Low numbers are good. And if the numbers begin to increase more than about 30 percent for most transplant centers, they would start to worry about rejection or something else going on, and none of that happened with her.

Q. Doctor, when you talk about rejection and early rejection and that's a good sign and you think that means that Ms. Tukes' transplant graft will last, you know, longer than average -- well, strike that.

Let me ask this question. Are environmental exposures, including by toxins, considered a risk for the development of chronic kidney disease?

A. Yes.

Q. Why?

A. So the best one known is aristolochic acid. It's an environmental toxin first known as Chinese herb nephropathy and later as Balkan nephropathy.

Q. But I didn't ask you for an example. You said that environmental exposures by toxins are considered a risk factor for chronic kidney disease. And I'm asking you why, not for an example, but why do toxins -- why are they considered that? How do they cause chronic kidney disease is my question?

A. Well, for the one I mentioned, because they won't all have the same mechanism, the aristolochic acid causes a tubulointerstitial inflammation that leads to chronic slow progressive scarring.

Q. Chronic slow progressive scarring of a kidney?

A. Yes.

Q. Is there a name for that?

A. You mean separate from Chinese herb nephropathy and Balkan nephropathy?

Q. For a kidney. If a kidney has chronic progressive scarring, does that fall within any diagnosis as to the condition of the kidney or what's happening in the kidney?

A. Yes.

Q. What is that, sir?

A. Tubulointerstitial nephritis.
Q. Does -- we know that Mr. Mousser -- well, strike that.
At any time based on your review of the records, sir, has Mr. Mousser had nephrosclerosis in one or both of his kidneys?
A. Are you referring to nephrosclerosis as a histopathology term?
Q. How do you understand that term to be used, sir?
A. It can be used in one of two ways. It's used by policies to describe a certain appearance of the kidney under the microscope. And it's sometimes used by clinicians, not very accurately, to describe kidney disease due to we're not sure what in a patient with high blood pressure.
Q. What is nephrosclerosis?
A. It's, on histopathology, referring to onion skinning -- a form of vascular disease of the small vessels within the kidney that leads to progressive dropout of entire nephrons, including at the level of the glomeruli.
Q. What is it when the clinicians

will use it to describe kidney disease?

A. Absent a kidney biopsy, it is sometimes used, not very accurately, to describe kidney disease we don't precisely know what from in a patient with high blood pressure.

Q. How does it manifest -- how does a kidney disease that is part of or leads to a diagnosis of nephrosclerosis, how does that kidney disease manifest itself in the kidney?

A. We would see a rising creatinine over time, and usually a bland urinalysis with a bland urine microscopic sediment. And the kidneys, on imaging, would often gradually become smaller in size as they shrink with progressive fibrosis.

Q. When you say bland urinalysis, can you operationally define the word bland for me?

A. When we're looking at a patient's urine under the microscope, we're trying to find features that are potentially alarming and indicate the need for a kidney biopsy. And if the urine has none of those features at all, and often very few cells, then it is a

bland urine.

Q. Okay. So let's take kidney disease -- excuse me, nephrosclerosis that you described clinicians sometimes using -- I think you made have said often inaccurately, to describe kidney disease.

So in that context of nephrosclerosis, based on your review of all of Mr. Mousser's medical records, did he -- has he ever had that in one or both of his kidneys?

A. So he could have had evidence of nephrosclerosis on pathology from his nephrectomy, because one of the causes -- two of -- I guess he has two or three of the causes, of nephrosclerosis on histopathology are smoking, diabetes, and heart disease, all of which lead to a similar appearance of those kidney arteries on a kidney biopsy. But does he have a progressive rising of creatinine of the other kidney? Not at this time fortunately.

Q. Okay. So that's how the clinicians -- so did he ever -- did any clinician ever diagnose him with

nephrosclerosis based on your review of the records?

A. I don't recall.

Q. Okay. Now, you just referred again to you'd see a progressive rising of the creatinine in the remaining kidney.

A. Uh-huh. Yes.

Q. Still you're putting that reliance on creatinine knowing, at least as to its identifying GFR, it's a -- it can be a very inaccurate estimation of it, true?

A. It's a good tool, but not perfect, yes.

Q. It's more than not perfect. It's often inaccurate and -- because it's influenced by so many different factors other than what the GFR is or other than whether there's chronic kidney disease. And we talked about a few of them, true?

A. I don't agree with it the way you've stated it, no.

Q. Okay. Now, you had talked about, when clinicians look at it, that can be often inaccurate, right? That is whether there's nephrosclerosis there or not.

A. Nephrosclerosis, yes.
Q. That's what I'm talking about.
A. That's not a very precise diagnosis.
Q. Right, I got it, in terms of clinicians.
A. Yeah.
Q. Is a histopathologic diagnosis or finding of nephrosclerosis more accurate or exact than, say, a clinician saying that that might exist?
A. I mean, the histopathology is simply what's seen under the microscope. It is what it is.
Q. All right. So did Mr. Mousser ever have nephrosclerosis of one or both of his kidneys? Can you answer that question?
A. He certainly could have. I don't recall the full pathology report after his nephrectomy.
Q. Now, you had mentioned that Mr. Mousser had two or three of the known risk factors for causing -- by the way -- excuse me. I'm sorry.
If you said this, I apologize.

Can you tell me what nephrosclerosis is precisely?

A. I think we've talked about this before. It has both a histopathologic diagnosis and a clinical diagnosis.

Q. I'm talking about the effect on the kidney. Does it adversely change the kidney, biologically, medically, anatomically, in a negative way; and, if it does, how?

A. So if referring to the histopathologic diagnosis, if you have progressive narrowing of the arteries within the kidneys, then you begin to have decreased blood supply to the glomeruli and then to the tubules, they become ischemic, they begin to die and drop out. So it leads to a progressive kidney disease over time with higher creatinine and eventually the potential for loss of kidney function.

Q. Is it your testimony you can't have nephrosclerosis unless you have higher creatinine levels?

A. Not quite.

Q. Okay. Well, so what would your answer be? Can you have nephrosclerosis

without having higher creatinine levels?

A. Yes, you can have the histopathologic diagnosis of nephrosclerosis. But if your creatinine is good, showing that you have overall good kidney function, then the nephrosclerosis can't be very severe clinically.

Q. And by the way, the way -- inexact as it may be, the way creatinine in -- like as you said, allows you to assess kidney function, is that if the glomeruli tubules are harmed or damaged, they can't filter as much creatinine out of the blood, and so you'd have a higher creatinine in the blood; is that a fair statement?

A. I think so.

Q. Yeah, okay. So if you would --

MR. MANDELL: Ted, if you could get the pathology report from October 20th, 2020, from the nephrectomy done in which Mr. Mousser's right kidney was removed.

Let's put it on the screen. And we'll mark that as the next exhibit, please.

MR. RUZICKA: What number on the index?

MR. MANDELL: It's 20 -- no. 28 on the index. But it will be exhibit number --

MR. BU: I think we're on 16.

MR. MANDELL: Did you say 16, Dedric?

MR. RUZICKA: Yeah, 16. I'm marking as Exhibit 16 the pathology report.

(Exhibit 16 was marked.)

Q. Okay. So can you see on the screen the pathology report that has been marked as 16, Dr. Johnstone?

A. Yes.

Q. All right. And it's dated October -- all right. It's dated -- or it was obtained October 20, 2020, which is the date the nephrectomy was done, correct?

A. 29 October 2020.

Q. Right. Okay. And this is the surgical pathology report from that surgery?

A. Yes.

Q. Okay. Now, do you see in this pathology report at the bottom of this page that's on the screen where it says Additional Findings?

A. Yes.

Q. And it says non-neoplastic renal

tissue.

A. Yes.

Q. What does it say?

A. Nephrosclerosis, chronic pyelonephritis, hydroureter, iron and Fontana Masson stains performed.

Q. Now, according to the pathology report of the kidney that was removed, the right kidney removed from Mr. Mousser October 20th, 2020, that right kidney had nephrosclerosis in it, true?

A. Yes.

Q. All right. So that's an exact -- not often inaccurate, as the clinician might have been, but an exact finding by pathology of the right kidney specimen, true?

A. True.

Q. Again, I'm sorry. I didn't hear you did you say true, sir? I'm sorry.

A. Yes.

Q. Okay. Now, is it -- you're not surprised by that, are you, since the risk factors you talked about, that is, smoking, diabetes, and heart disease, at some point in Mr. Mousser's life, and as to diabetes and

heart disease, existed up to the removal of his kidney, true?

A. True. It's a very common finding on kidney pathology.

Q. But you're not surprised by it because those risk factors, particularly diabetes and heart disease, existed inside -- the results of that existed inside Mr. Mousser's kidney, correct?

A. And the finding can also occur with age in the absence of those risk factors. It's a fairly common finding in a subset of the kidney tissue in most nephrectomies for folks his age.

Q. Does the fact that it's a common finding according to you mean it's not -- that it's a good thing, that it's a positive finding?

A. No.

Q. Does the fact that you say it's common mean that it's not a finding that shows some harm has been done to the kidney?

A. No. It means you need to correlate it with an assessment of the global kidney function.

Q. Right. So does Mr. Mousser still have diabetes?

A. Gosh, I -- I can't say for certain yes or no right now. I think he probably does, but I don't know.

Q. Okay. What is the basis of your opinion that you think he probably still has diabetes now?

A. I don't remember his most recent medication list. And if he's on diabetic medications, then he's certainly getting treated for diabetes.

Q. Okay. So you don't know one way or the other whether he has diabetes now, right, as you sit there?

A. I can't recall, no.

Q. Does he still have heart disease?

A. To the best of my knowledge, a heart doctor wouldn't say it goes away or it disappears entirely. So he's continued to have persistent heart disease for the rest of his life; it's just medically managed.

Q. Okay. So how does diabetes harm the kidney so that it would lead to a condition like nephrosclerosis?

A. So there are a series of classical findings of diabetes in the glomeruli. This is different. So this is the association between diabetes and vascular disease, and vascular disease doesn't tend to happen just in the arteries of the heart. It will happen throughout the body.

And the kidney gets one-fifth of the blood supply from the heart every second. So if there's vascular disease in the heart, there's a highly likely finding of vascular disease or nephrosclerosis within the kidney.

Q. Right. And would you agree that the -- with those risk factors Mr. Mousser has -- has and has had and that -- and the finding of nephrosclerosis in his right kidney when it was removed likely means he has nephrosclerosis in his left kidney as well since that's --

A. Yes.

Q. -- receiving blood from the heart and diabetes still has the same effect?

A. Yes.

Q. Okay. So would you agree that comorbidities such as diabetes -- and by the

way -- strike that. Let me just take half a step back.

The heart disease Mr. Mousser has had in the past and continues till today, can you describe that heart disease by diagnosis or diagnoses?

A. I'd have to look back at the Mousser report for the summary that I took.

Q. Okay. So Mr. Mousser -- well, actually why don't we do that. Why don't you take a look at your report and identify for us, if you would, please, what heart disease he has. And I'm including in that what peripheral arterial disease he has.

A. Well, coronary artery disease for which he underwent percutaneous coronary intervention times four. That either means angioplasty or stents within the arteries of the heart.

Q. He had a CABG times four. Are you aware of that?

A. That's what the next line says, as well as coronary artery bypass graft surgery, four vessel, about four years ago.

Q. Now, that's the vascular disease,

or do you consider that cardiovascular?

A. It's all part of the vasculature.

Q. Okay. Now, you've told us how diabetes harms the kidney. How does that kind of cardiovascular disease, peripheral artery disease, too, how does that adversely affect a kidney?

A. So it's -- with regard to nephrosclerosis, it's the same process. Decreased kidney flow, shrinkage of small vessels within the kidney, eventually ischemia to individual glomeruli and tubules, and then dropout of nephron after nephron.

Q. All right. So because of the diabetes and the heart disease -- strike that.

The diabetes and the heart disease, peripheral arterial disease, they don't just have a snapshot one time adverse effect on the kidney, true, meaning that the longer that vascular disease and peripheral artery disease and diabetes exists, the greater potential harm there is to the kidney, true?

A. That's true. And it also depends on how well those disease processes are

controlled.

Q. So both up to and including the date on which Mr. Mousser had his right kidney removed and up until today, cerebrovascular disease, peripheral artery disease, and diabetes is still present and adversely affecting Mr. Mousser's left kidney, true?

A. True.

Q. All right. And I think you just testified a few minutes ago that Mr. Mousser -- Mr. Mousser likely has nephrosclerosis in his left kidney as well, true?

A. Yes.

Q. Okay. So the fact that Mr. Mousser has those comorbidities of heart disease and diabetes and that he has nephrosclerosis in his left kidney, if they progress he doesn't have his right kidney anymore, because he had to have it removed due to having cancer, true?

A. True.

Q. Is there a reason, Dr. Johnstone, that in your report for Mr. Mousser you don't mention at all that he has nephrosclerosis in his left kidney?

A. Well, I think the answer goes back to what I said a few minutes ago. If you have nephrosclerosis in your left kidney, but the assessment of your total kidney function based on serum creatinine is really pretty darn good, then that nephrosclerosis can't be severe.

And we know that his creatinine was coming down into -- I'd have to check. I think it was in the range of 1.3 or maybe even 1.2, lower than it was after he had the kidney removed. So his kidney is not getting worse. His account is appropriately undergoing hypertrophy and hyperfiltration and at least at this time has pretty darn good function.

Q. To the point where you would graduate him from kidney clinic, right?

A. If he -- especially if he has a good PCP who can remain in contact with me, so that if something changes in two years, four years, eight years, that PCP can then reach back out and say, hey, it looks like things are changing, can you take a look at him again.

Q. Do you consider insomnia to be a

psychiatric issue?

A. You know, I don't know. It's not something I think of as primarily a kidney issue.

Q. I'm just asking, do you -- okay, so you don't know. All right. Does Mr. Mousser have insomnia?

A. I think I've read that in his medical record.

Q. By the way, how long has Mr. Mousser likely had nephrosclerosis in his left kidney?

A. Likely just as long as in the right kidney.

Q. How long was that?

A. Because you can really only tell on biopsy or pathology. It's likely that it has been present years before he underwent nephrectomy, but I can't say for how long.

Q. Okay. What is your understanding of what Mr. Mousser's smoking history was?

A. I read a couple of clinic notes that discussed his smoking history I think while he was still -- while he was still a Marine. I think it might have been in

relation to the gross hematuria.

Q. What is your memory as to what that history was in those clinic notes you just referred to?

A. I think he had an evaluation once while he was stationed overseas, and then years later a second evaluation somewhere in the US.

Q. I'm just asking you what was his smoking history. Can you tell me how many packs a day he smoked for how long?

A. Oh, I don't remember.

Q. Okay. Do you have any knowledge, sir, of what the scientific and medical literature indicates happens when you stop smoking, whether -- what happens with that smoking history being a risk factor for kidney cancer?

MR. BU: Object to form. You can answer.

Q. (By Mr. Mandell) Do you understand my question, sir? Smoking is a risk factor for kidney cancer, true?

A. Yes.

Q. All right. Smoking is a risk

factor for damage to the kidneys such as nephrosclerosis? You've already said that, true?

A. True.

Q. So if you stop smoking, what is your understanding as to smoking being a risk factor for harm to the kidney, including nephrosclerosis and/or kidney cancer?

A. Without knowing the details off the top of my head, my guess is that the risks would -- that the earlier you quit the better; and that the risks would gradually abate over time; but that if you've had significant damage to the kidney, it can't re-grow.

Q. I just, if I could, you -- in terms of how long Ms. Tukes' kidney transplant is expected to last in terms of being functional and not failing, your report indicates you think it is 10 to 12 years with wide variation. And Dr. Cooper, you said, said 13 years.

So do you consider that to be a difference -- a big difference in opinion, 10 to 12 years versus 13 years?

A. To clarify, the 10 to 12 years I

was talking about is the average duration for a deceased donor kidney transplant in this country.

Q. Right. That's what Ms. Tukes got, isn't it, a deceased donor kidney transplant, or do you not know?

A. I do know. Your statement was that I was predicting hers would last 10 to 12 years, and that's not what I've said.

Q. Did you -- do you agree that a deceased donor kidney transplant is expected to last about 10 to 12 years with wide variation?

A. Yes.

Q. Okay. Now, you say that Ms. Tukes' -- you think her kidney transplant is going to last longer than 10 to 12 years, because you say she doesn't have diabetes, she doesn't have cerebrovascular disease, she's never smoked, am I correct?

A. The major risks are actually different than those.

Q. What are they?

A. Whether or not someone has delayed graft function and then whether or not someone

has acute rejection, followed by what is their transplant allograft function roughly judged by serum creatinine at one year.

Q. You focused in your report, and you just said it again, acute rejection. Isn't it with -- a significant issue with kidney transplants and whether they -- how long they last before they fail, isn't chronic rejection a significant issue that has to be considered and not just acute rejection?

A. That's true but we're talking about within the first year. And if you've had no acute rejection within the first year, your long-term prognosis is better. She hasn't, so her prognosis is expected to be better than the average.

Q. Now, where -- what learned study are you -- or article in the peer-reviewed medical literature are you relying on for your statement that says the fact she hasn't had an acute rejection in the first year means she's less likely to have a chronic rejection in the future?

MR. BU: Object to form. You can --

Q. What study -- what are you using

as a basis for that opinion in terms of any learned treatises, medical literature, and in peer-viewed journals, not journals people had to pay for to get articles in?

MR. BU: Object to form. You can answer.

A. So, once again, I didn't pay to get my article in --

Q. (By Mr. Mandell) Yeah, I wasn't referring to you, sir. I was referring to journals like Current Therapeutic Research and other journals that pharmaceutical companies do pay to get articles in.

A. So I would turn to the end of my general introductory section. The article from Harry Herron in the New England Journal of Medicine. And then the -- the KDOQI clinical guidelines for care of kidney transplant patients.

Q. All right. Are you aware, by the way, that Dr. Jayaram testified in his deposition that he -- that a kidney transplant is expected to last 10 to 15 years, and he was referring to Ms. Tukes' transplant, and that she will likely need a second kidney

transplant?

A. I did not see that in Dr. Jayaram's. And I think he's a medical oncologist.

Q. So you didn't see that in his testimony, okay.

By the way, you mentioned that when Dr. Cooper -- you're saying he said 13 years graft survival. And you're -- on Page 29 and 31 in your Tukes' report -- and, in fact, let's go there. Let's go to the -- your conclusion in Tukes' report on Page 31.

So look at Paragraph 82, sir, on Page 31 of your Tukes' report. It is also quite speculative, about halfway down in that paragraph you said, to predict her transplant will fail in 13 years at the median time cited by Dr. Cooper, and then you continue on why you feel that way.

And you also mention that -- the same thing about the median time cited by Dr. Cooper on Page 29 of your report -- that report.

So I'm asking you where did you get the information that Dr. Cooper -- strike

that actually.

What's your understanding as to the difference between the median and the mean? How would you define that difference? I mean generally, not just estimates.

A. The -- sure. The mean of 100 numbers would be derived by adding them all up together and dividing by 100. The median would be looking at those 100 numbers in a sequence and picking the 50th number, which could be slightly higher or slightly lower than the mean. They're both approximations of what's the middle of the pack.

Q. So the mean is the average, right?

A. Correct.

Q. And the median is just basically the number, if you have 10 numbers, in between the fifth and sixth number. Or, if you have 11 numbers, it would be number -- the sixth number. It's the number that's halfway, where half the numbers are below it and half the numbers are above it, right?

A. Correct.

Q. Now, where did you obtain information that Dr. Cooper was talking about

the median? Where does he say that in his report anywhere? And I'll submit to you you got it wrong. He talked about the mean, not the median.

A. All right. Then I wrote it down wrong. I apologize.

Q. No need to apologize, Doctor. There's a big difference between the median and the mean, isn't there?

A. Depends. There can be a very small difference.

Q. Right. And there could be a huge difference, right?

A. In this case, if it's between 10 to 12 years versus 13 years, I don't think I'd characterize that as huge.

Q. Okay. So, Doctor, you did say 10 to 12 years with wide variation. But let me ask you this question. You make a comment in your report that, because so many people in that New England Journal of Medicine study, I think it was figure 3, had graft rejection in the first year, that using the median that would skew the numbers so that Dr. Cooper would be wrong about the number he used. And

I want to ask you --

A. Median or the mean, sure.

Q. Well, you said the median is what you said in your report.

Let me just ask you, using that, if there were, say, 11 numbers and a disproportionate number of rejections, say, five, were in the first year, but numbers seven, eight, nine, 10 and 11 were 10th year, 12th year, 15th year, 20 year. It really doesn't matter to the median how many transplants failed in the first year because you're not averaging. They're not entitled to the equal weight of what, you said, divide by 10 or divide by 100. All that really matters is what's the -- what's the -- what are the two numbers that the mean falls in between. Isn't that true?

MR. BU: Object to form. You can answer.

A. I think we're mixing up a couple of things.

Q. Doctor --

MR. MANDELL: Ted, could you get the New England Journal of Medicine article,

Long-Term Survival After Kidney Transplantation. It's item number 42 on that list. And let's mark it as the next exhibit.

MR. RUZICKA: I'm marking the New England Journal of Medicine article as Exhibit 17.

(Exhibit 17 was marked.)

Q. Doctor, before I get there, I just want to ask you just a couple questions. I'm sorry.

MR. BU: Sorry, Mark, before you go ahead, there are two stapled packets. Is this all just one exhibit?

MR. MANDELL: Yeah. Yeah.

MR. BU: Thank you, Mark.

MR. MANDELL: In fact, you know what we could do, Nathan, the article can be one exhibit and the appendix can be -- like it can be 17-A and 17-B or something like that, just to identify it. Okay?

MR. BU: Okay.

MR. MANDELL: Thank you.

Q. (By Mr. Mandell) Doctor, when Ms. Tukes got her kidney there were several cautionary predictive risk factors associated

with it in addition to being a deceased donor kidney as opposed to a living person's kidney?

A. Yes.

Q. Isn't that true?

A. Yes.

Q. All right. So the kidney -- donor kidney had an elevated KDPI of 62, right?

A. Yes.

Q. Now, a KDPI is a kidney donor profile index, correct?

A. Yes.

Q. And what they do is there are 10 donor variables that are used to determine the quality of the deceased donors and the kidney, right?

A. Correct.

Q. And they include things like is there hypertension, is there hepatitis C, how did the donor die, that kind of stuff --

A. Exactly.

Q. -- right?

A. Yes.

Q. And the range of the KDPI goes from one to 100?

A. Yes.

Q. One is the best, 100 is the worst?
A. Yes.
Q. And there are four stages, or four grades. A is one through 20, that's the best, B is 21 to 55, C is 55 to 85, and D is the worst at 86 to 100, right?
A. Yes.
Q. So 62, that's in grade C, that's not a good grade, is it, when donating a kidney?
A. It's not great.
MR. BU: Let Mr. Mandell finish his question before you respond.
Q. (By Mr. Mandell) Now, there was a prolonged cold ischemia time of 17 hours and 31 minutes, and a visible lower pole ischemia at the time of transplant. So they were not positive predictive factors, they were cautionary factors, that said, Ms. Tukes, you're not getting the best kidney, colloquially, true?
A. I completely agree.
Q. So let's go to the article because I just want to ask you a few questions about it.

A. Sure.

Q. First, on Page 27, paragraph 72, of your Tukes' report, you make the statement that, from the general introduction section above, it's in the fifth line or fourth line -- fifth line, deceased donor kidney transplant grafts have about 70 percent chance of working after 10 years. Do you see that, sir?

A. Yes.

Q. Okay. Now, in the donor -- excuse me. In the general introduction section, you cite to this article that has just been marked -- is it 18-A and B, or what number is it?

A. 17.

Q. 17-A and B, okay. So 17-A. So you cite figure 3D and -- if we can go to figure 3D, it's on Page 736 of the article. Do you see it in front of you, sir?

A. Yes.

Q. Okay. And if you look at that article and that figure -- actually in your general introduction, I apologize, you refer to figure 2, not figure 3. So I think we need to go there for this point. But if you look

at figure 2 --

A. All right.

Q. -- which is the only reference to this article you make in the general introduction, you should be looking at 2D, which is the graft survival from a deceased donor, right?

A. Yes.

Q. Now, if you look at the most recent data from graph 2D for 10 years post-transplant, that actually shows the rate of graft survival is around 55 percent for the 208 -- or 2008 to 2011 cohort; isn't that correct?

A. That's not the most recent data.

Q. Well, it's the most recent data for 10 years, true? The 2012 to 2015 does not extend out 10 years. Since your statement said 70 percent for 10 years, I went to 2008 to 2011 which goes halfway between 10 and 15 years, correct?

A. Correct.

Q. And at 10 years the useful life of the graft survival number is really like 50 percent on graph 2D, not 70 percent, true?

A. It was for that four-year era.

Q. That's right. And that's the most recent era that deals with 10-year survival, because if you go to the 2002, 2004, 2007 for 10 years, it's about the same? It's actually lower --

A. It's lower --

Q. -- than 50 percent?

A. And that's one of the points that Harry Herron and group were making is that --

Q. But I'm talking about the point you were making. This is not a 70 percent graft survival at 10 years in this article you cited us to. It's 50 percent if you use 2008 to 2011. It's like 40 percent if you use 2004 to 2007.

My point is that it's 20 to 30 percent lower graft survival at 10 years than you said in your report, which you said 70 percent; isn't that true?

A. No. The current projection is that, since graft survival tends to improve slightly in every four-year cohort with improvements to transplantation medicine, and that's why each of these curves looks like

they're slightly better over time. That's because of improvements in transplant algorithms and --

Q. But you knew that when you wrote your report, and you still said 70 percent --

A. That's the projected --

Q. -- and yet for 10-year survival -- okay.

So, Doctor, there is also an appendix to this article that, if you look at the appendix in terms of Figure 1, for 10-year survival of the graft, the most recent data, that is, the 2008-2011 that I used, is 53.62 percent, almost 20 percent less than what you said in your report; isn't that true?

A. For that four-year era, yes.

Q. But you're citing this article and you're citing that graph and you --

A. But we've got more recent transplant.

Q. But you cited this article?

A. Yes.

Q. You're trying to say this article supports, and you cited to it in your brief -- in your report, and you're wrong. You way

overstated how -- the percentage by -- what I just showed you, by 20 percent or more; isn't that true?

A. No, sir. You're misunderstanding the figure.

MR. BU: And you do need to wait for Mr. Mandell to finish his question before you respond.

Q. (By Mr. Mandell) Okay. So, Doctor, in this article, same article, look at Page 731 of the article. Look in the right-hand column. Look about halfway down. It says, During the first year after transplantation most graft losses were due to technical issues and vascular complications. 41 percent of graft losses for technical issues and vascular complications, followed by acute rejection, 17 percent, and then glomerulonephritis, 3 percent.

It then goes on to say, beyond one year, which is where Ms. Tukes is now, it said most graft losses were due to chronic rejection, 63 percent, and glomerulonephritis of 6 percent. Did I read that correctly?

A. Correct.

Q. So beyond the first year, it isn't like chronic rejection doesn't happen or it almost never happens. 63 percent of graft losses after the first year are due to chronic rejection, true?

A. I agree.

Q. Now, when you have somebody who is older, rejection is not the only thing you're concerned about with a transplant of a kidney, true?

A. True.

Q. And, by the way, do you know what age the studies that assessed what the risks are to a patient who'd had a transplant surgery who is older, is in terms of chronic rejection and the other bad issues that could happen, how they defined older? What -- how of studies actually -- what age they put on older --

MR. BU: Object to form.

Q. -- to make those assessments, sir?

MR. BU: I'm sorry. I'm going to object to form. You can answer.

Q. (By Mr. Mandell) Go ahead. Do you know how the studies define older?

A. Okay. In most studies it's probably age over 60. Some will have age over 70.

Q. Now, what's the biggest potential danger to a patient over 60 who has had a kidney transplant surgery after one year?

A. As age goes higher, it's going to be death with functional graft.

Q. And what condition causes that death most of the time?

A. Cardiovascular disease.

Q. Are there any other causes?

A. The second would probably be infections, sepsis.

Q. Okay. So one thing that happens with older people is their immune system is weaker than it was when they were younger, and so in the first year they may not have as much acute rejection because their immune system just isn't as strong, true?

A. True.

Q. But because their immune system isn't as strong and because they're on medications, immunosuppression medications, to try to prevent rejection, they are more

susceptible to life-threatening and dangerous infections, true?

A. True. That's also why some older patients are treated with lower levels of immunosuppressant.

Q. Now, you also say in your report that the rate of graft loss at the year -- first year post one is 5 percent. And then you say that the chance Ms. Tukes' transplant graft will stop working per year is about 5 percent.

And I'd like to ask you, where in this, either figure 2 or figure 3 in the New England Journal of Medicine article, Exhibit 17-A, or the appendix, 17-B, is any attempt to measure the per year graph loss and that it's 5 percent? Where is that in any of these grafts, either 2D or 3D, since those are the sections that deal with greater graft loss from a deceased donor.

So my question is show me where it says -- show us where it says that they're trying to measure per year graft loss.

A. So in figure 3, the rate percentage, rate of graft loss deceased donor,

that is a rate per year.

Q. You said the first year is five percent. Show me where every it's 5 percent loss. They don't measure per year graft loss at 5 percent, do they?

A. I don't think I said it was 5 percent in the first year. The overall rate of graft loss in the first year will be higher because that's the riskiest year.

Q. Your report will stand as to what you said about the 5 percent at one year. But my question to you is, where in that graph does it indicate that every single year the rate of graft loss is 5 percent?

A. So most of those rates that we're looking at, especially for recent years, are somewhere between 4 and 6 percent.

Q. You're saying at which line or lines?

A. Figure 3 --

Q. Blue line?

A. Figure 3D.

Q. Yeah. Which lines?

A. The blue line looking at the rate of loss in the first year in folks who were

transplanted in 2016 to 2018 is already at or below 6 percent. And the rate of graft loss after the first year, if you go year one through year five, and this is people transplanted between 2010 and 2014, is already somewhere in the 4 percent range, mid-fours.

MR. MANDELL: Dedric, could I ask you how much time is left, please?

VIDEO TECHNICIAN: So we had two hours, and we're at an hour 13, so 50 minutes left.

MR. MANDELL: How much? I'm sorry. Five-zero?

VIDEO TECHNICIAN: Yes.

MR. MANDELL: Okay. Thank you very much.

MR. BU: Dedric, do you need to switch out the video?

VIDEO TECHNICIAN: I'm going to need to, but in a little bit, unless he wants to do it now. Do you want to take a moment now for me to just switch the tape, the video?

MR. MANDELL: Whatever is best for you, Dedric.

VIDEO TECHNICIAN: Let's just do it

now while we're at a break point here. So we're off the record at 4:15.

(Recess.)

VIDEO TECHNICIAN: We are back on the record at 4:21.

Q. (By Mr. Mandell) All right. Dr. Johnstone, in your report, the Tukes' report, you made some comments about whether age is a factor in eligibility or candidacy for a transplant. And I'm specifically referring, for example, to Page 29 of your report, paragraph 77.

And you make the comment particularly -- and tell me -- are you there, sir? Because I'll wait for you to get there.

A. 77? Which one?

Q. Paragraph 77. Page 29, sir.

A. Yep, I'm there.

Q. Okay. Thank you. You say there is -- in the third line, There is no standard age limit for kidney transplantation. And if she remains quite healthy, she may be a good candidate. But then you say, In the literature on kidney transplantation in older adults, the consistent, and then you put in

quotes, you're quoting, the consistent theme is that chronologic age is substantially less important than physiologic age in the nature and severity of any coexisting conditions, and then you cite to an article by GA Knoll, Kidney Transplantation, in the footnote, In the Older Adult, true?

A. True.

Q. Okay. So do you know how old Ms. Tukes will be -- well, how old is she now, do you know?

A. I think it was 59 going on 60.

MR. BU: You may need to speak up, Dr. Johnstone.

A. I think it was 59 going on 60.

Q. (By Mr. Mandell) Okay. And so in 12 to 15 years she'll be in her mid-70s --

A. Yes.

Q. -- early, mid-70s? Okay.

Now, with that article, that is the Knoll article, I'm going to put it on screen share so we can see it.

MR. MANDELL: Ted, can you mark that as the next exhibit, the Knoll article.

MR. RUZICKA: Yes, I'm marking it as

Exhibit 18.

(Exhibit 18 was marked.)

Q. (By Mr. Mandell) So, Doctor, can you see the beginning of that article on the screen?

A. Yes.

Q. And on the first page it does have that reference similar to your report -- in your report at the bottom of the right-hand column that says, Although no guideline reports an upper age limit for transplantation, the consistent theme is that chronologic age is substantially less important than physiologic age in the nature and severity of any coexisting conditions.

Do you see where I read that from, sir?

A. Yes.

Q. Now, if you take a look at the beginning of the abstract, let's start there. It talks about the end stage renal disease population is aging and nearly half of all new patients are older than 65 and a third are actually older than 70.

And then it says, Assessing the

possibility of transplantation for older patients with end stage renal disease often involves contemplating more complex issues, including cognitive impairment, decreased functional status, and frailty, which makes selecting appropriate candidates more difficult.

All right. So I read that correctly first, correct?

A. Yes.

Q. All right. Now, cognitive impairment, is that something outside the scope of a nephrologist, so you would ignore that like you would psychiatric issues?

A. I don't ignore, either, sir.

Q. Well, I thought you said you put it aside, you don't read it. What is that, if not ignoring it, as to psychiatric issues, sir?

A. I think you're misclassifying what I've said.

Q. Well, the record will stand on itself.

A. That's fine.

Q. What about cognitive impairment is

that something you pay attention to as a neurologist -- a nephrologist or not?

A. I am not a neurologist. So I pay attention to it, but it's not my area of expertise.

Q. And then it says, older patients -- older transplant patients have decreased patient and transplant survival compared with younger recipients. So it says, for example, 75 percent of deceased donor transplant recipients, age 30 to 49 years, are alive after five years compared to only 61 percent for those older than 65.

Did I read that correctly?

A. Yes.

Q. A little further down, it says, Older transplant recipients experienced more infectious complications and less acute rejection, but the risk of transplant loss from rejection is increased compared with younger patients.

Do you agree with that statement?

A. I -- I think it's correct. It's what's listed in the literature of -- from experts on transplantation in older adults.

Q. Then it continues on, These immunologic issues, along with the fact that older patients often are excluded from transplant trials, have made selecting an ideal immunosuppressive regimen challenging.

Do you agree that older patients often are excluded from transplant trials just because of their age?

A. They have been, yes. Do I agree with that practice, no.

Q. And then the next page, Page 791, just above the heading patient survival, it reads, "Given the strong influence of age on transplantation outcomes, it is not surprising that older recipients have decreased patient in transplant survival rates compared with younger recipients.

Is that an accurate statement, Doctor?

A. Yes.

Q. And then on Page 796, the last page of the narrative, in the right-hand column where it talks -- the heading is, in the left column, Evaluation Issues in the Elderly. It says, although -- in the

right-hand column and the last paragraph, about halfway down, it says, Although most data focused on patient survival, transplant survival, and infections, elderly patients have a limited reserve and major complications can lead to loss of mobility, cognitive decline, and even a loss of independence.

Is that an accurate statement, sir?

A. Absolutely.

Q. In the records have you observed any comments concerning Ms. Tukes' reaction emotionally to what she has gone through because of the kidney cancer she has experienced that resulted in a loss of both of her kidneys and dialysis and a transplant?

A. No specific overview, no.

Q. Okay. How do you -- how would you describe your understanding as to the emotional reaction experienced by Ms. Tukes to having cancer in both her kidneys, removal of both her kidneys, being on dialysis, and having kidney transplant? What's your understanding of that reaction?

A. I think it's been a very hard road

for her. I think it was very hard to hear about kidney cancer for her, to want the cancers out as soon as possible. I think she had a hard time on dialysis. And I think, but am not certain, that she's doing a lot better now that she has a functional kidney transplant.

Q. Dr. Johnstone, you mentioned on Page 28 of your report in the Tukes case, Paragraph 75, you talk about, to minimize the risks of chronic rejection and medication toxicity from one year onward, Ms. Tukes will require monitoring, and then you go on with some detail as follows.

So I'd like you to go through subparagraphs A through H, and I've put it up on the screen. 28.

All right. I'd like you to go three each of these subparagraphs, A through H, and explain why you feel those -- that monitoring and those future treatments are necessary.

A. So regular clinical visits every six months with a nephrologist or transplant specialist.

Q. Why is that necessary?

A. That was my training during fellowship. It's the recommendation of the KDOQI guideline and is part of general practice, meaning if not most transplant centers. It's important to give the patient the opportunity to ask questions and for the doctor and the team to review blood pressure, functional status, overall infection issues, overall transplant allograft function.

And like clinical visits for people who have chronic kidney disease, try to make any adjustments to medications or to the kind of personal monitoring that a patient does at home in terms of diet and blood pressure that can help them do as well as possible.

Q. What about subparagraph B, blood tests every one to three months, why is that necessary?

A. So your blood tests are monitoring kidney function, electrolyte disorders. So kidney function you're looking for transplant rejection. Electrolyte disorders can arise either by themselves or because of the

transplant medications, so hyperkalemia acidosis and such like.

Q. How about section C, urinalysis every month, why is that necessary?

A. So a urinalysis can detect the onset of protein in the urine, which is for folks who had hypernephritis, one of the signs of occurrence. In folks who after a few years start to be at risk for chronic transplant rejection, one of the hallmarks of that is progressive protein in the urine. And then you can also detect infections which can sometimes have minimal symptoms in the urine but still need -- still need treatment.

Q. How about D, periodic renal ultrasounds, why are they necessary?

A. So for a couple of reasons. The first is that it's possible to detect changes in the echogenicity of an ultrasound that can correlate with changes in kidney function, either from rejection, infection, or allergic reactions to medications. It's also possible to detect kidney masses, essentially kidney cancers that can arise within a transplanted kidney. And the surveillance allows you to

detect those early on.

And then sometimes you're able to detect new onset of blockages in either the arteries that go to the kidneys, veins that come away, or the ureter that comes away. And that can be detected before the onset of very overt trouble.

Q. Okay. How about the medications, including prednisone, et cetera. Why are they necessary?

A. So everyone with a transplant allograft needs some degree of immunosuppression to reduce the risk of rejection and to encourage a state of tolerance. And the medications listed are the ones that are most commonly used in the United States at this time. And this is the regimen that's she's getting from Carolina University.

Q. How about screening for the virus and the HLA antibodies at one year and then annually, why is that necessary?

A. So BK virus is an opportunistic virus. It really mainly arises in folks who are on immunosuppressant medications. If present at high degrees in the kidney, it can

contribute to transplant graft failure. So it's good to try to screen for that. And then, if it's present, make adjustments to help that virus go away.

HLA antibodies are ways to screen for antibodies that the patient, the donor -- I'm sorry, the patient is making against the donor kidney and can lead to chronic transplant rejection. So in both cases, a transplant doctor could see that test result and then adjust the immunosuppression and then keep monitoring.

Q. How about monitoring fasting lipid levels, why is that necessary?

A. Especially for people who had either diabetes or cardiovascular disease. But, in general, with transplant patients, there is a risk of hyperlipidemia and -- and that can arise because of the transplant medications themselves.

So if it's happening, you want to help detect it early on, get them on statins, get them on the appropriate diet to lower their cholesterol, sometimes add additional medications. Because lower levels of fasting

lipids will lead to a slower rate of atherosclerotic disease throughout their body, lower rates of heart disease, stroke, and loss of their transplant kidney.

Q. And then finally, what about cancer screening, why is that necessary, in subparagraph H?

A. So necessary for all of us, but more so for folks who have a transplant. When you are suppressing your immune system, you're also suppressing your body's natural surveillance for cancer. So transplant folks have an increased incidence of -- of cancer, especially of the skin. And so surveillance is suggested as part of their routine transplant follow-up.

Q. In your report you speak of Ms. Tukes demonstrating atypical early -- in your report you speak of Ms. Tukes demonstrating atypical early bifurcation of renal arteries, 2.1 centimeter from bifurcation.

So first question is, why do you believe this to be atypical?

A. I think that's the wording in the

radiology report from the VA. I don't remember which kidney it was on. But it's an anatomic variant of her vasculature.

Q. Do you believe that to be causative or contributory at all to her kidney problems?

A. Not causal or contributory.

Q. You had mentioned earlier that you have worked on other cases in the past for Versed, or Versed. What cases are you referring to, sir?

A. I think they were involved with two or three of the cases in Pittsburgh and one or two of the cases in Philadelphia for which I was an expert witness.

Q. What was the subject matter of those cases? What kind of cases were they?

A. In Pittsburgh, one of them was a patient on lithium who was concerned that she developed kidney disease.

A second was a patient who had been transported from one small hospital to another with circulatory shock, on the verge of death, and the transport was -- hoped would allow that person to have a special form of

dialysis, and they died en route.

Q. So that was -- the first one was a suit against who or which entity?

A. I think the treating psychiatrist.

Q. Okay. And you were retained to testify as an expert on behalf of who, plaintiff or defendant?

A. I think defendant.

Q. And the transport from one small hospital to another, that case, were you working for the plaintiff's lawyer or the defense lawyer?

A. Defense lawyer.

Q. Okay. Any other Versed cases?

A. I think there was a third in Pittsburgh that I'm not recalling at the moment and -- yeah, I think it was a -- maybe it was a different company in Philadelphia.

Q. Have you worked on any other cases in addition to the Camp Lejeune cases and those cases, the two you just described, the lithium and the transport case, and maybe a third case in Pittsburgh or the two cases in Philadelphia.

Have you worked on any other

cases, to review them, et cetera, testify, or anything, as an expert?

A. Somewhere between a half dozen and a dozen in total. And probably closer to a half a dozen.

Q. Okay. And what kind of cases?

A. Some of them had to do with --

Q. Were they environmental toxins?

A. No.

Q. Okay. What kind of cases?

A. I think adverse events on dialysis for a couple of them.

Q. Okay. And who generally were the defendants, the hospital or dialysis center? Who would be the defendants in those cases?

A. I forget if it was the dialysis center or -- I think it was the physician involved.

Q. And were you working on behalf of the patient or the plaintiff or the defendant?

A. Defendant for both of the dialysis cases that I recall.

Q. Okay. In all of your work as an expert witness in medical-legal work, has it always been on behalf of the defendant or

defendants?

A. I think so. That's who's approached me.

Q. Okay. Have you ever testified before in a deposition or at trial?

A. This is my first time as an expert witness in a deposition.

Q. Have you ever testified at trial?

A. No.

Q. Okay. Just so I'm clear, 100 percent of your work as an expert witness has been on behalf of the defense; is that true?

A. I think so. One of the cases in Philly might have been for prosecution. I can't recall.

Q. Meaning in a criminal case?

A. I don't think it's criminal. I think it was probably a civil case.

Q. Okay. As you sit here now, to the extent that you remember the cases you worked on, 100 percent were on behalf of the defense; is that true?

A. I think so.

Q. Okay.

MR. MANDELL: Nathan, I have no further questions.

MR. BU: Do you mind if we take a 10-minute break? I'll talk to my co-counsel.

MR. MANDELL: Sure, of course.

VIDEO TECHNICIAN: That will put us off the record at 4:50.

(Recess.)

VIDEO TECHNICIAN: We are back on the record at 4:57.

EXAMINATION

BY MR. BU:

Q. So, Dr. Johnstone, can you tell us a little bit about your clinical practice and your experience treating patients who have chronic kidney disease.

A. Been in practice since about 2007. Fellowship up until 2006 -- or I guess I've been in practice since then. I'm currently the clinical director at University of Kansas, so in that role I see patients in the outpatient clinic twice a week.

And then about three months, four months a year, four months a year, I take care of patients in the hospital, all around the

hospital. And then for about three months a year, I go to an outpatient dialysis center.

And the rest of the time is spent with a combination of meetings, administration, teaching of students, teaching of residents, teaching of fellows, and quality improvement throughout the hospital.

Q. Do you see patients who are either on dialysis or may need dialysis in the future?

A. Yes, both.

Q. When you're thinking about whether a patient may need dialysis in the future, what are the factors you normally consider in your practice?

A. The likelihood that their kidney disease will progress in the relatively near future. And then I try to incorporate in that some idea of their comorbidities, their quality of life, and what their goals are.

Q. And when you think about the progression of kidney disease and its likelihood, are there -- I guess what data would you consider in making that determination?

A. So the first thing I always try to do is to find the cause. I think once I know the cause, I can design a better treatment plan. And then as a generalization, there is a prediction equation, the kidney failure risk equation. It's best for common forms of kidney disease. It's imperfect but okay for other causes of kidney disease. And it can be used to predict the likelihood that that patient will end up needing dialysis either in two years or five years.

Q. What are the inputs for the kidney failure risk equation?

A. They have a couple of different iterations. But the weight of it is on age, serum creatinine, and the amount of albumin that's leaking from their blood into their urine. Some iterations also include phosphorous or albumin or gender. It doesn't have to.

Q. Are these kidney failure risk equations widely used by nephrologists?

A. Yes, increasingly so.

Q. The various factors that we just discussed, did you consider these for your

report in Mr. Mousser's case?
A. I did.
Q. So you considered his age?
A. Yes.
Q. His serum creatinine?
A. Yes.
Q. His albumin?
A. Yes.
Q. Mr. Mandell asked you some questions about Mr. Mousser's voc rehab. Do you believe that's relevant to determining the likelihood that Mr. Mousser will need dialysis in the future?
A. I don't think it's directly relevant.
Q. Why not?
A. Again, something new, some surprise, can always come up in someone's life. I could be hit by a car, develop some critical viral infection in the next week that puts me on dialysis.
But if you're just asking will I end up on dialysis in five or 10 years, you'd base it on the facts and clinical characteristics you see in front of you.

And when I looked in his record and I found his current -- most current serum creatinines, not one, but several. And then, not one, but several checks of his urine looking to see if albumin is leaking into the urine. All of those together are fairly reassuring.

Q. Mr. Mandell also showed you or referenced some of Mr. Mousser's psychiatric records. Do you recall that?

A. Yes.

Q. Do you find those relevant to your opinion about Mr. Mousser's potential need for dialysis in the future?

A. I don't.

Q. And why not?

A. So I'm not trying to make light of mental health. It's simply a different disease with different doctors and different considerations.

Q. And --

A. When I'm asked what's the likelihood he's going to end up on dialysis, it's just dealing with those -- those factors that go into the kidney failure risk equation

and to thinking about the cause of why he has the kidney disease that he has at present.

Q. Mr. Mandell also referenced a bladder cancer recurrence. Do you recall that?

A. Yes.

Q. Do you find that relevant to your opinions about Mr. Mousser's potential need for dialysis in the future?

A. That's a tricky one. It may or may not be. I just don't have any information about the extent of that cancer, what's going to have to be done. And, as far as I know, maybe -- it still isn't known this month. I don't -- I know that from the last data that I had in the kidney function of his remaining kidney was really very good for a single kidney.

Could that change, yes. Was there any evidence it was changing so far, no. All the evidence was still making me very optimistic about the health of that one kidney.

Q. When you say could have changed, yes, what are you referring to?

A. Oh, gosh. I mean, in the worst case scenarios, someone could require a full cystectomy, which means removal of the entire bladder. If that occurs then there are urologists who are very, very good at taking a segment of ileum and using that to create an artificial ureter so that that left kidney could still drain to the outside.

But even though that might retain the function of that left kidney, it would be a change in lifestyle for him, and it would require another surgery. Depending on the extent of his bladder cancer, it could require chemotherapy. Most often that's local and doesn't affect the kidney. But it depends on the extent of out cancer within the bladder.

In the -- early bladder cancer is actually pretty amenable to treatment by a urologist just within the kidney. So the other end of the spectrum is that it could be really easy to treat and not affect his kidney at all in any way.

Q. Is the recurrence itself reason to think that Mr. Mousser is likely to need dialysis in the future?

A. I guess so. But, again, the caveats are what kind of recurrence, can it be treated with local means, are they able to resect it, get negative margins, and have a likely cure, is it amenable to BCG local therapy. I'd have to know a lot more. And I'm not even sure it's known yet about what's going to happen with his disease.

Q. I think Mr. Mandell also asked you some questions about the standards you applied in your report. Are the standards you applied in your report the standards you would apply in your normal medical practice?

A. Yes.

MR. MANDELL: Objection.

A. Yes. And I do this all the time with using estimates of likelihood of progression. And I -- I allow patients the opportunity to graduate from my clinic all the time. If an occasional patient says, no, I want to see you in six months, I say okay. I'm not going to turn them away.

But I give them the opportunity to graduate. And some patients are delighted to have that opportunity. And they know they're

going to go back to their primary care providers and still have their kidney function looked at every six months or every year. And they know that if -- if things change, their primary care provider will reach out to me right away.

Q. You had mentioned having some difficulty accessing some records from DOJ. Were there any missing records -- or any records you felt were missing that you were not able to access by the time you issued your reports in April?

A. I don't think so. It's just the CORA database is huge and it took a while to get permission to finally access it. But once I was in and learned how to go through everything and find Tukes and Mousser, I think -- there were just a huge number of files there. I think everything was complete.

Q. Thinking about Ms. Tukes' predictions regarding graft survival, what do we know about her current medical condition that might be relevant to predicting her graft survival?

A. So I completely agree that the

kidney she got had a higher risk of rejection and failure initially. And what I was struck by is that so far she is defying all the odds.

So she had a kidney with a pretty high KDPI, prolonged cold ischemia time. If I'm remembering correctly, I think it was a four match, and it had a purplish-looking, I think, inferior pole, which isn't even officially on the predictions because that's not very common.

So four bad things and yet -- and you can tell this in -- in the notes from the Carolina transplant group. You can tell how delighted they are, because doctors get really happy when things go well. And at all of those November follow-up notes, they are very happy with how -- how good her kidney function is, how she didn't have any delayed graft function, no episodes of rejection.

That she had some mild viremia, but that it went away with gentle reduction of her transplant medications. So it allowed her own immune system to sort of attack and kill the virus without causing rejection. And so they got her into a nice balance. So it

sounds like they did a very good job of getting that balance.

And one of the next big predictors for long-term outcome is what's your transplant kidney function like at one year. And with all those negative predictors, you might have said I'm not so sure it's going to be that great at one year; and, yet, as far as I could get the data for, she was getting close to a year and had very good kidney allograft function, which means -- again, overall we predict she should be better than both the mean and median for deceased donor kidney transplants in this country.

MR. MANDELL: I just want to move to strike that answer as nonresponsive to the question. Go ahead, though.

Q. (By Mr. Bu) You also were asked some questions about a 5 percent probability of rejection. Do you recall those?

A. Per year, yes. Yeah.

Q. And is that for every year after a transplant?

A. It's not really the -- so the first year is going to be the highest. And

then it will start to go down. Overall, the rate per year is about five. The further you get out, the lower it will be per year. And at the same time as you're looking at that rate decrease every year, it doesn't go to zero ever.

But we end up having a new -- a new graph for every four-year block, because, with small advances in transplant medicine, the rates per year keep improving. They come up with new ways for induction, which is what you do immediately once the patient is on the operating table. So basiliximab didn't exist 20 years ago.

We get better with knowing where the right level should be for the transplant medications and how to detect it and what assay should be used. Tacrolimus didn't even exist 20 years ago. It was -- it was just -- just coming on the market at that time.

The Myfortic that she takes, that started in about 2006. So transplant outcomes before that even going to be a little bit worse. We use lower amounts of prednisone now to minimize the chance of long-term

complications from prednisone. So it's not that it's easy. It's that, so far with her transplant, she's doing extremely well. She's beating the curve.

MR. MANDELL: So I move to strike that answer as nonresponsive. And I object to the question based on a lack of foundation and form.

Q. (By Mr. Bu) You were also asked some questions about a 70 percent graft survival rate at ten years. Do you recall that?

A. Yes.

Q. Why do you think 70 percent is an appropriate figure?

MR. MANDELL: Objection. Go ahead. You can answer, Doctor.

A. I think from looking at that figure that we were looking at, Harry Herron's point was that, again, the graphs are getting a little better every year. And if you extrapolate from the data that we have, the estimated 10-year rate for current transplants is about 70 percent.

Q. When measuring kidney function is

eGFR commonly used?

A. Yes.

Q. Why is eGFR commonly used?

A. Serum creatinine is easy to measure and detect. There are a number of caveats, and so I think about those caveats whenever I'm looking at an individual patient to decide if I think that serum creatinine is accurate.

When trying to look at eGFR, its creatinine is stable for several days. It can't be a single measurement. But if it is stable for several days and you're at what we call the steady state, then the eGFR, the estimated glomerular filtration rate, is a pretty good test.

Q. When you were discussing Ms. Tukes' need for future care, were there any guidelines that you consulted?

A. So I think the main guideline that I looked at was the KDIGO guideline on care of kidney transplant patients. The second article was Harry Herron's New England Journal paper on long-term survival of the kidney transplant patient.

Q. And what is KDIGO?

A. It's a global forum for coming out with guidelines based on as much evidence as we have for care of different kinds of kidney disease. So Kidney Disease Improving Global Outcomes. And it involves a couple of kidney doctors from every region around the world.

MR. BU: Thank you, Dr. Johnstone. That's it for me, Mark.

MR. MANDELL: I don't have any further questions. Thank you very much, Doctor.

VIDEO TECHNICIAN: What about read and sign?

MR. BU: Yes. You can send it to DOJ.

VIDEO TECHNICIAN: All right. That will conclude the deposition at 5:18.

(The deposition concluded at 5:18 p.m. CST)

GOLKOW LITIGATION SERVICES
Deps@golkow.com

July 7, 2025
Mr. Nathan J. Bu
U.S. Department of Justice
1100 L Street NW
Washington D.C. 20044
nathan.j.bu@usdoj.gov

In Re: CAMP LEJEUNE WATER LITIGATION

Dear Mr. Bu:

Please find enclosed your copy of the deposition of DUNCAN JOHNSTONE, MD, taken on June 20, 2025, in the above-referenced case. Also enclosed is the original signature page and errata sheet.

Please have the witness read your copy of the transcript, indicate any changes and/or corrections desired on the errata sheets, and sign the signature page before a notary public.

Please return the errata sheet and notarized signature page to me at the address above within 30 days of receipt of this letter.

Thank you for your attention to this matter.

Sincerely,
/s/ Stacy L. Decker

STACY L. DECKER, C.S.R.

Enclosures
cc: Mark Mandell

CERTIFICATE OF WITNESS

RE: CAMP LEJEUNE WATER LITIGATION
DEPOSITION OF: DUNCAN JOHNSTONE, MD
DATE TAKEN: 06/20/2025

PG/LN NO.	CORRECTION	REASON FOR CHANGE

I, DUNCAN JOHNSTONE, MD, certify the foregoing transcript to be my said deposition in said action. I have read, corrected, and hereby affix my signature to said deposition.

_____ _____
Date DUNCAN JOHNSTONE, MD

Subscribed and sworn to before me this____ day of _____, 20____

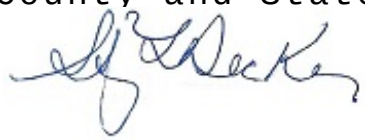
_____
Notary Public
State of _____
County of _____
My commission expires _____

C E R T I F I C A T E

I, STACY L. DECKER, a Certified Court Reporter within and for the State of Missouri and Certified Shorthand Reporter within and for the State of Kansas, hereby certify that the within-named witness was first duly sworn to testify the truth, and that the testimony by said witness was given in response to the questions propounded, as herein set forth, was first taken in machine shorthand by me and afterwards reduced to writing under my direction and supervision, and is a true and correct record of the testimony given by the witness.

I further certify that I am not a relative or employee or attorney or counsel of any of the parties, or relative or employee of such attorneys or counsel, or financially interested in the action.

WITNESS my hand and official seal at my office in said County and State, this 7th day of July, 2025.



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STACY L. DECKER, CSR, CCR

CCR No. 858

CSR No. 1540

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

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VERITEXT LEGAL SOLUTIONS

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