

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
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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

A P P E A R A N C E S

For the Plaintiffs:

Mr. Mark S. Mandell (remote)
Mr. Zachary M. Mandell (remote)
Mandell, Boisclair & Mandell, Ltd.
1 Park Row
Providence, Rhode Island 02906
mmandell@mbmjustice.com

Mr. Ted Ruzicka
Davis Bethune & Jones, LLC
1100 Main Street, Suite 2930
Kansas City, Missouri 64105
truzicka@dbjlaw.net

Mr. Randall L. Lee (remote)
Bell Legal Group
219 Ridge Street
Georgetown, South Carolina 29440
rlee@belllegalgroup

For the Defendant:

Mr. Nathan J. Bu
Ms. Camille D. Johnson
Mr. Carson Garand (remote)
Trial Attorneys
U.S. Department of Justice
1100 L Street NW
Washington D.C. 20044
nathan.j.bu@usdoj.gov
camille.d.johnson@usdoj.gov

Also Present:

Ms. Zina Bash (remote)
Keller Postman
zina.bash@kellerpostman.com
Mr. Dedric Moore
Videographer

Reported by:

Ms. Stacy L. Decker
Certified Court Reporter

I N D E X

EXAMINATION BY:

PAGE:

Mr. Mandell.....6

Mr. Bu.....278

EXHIBITS

No. 1 Johnstone's Mousser Report.....14

No. 2 Johnstone's Tukes Report.....14

No. 3 Shahnasarian's Mousser Report.....22

No. 4 Shahnasarian's Tukes Report.....22

No. 5 Tukes Medical Records.....76

No. 6 Johnstone's CV.....99

No. 7 Depo Transcript of Dr. Nagesh
Jayaram, MD.....108

No. 8 Dr. Johnstone's billing records.....120

No. 9 Facts and Data Considered, Mousser..130

No. 10 Facts and Data Considered, Tukes...130

No. 11 Overview & Chronology Mousser.....140

No. 12 Overview & Chronology Tukes.....140

No. 13 VA Benefits Letter, Mousser.....172

No. 14 Employability Evaluation, Mousser..180

No. 15 Supplemental Vocational &
Employability Report, Mousser.....180

No. 16 VA Pathology Reports, Mousser.....229

EXHIBITS (Continued)

No. 17A JAMA Article: Long-Term
Survival after Kidney
Transplantation.....248

No. 17B Supplementary Index.....248

No. 18 AJKD Article: Kidney
Transplantation in the
Older Adult.....263

* * *

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

9 * * *

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

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

18 MR. BU: Nathan Bu for the United
19 States.

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

23 MS. JOHNSON: Camille Johnson for the
24 United States.

25 MR. RUZICKA: Ted Ruzicka for the PLG.

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

3 DUNCAN JOHNSTONE, MD,
4 of lawful age, having been first duly sworn to
5 tell the truth, the whole truth, and nothing
6 but the truth, testified as follows:

7 EXAMINATION

8 BY MR. MANDELL:

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

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

19 A. Will do.

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

24 A. Fair.

25 Q. Okay. And the only other thing I

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

7 A. Understood.

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

12 A. Of course.

13 Q. An objective physician witness?

14 A. Of course.

15 Q. Why is that important, sir?

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

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

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

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

4 A. Yes.

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

8 A. Yes.

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

14 A. I'll have to have you repeat.

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

18 A. Yes.

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

23 A. Yes.

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

1 A. Yes.

2 Q. Would you agree you should not
3 intentionally stretch or overstate facts or
4 opinions solely so they would fit defense
5 arguments or claims?

6 A. Yes.

7 Q. All right. Would you agree you
8 should not provide opinions outside of your
9 expertise as if they were within your
10 expertise?

11 A. Yes.

12 Q. All right. In terms of your
13 approach to your work in this case, have you
14 been part of any coordinated effort with other
15 defense experts to be sure you all were on the
16 same page as to opinions expressed?

17 A. No.

18 MR. BU: I'm going to object to form.
19 Sorry.

20 Q. (By Mr. Mandell) Go ahead,
21 Doctor. If you answered it, I didn't hear it.
22 I'm sorry.

23 A. No.

24 Q. Okay. So just so we're clear, you
25 have not been part of any coordinated effort

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

5 A. Yes.

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

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

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

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

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

1 defense experts in these cases?

2 MR. BU: Same objection. Same
3 instruction.

4 A. Yes.

5 Q. (By Mr. Mandell) All right. How
6 many? How many times -- strike that.

7 How many different defense experts
8 have you had those kinds of contacts,
9 discussions, or exchanges with, sir?

10 A. To the best of my recollection
11 right now, maybe four. Maybe three.

12 Q. All right. Could you identify the
13 three or four experts that you have in mind,
14 sir, that you have had contacts, discussions,
15 or exchanges by email, text, or otherwise
16 with?

17 MR. BU: So similar instruction, Dr.
18 Johnstone. You can answer that, but the
19 substance of your conversations with those
20 experts are protected.

21 MR. MANDELL: And I -- I have the same
22 reaction to that. And I assume we'll get to
23 that sooner than later.

24 Q. (By Mr. Mandell) Go ahead, Dr.
25 Johnstone. Who have you had contact with who

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

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

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

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

13 Q. You mean a life care planner?

14 A. Yeah.

15 Q. Okay. Thank you.

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

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

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

1 A. Yes, it does.

2 Q. Okay. Now, actually in your
3 report, when you refer -- you do refer to Dr.
4 Stadler in your report, at least one of your
5 reports, if not both, true?

6 A. I believe that's the case. You
7 could show me where in the report.

8 Q. All right. And I'm happy to do
9 that, but do I really have to do that? Are
10 you saying you don't remember mentioning Dr.
11 Stadler in your reports?

12 A. I remember reading his report and
13 probably referencing him.

14 Q. Okay. Is there any question in
15 your mind that you referenced him in your
16 report or reports?

17 A. You can show me where in my
18 report. I'm not remembering putting in his
19 specific name.

20 Q. Right. Okay. Well --

21 MR. MANDELL: Ted, could you, if you
22 don't mind, produce Dr. Johnstone's reports,
23 both in Mr. Mousser's case and also the report
24 he did in Ms. Tukes' case, and we can mark
25 them as Exhibits 1 and 2.

1 (Exhibits 1-2 were marked.)

2 MR. BU: Madam Court Reporter, which
3 report is Exhibit 1 and which one is
4 Exhibit 2?

5 THE DEPONENT: It looks like Mousser
6 is one and Tukes is two.

7 Q. (By Mr. Mandell) You have both,
8 Doctor, in front of you, or just one?

9 A. Both.

10 Q. Oh, okay. Good. Now, if you look
11 at -- which one is Exhibit 1?

12 A. Mousser.

13 Q. Mousser, okay. Doctor, if you
14 look at Exhibits 1 and 2, Exhibit 1 being your
15 report concerning Mr. Mousser, and Exhibit 2
16 is your report concerning Ms. Tukes, you'll
17 see that next to each paragraph there is a
18 number. Do you see that, sir?

19 A. Yes.

20 Q. Now, we did that in my office to
21 make it easier to refer you to certain parts
22 of your reports as we go through this
23 deposition. So I may say if you look at Page
24 1, Paragraph 2, that's just for ease of
25 reference. That's why we did that. Okay?

1 A. Understood.

2 Q. So take a look at Page 26,
3 paragraph 68, of your report of Ms. Tukes.

4 MR. BU: I'm sorry, Mark, can we
5 actually pause briefly. I think --

6 MR. MANDELL: I'm so sorry, Nathan. I
7 didn't hear you.

8 MR. BU: I'm sorry. I have two
9 Mousser reports.

10 MR. MANDELL: Okay. All right.

11 MR. BU: Thank you, Mark. You can go
12 ahead.

13 MR. MANDELL: Thank you, Nathan.

14 Q. (By Mr. Mandell) Doctor, are you
15 on Page 26, paragraph 68, of the Tukes report?

16 A. Yes.

17 Q. And do you mention in paragraph 68
18 Dr. Stadler?

19 A. Yes.

20 Q. I'm sorry. I didn't hear you.

21 A. Yes.

22 Q. Okay. So we've cleared that up,
23 right? You've mentioned Dr. Stadler in your
24 report on Ms. Tukes in this case, correct?

25 A. Correct.

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

5 A. Correct.

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

8 A. I don't think so, no.

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

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

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

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

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

1 protected.

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

10 A. I think that's true, yes.

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

14 A. That may have been the geneticist.

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

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

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

24 A. I did.

25 Q. Okay. Are you sure that Dr. Vance

1 is from the University of North Carolina?

2 A. No.

3 Q. Okay. Then why say it?

4 A. I was trying to recollect the
5 reference.

6 Q. All right. Is she from Indiana,
7 sir?

8 A. I don't know, sir.

9 Q. Now, you mentioned that you never
10 met Dr. Stadler before you had this
11 conversation with him and at least one other
12 expert, true?

13 A. Correct.

14 Q. Did you ever hear of him before
15 you met and had that conversation?

16 A. No.

17 Q. My question is did you ever hear
18 of him before? Did you know he existed in
19 life, in the world, before you had that
20 contact with him?

21 A. I replied no.

22 Q. Oh, okay. I didn't hear you. I'm
23 sorry. I'm sorry.

24 All right. You had no idea of his
25 background, his training, or his practice or

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

3 A. True.

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

9 A. I replied true.

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

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

20 A. Dr. Stadler.

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

24 A. Yes.

25 Q. All right. So is it fair to

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

3 A. I -- that's probably true.

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

6 A. Probably, yes.

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

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

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

18 A. Yes.

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

24 A. Yes.

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

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

6 A. That's very possible.

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

11 A. No.

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

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

19 A. In part.

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

22 A. Some preliminary drafts.

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

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

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

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

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

11 A. I think so.

12 Q. Did you see that?

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

16 Q. Okay. Fair enough.

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

24 (Exhibits 3-4 were marked.)

25 MR. RUZICKA: Yes. I'm handing doctor

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

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

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

13 A. All right.

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

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

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

1 A. Yes.

2 Q. Okay. So the first page after
3 that, what do you have?

4 A. It says Page 45, "Financial
5 Information From Clinical Interview."

6 Q. Okay, fair enough. Fair enough.
7 What I was asking you was -- there is a full
8 report, and in the table of contents it
9 actually refers to Page 45.

10 All right. So you're on Page 45
11 now, Dr. Johnstone?

12 A. Yes.

13 Q. All right. Towards the top do you
14 see the bold black title of the section on
15 that page?

16 A. Yes.

17 Q. All right. And what does it say
18 sir?

19 A. "Consultation with disease
20 experts, Dr. Walter Stadler, medical
21 oncologist, and Dr. Duncan Johnstone,
22 nephrologist."

23 Q. Now, in the very beginning of that
24 four-paragraph section, it indicates that you
25 met or had a conversation with Dr. Stadler and

1 Dr. Shahnasarian on what date?

2 A. On March 5.

3 Q. Of what year?

4 A. 2025.

5 Q. All right. So just a few months
6 ago, correct?

7 A. Yes.

8 Q. True?

9 A. True.

10 Q. And this was -- do you recall the
11 format? Was it in person, was it a telephone
12 call, was it a Zoom?

13 A. It was remote. Either Zoom or
14 Teams.

15 Q. Okay. So if Dr. Shahnasarian
16 described your contact as a telephone call,
17 he's wrong?

18 A. I don't recall ever having a
19 telephone call with Dr. Shahnasarian.

20 Q. Now, do you see where Dr.
21 Shahnasarian, as he described in that heading,
22 indicates it was you, him, and Dr. Stadler on
23 that -- in that consultation, Zoom or Teams?

24 A. Yes.

25 Q. Okay. So no Dr. Vance in that

1 conversation, right?

2 A. True.

3 Q. Now, if you would, take the Tukes
4 exhibit, Number 4, and look at Page 19 if you
5 would, please. Are you there?

6 A. Yes.

7 Q. Do you see the heading, bold
8 black, about halfway down the page, that
9 reflects that meeting?

10 A. Yes.

11 Q. What does it say?

12 A. "Consultations with disease
13 experts: Dr. W. Stadler and Dr. D. Johnstone."

14 Q. And it says in the first sentence
15 on March 5th, 2025, "Dr. Shahnasarian and
16 Ms. Hilby had an opportunity to consult with
17 Dr. Walter Stadler, medical oncologist, and
18 Dr. Duncan Johnstone, nephrologist."

19 Did I read that accurately, sir?

20 A. Yes.

21 Q. So who is Ms. Hilby?

22 A. I don't remember.

23 Q. Okay. And it identifies you as a
24 nephrologist, correct?

25 A. Correct.

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

9 A. What part are you referring to?

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

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

18 Q. And we is who?

19 A. Me and Dr. Stadler.

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

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

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

4 A. I --

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

7 A. I reviewed everything myself.

8 Q. Okay. Before you had this
9 conversation?

10 A. Yes.

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

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

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

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

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

12 A. True.

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

16 A. No. His records were much less
17 extensive.

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

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

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

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

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

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

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

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

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

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

1 before this meeting on March 5th, 2025?

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

5 Q. Okay.

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

14 So I will tell you, and I'm more than
15 happy to put it up and share the screen on
16 this, if it's necessary, the Case Management
17 Order 17, to the extent that it addresses
18 conversations that do not have to be disclosed
19 between retained testifying experts along with
20 several other categories, if you look at the
21 very first subparagraph and section, Paragraph
22 3, which would be 3-A, it actually reads
23 defining what will be protected.

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

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

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

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

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

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

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

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

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

17 MR. BU: Thank you, Mark.

18 MR. MANDELL: What do you think?

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

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

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

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

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

21 MR. BU: Right.

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

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

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

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

17 MR. BU: Yes, I am.

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

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

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

5 MR. BU: Sure.

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

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

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

25 So I hope we don't spend too much time

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

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

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

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

1 questions?

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

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

14 MR. BU: Yes, I will.

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

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

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

1 A. That's true.

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

6 A. True.

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

11 A. True.

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

20 A. Yes.

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

1 malpractice by doing those surgeries?

2 A. No.

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

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

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

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

24 Q. Okay. So --

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

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

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

5 MR. BU: So allow or deny?

6 VIDEO TECHNICIAN: Just allow.

7 MR. BU: Sorry, Mark.

8 MR. MANDELL: Are you all set?

9 MR. BU: Yes. Thank you.

10 MR. MANDELL: Nothing nefarious here,
11 trust me.

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

14 I understand you were writing your
15 reports as a nephrologist.

16 A. Correct.

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

19 A. Correct.

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

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

1 of expertise.

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

7 A. Yes.

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

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

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

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

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

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

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

12 A. Yes.

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

15 A. Yes.

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

21 A. No, I'm not.

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

1 A. I do not.

2 Q. You have in your reports commented
3 about whether or not, for example, Ms. Tukes
4 -- well, strike that -- whether or not
5 Mr. Mousser will need transplant surgery,
6 right? You commented on that in Mr. Mousser
7 -- in your report on Mr. Mousser --

8 A. I believe so.

9 Q. -- whether he will need transplant
10 surgery?

11 A. I believe so. Can you -- can you
12 direct me to the part you're referencing?

13 Q. I can. But is there really any
14 question in your mind that you commented and
15 said you don't think he's going to need
16 transplant surgery?

17 A. I think it's extremely unlikely,
18 yes.

19 Q. Okay. And you made a comment
20 about whether Ms. Tukes would be a candidate
21 for another kidney transplant in the future,
22 right? And you said she'd be a -- in your
23 mind you disagree with Dr. Cooper as to
24 whether or not she might not be eligible or
25 she might not be a good candidate. Do you

1 recall that?

2 A. That's partially correct.

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

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

9 Q. And you disagree with that, right?

10 A. Correct.

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

19 A. Yes.

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

22 A. True.

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

1 training?

2 A. I think it's 18 now.

3 Q. 18. All right. So in those
4 18 years, have you ever done transplant
5 surgery yourself as the person operating?

6 A. I am not a surgeon.

7 Q. So is the answer, no, you've never
8 done transplant surgery?

9 A. Correct.

10 Q. All right. Have you ever done
11 surgery on a kidney?

12 A. On a human kidney, no.

13 Q. Have you ever done surgery on any
14 part of the body of the human, any body organ,
15 since you've been in private practice for
16 18 years?

17 A. I've never been in private
18 practice. I have performed surgeries during
19 training.

20 Q. I'm saying after your training,
21 sir. You've been in practice for 18 years
22 after training, true?

23 A. Correct.

24 Q. All right. Now, during training
25 you may have been involved in surgery, but

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

3 A. Or fellowship, yes.

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

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

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

13 A. Most often a transplant surgeon.

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

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

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

23 A. Yes.

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

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

6 A. True.

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

11 A. Not necessarily, no.

12 Q. How is that untrue, sir?

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

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

22 A. True.

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

1 multidisciplinary team --

2 A. No.

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

5 A. No.

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

11 A. That does not surprise me, no.

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

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

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

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

3 A. Not necessarily, no.

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

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

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

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

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

1 Q. Have you ever made the final
2 decision with a patient as to what surgery is
3 to be done on them, on any patient in your
4 18 years?

5 A. No.

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

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

14 Q. Did you ever communicate that to
15 anybody?

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

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

1 reasonable?

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

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

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

23 A. I'm not aware.

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

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

3 A. I don't think so, no.

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

10 A. True.

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

14 A. I don't think so, no.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17 A. I don't have specific
18 recollection.

19 (Off the stenographic record.)

20 Q. Dr. Johnstone?

21 A. Yes.

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

1 me just go back for one second.

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

8 Is there any reason why you didn't
9 identify that you had that conversation with
10 Dr. Shahnasarian and Dr. Stadler on March 5th,
11 2025, in your description of the work done?

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

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

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

25 Q. Earlier when we were talking --

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

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

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

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

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

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

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

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

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

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

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

14 Q. Did you have any other contact
15 with Dr. Vance of any kind other than a
16 10-minute group call with her on March 10th,
17 2025?

18 A. Not that I recall, no.

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

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

1 You can answer to the best of your ability.

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

6 A. At least some of it.

7 Q. -- with the geneticist?

8 A. At least some of it, yes.

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

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

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

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

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

25 A. Probably a few members of the

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

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

7 What expert, sir, May 29th?

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

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

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

18 MR. BU: Same instruction, Dr.
19 Johnstone.

20 A. Yeah, I don't.

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

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

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

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

9 A. None.

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

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

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

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

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

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

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

10 MR. BU: So I --

11 MR. MANDELL: -- generally.

12 MR. BU: I'm sorry.

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

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

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

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

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

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

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

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

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

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

1 That's what you're referring to?

2 MR. BU: Is that again to me?

3 MR. MANDELL: Yeah. I'm just
4 saying --

5 MR. BU: Yes, that's what I'm
6 referring to. I think there is an early bill
7 that refers to EO settlement.

8 Q. (By Mr. Mandell) All right. I'm
9 going to ask you about that, Doctor. But
10 before I do, when I asked you who the expert
11 was that you talked about -- that you talked
12 to on May 29th, you said you don't recall,
13 just a few minutes ago; is that true?

14 A. True.

15 Q. All right. Now, it's June 20th
16 now. We're talking about three weeks ago.
17 And you don't remember who the expert is that
18 you spoke to so that you had an entry here
19 "Questions with expert and DOJ"?

20 A. I don't remember the name.

21 Q. You honestly -- do you remember
22 what kind of expert, what subject matter
23 expert it was?

24 MR. BU: I'm going to instruct you not
25 to answer, Dr. Johnstone.

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

3 A. Zoom call.

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

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

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

20 MR. BU: Same instruction.

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

25 MR. BU: You can describe the manner

1 of the communications, but the substance of
2 the communications are protected, and you
3 should not disclose the substance of those
4 communications.

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

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

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

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

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

23 A. I think so.

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

1 DON, are protected.

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

4 MR. BU: Yes.

5 MR. MANDELL: Okay.

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

12 A. I don't think so, no.

13 Q. Anyone else?

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

16 A. No.

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

19 A. No.

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

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

25 Q. What was the purpose of the call?

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

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

11 A. Discussions of the Tukes and
12 Mousser case.

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

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

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

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

1 extent of my recollection.

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

5 MR. BU: Same instruction as before.

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

8 A. I haven't even --

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

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

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

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

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

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

1 had with a company called Versed; is that
2 true?

3 A. Yes.

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

6 A. Yes.

7 Q. Do you know how they got your
8 name?

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

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

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

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

23 A. Yes.

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

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

7 A. Sure. Yes.

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

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

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

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

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

1 A. Generalizations, yes. No specific
2 other cases.

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

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

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

14 A. Right.

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

23 A. I don't think so, no.

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

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

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

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

18 A. True.

19 Q. Okay.

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

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

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

5 (Recess.)

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

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

13 A. Sure.

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

19 A. Uh-huh. Yes.

20 Q. Do you see that?

21 A. Yes.

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

25 A. That sounds like the correct name,

1 but I -- I think so.

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

6 A. Beginning with she also met?

7 Q. Correct.

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

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

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

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

24 A. Yeah.

25 Q. Okay.

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

5 (Exhibit 5 was marked.)

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

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

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

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

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

19 MR. MANDELL: As Exhibit 5?

20 MR. RUZICKA: Yes.

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

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

4 Q. Page 29, sir, of that packet.

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

9 MR. MANDELL: Correct, it is.

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

14 THE DEPONENT: I don't see 441.

15 MR. BU: You have to keep going back.

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

19 A. Yes.

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

25 A. Uh-huh.

1 Q. Yes?

2 A. Yes.

3 Q. Okay. So in this letter,
4 November 26, 2018, Ms. Garbarini, who is the
5 genetic counselor at UNC, wrote to Ms. Tukes,
6 and in that paragraph, if you'll look halfway
7 into the paragraph, she uses language that is
8 what you put in your report, "since the
9 current test is not perfect." Do you see
10 that?

11 A. Yes.

12 Q. All right. And they're referring
13 to genetic testing that was done that did not
14 reveal a known pathogenic mutation in any of
15 the genes tested, true?

16 A. That's true.

17 Q. Now, what you've put in your
18 report, that the 30 gene test is not perfect
19 in ruling out hereditary renal papillary
20 cancer, that addresses the -- what you just
21 read that is the first part of the sentence in
22 the third paragraph on November 26, 2018, that
23 is, since the current test is not perfect,
24 right?

25 A. All right.

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

9 A. And that's true, yes.

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

18 A. I also left out the sentence after
19 that.

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

25 A. I'm not trying to be an advocate

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

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

6 A. True.

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

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

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

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

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

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

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

18 A. Okay, that's fair.

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

1 Did you leave it out deliberately?

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

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

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

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

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

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

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

5 A. Yes.

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

11 A. That was in one of her medical
12 records.

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

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

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

1 A. Yes.

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

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

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

17 Now, Doctor, in the North Carolina
18 records look at -- in that same record, the
19 same letter that's on the screen, November 26,
20 2018, you keep saying that there's -- it's
21 speculative you admit on your part, but you
22 keep saying there's a chance that it could be
23 this hereditary predisposition to renal
24 cancer. Take a look at the fifth paragraph in
25 that letter with the bold heading "Cancer

1 Screening." Do you see that?

2 A. Yes.

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

10 A. Correct.

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

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

19 Do you see that?

20 A. Yes.

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

25 MR. BU: Objection, foundation. You

1 can answer.

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

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

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

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

17 MR. MANDELL: Yeah. It's 435.

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

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

1 benign."

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

7 A. Correct.

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

11 A. Yes.

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

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

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

20 A. True.

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

23 A. Again, true.

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

1 Center called the Genitourinary Cancer Center?

2 Are you aware of that center, sir?

3 A. Yes.

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

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

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

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

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

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

4 Q. All right. Not you, though?

5 A. Sure.

6 Q. True?

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

9 Q. Doctor, do you consider yourself
10 an oncologist?

11 A. No.

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

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

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

19 A. No.

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

23 A. True.

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

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

8 A. Yes.

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

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

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

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

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

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

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

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

11 A. I -- probably not.

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

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

17 Q. At what time, sir?

18 A. The time I was --

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

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

25 MR. MANDELL: Thank you.

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

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

11 A. That sounds right.

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

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

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

25 Is that true or not true?

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

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

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

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

16 A. Yes.

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

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

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

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

8 A. I don't.

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

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

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

18 A. Sure.

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

21 A. Yes.

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

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

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

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

14 A. All right.

15 Q. Look at paragraph 53 on Page 23.

16 A. I'm there.

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

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

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

9 Renal carcinoma means kidney
10 cancer, doesn't it?

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

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

18 A. I don't know that at all.

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

21 A. I never saw those records, true.

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

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

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

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

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

14 A. I don't recall, sir.

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

17 A. Between recurrence and metastasis?

18 Q. Yes.

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

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

1 relevant; is that your testimony?

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

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

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

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

13 A. True.

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

18 A. True.

19 Q. -- right? All right.

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

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

1 (Exhibit 6 was marked.)

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

4 A. Yes.

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

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

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

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

21 A. Uh-huh.

22 Q. -- that you got in January of
23 2013. You said that is considered an honor,
24 right?

25 A. Yes.

1 Q. By whom?

2 A. Professional colleagues.

3 Q. Okay. Well, let me ask you a few
4 questions about that. The Faculty of 1000
5 recommended article --

6 A. All right.

7 Q. -- what is the Faculty of 1000,
8 sir?

9 A. A group of scientists who look
10 through the medical and scientific literature
11 to decide which papers should be of particular
12 interest, and they try to highlight those
13 because there are just so many other articles
14 written.

15 Q. Why is it Faculty of 1000? What
16 does the 1000 refer to?

17 A. The number of people involved in
18 the judging and selection process of notable
19 articles.

20 Q. Yeah. All right. So the articles
21 that you -- you've had one article that you
22 put the link there for and Faculty of 1000,
23 right?

24 A. Yes.

25 Q. And the article is titled APOL1,

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

4 A. Yes.

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

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

15 Q. Okay. Doctor --

16 A. That article was peer reviewed.

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

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

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

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

1 published? Isn't that a fact?

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

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

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

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

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

21 A. Again, by design.

22 Q. Yes, it is by design.

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

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

4 A. No, I'm not a member.

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

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

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

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

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

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

25 Q. Doctor, how many -- you say you

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

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

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

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

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

23 A. I'm not aware of that.

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

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

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

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

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

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

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

15 THE DEPONENT: I'm sorry.

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

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

25 Q. All right. So your testimony

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

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

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

11 A. All right.

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

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

20 A. Yes.

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

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

3 A. Yes.

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

7 A. Correct.

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

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

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

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

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

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

4 A. I don't think I did.

5 Q. All right.

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

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

13 (Exhibit 7 was marked.)

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

16 A. Yes, I've got it.

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

21 A. All right.

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

1 A. Yes.

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

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

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

25 And then the next question by the

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

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

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

10 A. Yes.

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

15 A. That's not really what it says.

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

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

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

1 A. Right.

2 Q. And the reason he didn't -- he
3 agreed with not recommending adjuvant
4 chemotherapy is because it's cytotoxic. Did
5 you know that?

6 A. Again, that's not the reason that
7 they're not recommending it. They're not
8 recommending it because it wasn't indicated in
9 her condition.

10 Q. You've never talked to him,
11 right --

12 A. No.

13 Q. -- in addition to not reading his
14 deposition, true?

15 A. I've never spoken to him.

16 Q. By the way, in both -- in
17 Ms. Tukes' and Mr. Mousser's reports by you,
18 you repeat language, almost verbatim, that Ms.
19 Tukes and/or Mr. Mousser, whoever's report it
20 was, is seeking judgment against the USA on
21 the basis that contaminated water from Camp
22 Lejeune caused kidney cancer which resulted in
23 bilateral nephrectomy, the need for dialysis,
24 and eventually led to kidney transplant.

25 Now, that is from Ms. Tukes'

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

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

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

14 A. Sure.

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

17 A. Balance between two competing
18 possibilities, favoring neither.

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

25 A. No.

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

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

8 A. No.

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

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

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

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

21 A. No.

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

1 A. Yes.

2 Q. Were you vetted at all by Versed
3 and/or the DOJ prior to your hiring to your
4 knowledge?

5 A. Probably.

6 Q. I think one of your references
7 indicates that you had references that you
8 sent. Did you do that, sir?

9 A. I don't remember exactly what
10 references, but I would have given them
11 something, yes.

12 Q. All right. On September 19th in
13 your billing records it indicates that you
14 were sending references. Does that help you
15 with your memory as to who the references
16 were?

17 A. I'll be honest, I don't know if
18 those are professional references or what we
19 would call references of literature, so papers
20 to read.

21 Q. The very first billing item in any
22 of your bills was September 19th. It was
23 actually before you were hired, true?

24 A. I don't recall. I'll take your
25 word for it.

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

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

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

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

21 A. That rings a bell, yes.

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

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

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

5 A. No.

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

8 A. No.

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

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

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

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

25 Q. Your fee in this case is \$850 an

1 hour for your time; is that true?

2 A. Partially true.

3 Q. What's untrue?

4 A. So my understanding is that Versed
5 is charging the DOJ. My contract is directly
6 with Versed.

7 Q. You pronounce it Versed?

8 A. Either is okay. I don't know how
9 it's pronounced.

10 Q. All right. Me too. Me too. All
11 right. So the -- are you paid by DOJ or by
12 Versed, or Versed?

13 A. I'm paid by Versed.

14 Q. And are you paid \$850 an hour?

15 A. No.

16 Q. So does Versed get a piece?

17 A. Yes.

18 Q. Of -- of what you charge?

19 A. Yes.

20 Q. -- or of the 850? How much?

21 A. I make 500.

22 Q. How much have you been paid to
23 date, sir?

24 A. I don't know offhand. My guess
25 would be between 20 and 35,000.

1 Q. Well, the time that you have spent
2 on this case, if it's tabulated up and it's at
3 \$850 an hour, that amount is still well over
4 \$80,000, true?

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

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

11 A. That's true.

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

14 A. Again, I haven't tabulated it.

15 Q. -- for these two cases?

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

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

20 A. Yes.

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

25 A. Right.

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

9 A. That's true.

10 Q. And for Ms. Tukes you've got a
11 31-page report that, just as Mr. Mousser's,
12 the section on her begins at Page 23, because
13 the first 22 pages are the same introduction
14 that Mr. Mousser had, so you've got eight
15 pages concerning specifically Ms. Tukes out of
16 the 31-page report, right?

17 A. Correct.

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

24 A. If you choose to characterize it
25 that way.

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

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

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

13 (Exhibit 8 was marked.)

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

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

20 A. All right.

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

24 A. Uh-huh. Yes.

25 Q. On September 27th, it says writing

1 general background report for two hours,
2 right?

3 A. Right.

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

7 A. Correct.

8 Q. September 30th, same, general
9 writing, general background report, that time
10 30 minutes --

11 A. Also correct.

12 Q. -- right?

13 All right. The next month,
14 October -- reflecting October, you've got work
15 on CKD, chronic kidney disease, overview, work
16 on introduction, work on introduction again,
17 CKD overview, for the dates October 4, 29, and
18 30, right?

19 A. Right.

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

22 A. Yes.

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

25 A. Yes.

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

6 A. Yes.

7 Q. And then on the last two dates of
8 December the 30th and 31st, you spent writing
9 intro overview, writing and editing, for
10 270 minutes, right?

11 A. Yes.

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

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

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

24 A. Correct.

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

1 review Tukes for 30 minutes, right?

2 A. Yes.

3 Q. Correct? Okay.

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

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

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

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

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

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

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

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

19 Q. Doctor, on February 23rd, '25,
20 does it not indicate that for three hours and
21 20 minutes, from 12:00 to 3:20 p.m., review of
22 plaintiff statements?

23 A. It does.

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

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

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

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

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

18 A. I don't remember --

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

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

24 A. March 2nd?

25 Q. 2nd.

1 A. All right.

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

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

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

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

20 A. I haven't said --

21 Q. Is that your testimony?

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

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

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

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

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

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

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

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

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

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

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

10 A. Yes.

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

15 A. Virtual.

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

19 A. No.

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

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

1 respond, you should let Mr. Mandell know.

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

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

7 A. Probably DOJ.

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

11 A. I don't think so, no.

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

14 A. I don't.

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

17 A. I did not know that.

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

21 A. No.

22 Q. No?

23 A. No.

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

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

4 A. I don't know.

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

8 A. I don't know.

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

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

14 Q. Sure, of course.

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

20 (Exhibits 9-10 were marked.)

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

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

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

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

6 A. Yes, all set.

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

10 A. I don't know.

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

14 A. Yes.

15 Q. Is that true?

16 A. Yes.

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

20 A. True.

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

25 A. All right.

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

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

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

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

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

17 A. And Cooper for the Mousser case,
18 also.

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

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

1 Q. So --

2 A. I think --

3 Q. The reports -- I'm sorry. Go
4 ahead.

5 A. I think I read part of a report
6 also from Mallon for Tukes, also.

7 Q. And is it a fair statement that
8 the rest of these reports on Page 2 from the
9 plaintiffs' experts you did not review, or you
10 might have started reviewing but none of it
11 registered to you so you didn't rely on it or
12 put any of it in your report; is that true?

13 A. Or, at most, I put a small part,
14 because I wouldn't have thought that it was
15 critical to what I was seeing elsewhere in the
16 record and trying to write.

17 Q. Can you remember any of these
18 reports that you might have taken a small part
19 and mentioned?

20 A. I'd have to go back to -- to the
21 writing process. I'm really not remembering.

22 Q. How about the DOJ experts'
23 reports, did you review any of those? Page 3.

24 A. Dr. Stadler and Dr. Vance and then
25 -- I reviewed parts of other reports. If it

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

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

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

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

12 A. I think I reviewed --

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

15 A. That name doesn't ring a bell.

16 Q. Savitz?

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

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

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

1 something that was different than the medical
2 record.

3 Q. Is there any part --

4 A. And I don't think there was.

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

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

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

16 A. I think I read part of Number 10.

17 Q. That's the National Research
18 Council 2009?

19 A. Yes.

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

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

23 Q. Do you remember anything you read
24 in it?

25 A. Trying to assess levels of a few

1 different compounds at different parts on the
2 base.

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

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

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

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

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

25 A. There were a few documents at

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

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

10 A. No.

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

13 A. Entirely.

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

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

25 Q. The analogy to the coffee maker

1 that you have --

2 A. Yes.

3 Q. -- on Page 5?

4 A. Yes.

5 Q. -- is that original to you?

6 A. It is. I think other people like
7 it and have used it, but it was my own.

8 Q. Your reports, did anyone help you
9 draft them, any part of them?

10 A. I don't have any assistants, so
11 no.

12 Q. Okay. Are they, the reports, a --
13 do they include all of the opinions that you
14 have on this case that you would testify to at
15 trial?

16 A. I certainly think so. Can you
17 tell me what you mean?

18 Q. Is there anything -- is there
19 anything, as you sit here now, understanding
20 this is -- this may be my only time to ask you
21 questions about your reports, is there
22 anything you want to change that's in your
23 reports or add to, add to them, as you sit
24 here now, sir?

25 A. If new information on the clinical

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

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

13 A. No.

14 Q. Okay.

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

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

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

23 A. Yes.

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

1 THE DEPONENT: Okay. I'm sorry.

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

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

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

9 (Recess.)

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

12 (Exhibits 11-12 was marked.)

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

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

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

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

25 A. It feels about that size. Yes,

1 281.

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

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

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

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

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

23 A. Yes.

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

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

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

18 Q. Okay.

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

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

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

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

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

12 Q. Okay. Well, if you --

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

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

19 MR. BU: Okay. Sorry, Mark.

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

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

1 actual medical records, not from any
2 summaries, like in Exhibit 11 and 12, and that
3 you didn't rely on those summaries, Exhibits
4 11 and 12, for any of the notations in your
5 reports or as a basis for any of your opinions
6 that you will testify to today or at trial.
7 Is that accurate?

8 A. That's very fair, yes.

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

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

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

25 A. I think it was December, right

1 around the holidays.

2 Q. So after you got access to the
3 CORA website or repository, did you look at
4 any summaries, whether you knew them to be LMI
5 summaries or not, that were Exhibits 11 and
6 12, or did you only look at the medical
7 records themselves?

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

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

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

1 dive into the medical record.

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

11 A. Probably, yes.

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

14 A. On which --

15 Q. -- on Ms. Tukes.

16 A. All right.

17 Q. Ms. Tukes. And look at Paragraph
18 55, sir.

19 A. All right.

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

25 A. Yes.

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

5 And if you look at the LMI
6 chronology for Ms. Tukes, you will see on
7 April 26, 2018, which is on Page twenty --
8 starts on Page 27 of 82 pages, Bates stamped
9 308, you will see several notations for that
10 date, including the pathology report on Page
11 28 and page -- the surgical pathology report
12 is on Page 28, do you see that, Bates stamped
13 309?

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

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

16 A. Yes.

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

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

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

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

1 Number 12? Is that your testimony under oath
2 today? You think this actually came from a
3 medical record and not from this summary, Page
4 309?

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

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

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

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

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

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

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

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

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

17 A. Nothing.

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

22 A. I don't know anything about LMI.

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

25 A. I know nothing about the

1 organization.

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

7 A. That's true.

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

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

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

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

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

1 report. Isn't that true?

2 A. I'll look at Page 31.

3 Q. Okay. Let's do that, sir.

4 Paragraph 82. Look at the first sentence in
5 Paragraph 82. Does it not say any predictions
6 for when her transplant might fail and require
7 her to return to dialysis are also quite
8 speculative?

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

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

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

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

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

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

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

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

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

22 A. Yes.

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

24 A. Yes.

25 Q. That's what you said. And then

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

6 A. That's also true.

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

12 A. Yes.

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

21 A. In part.

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

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

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

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

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

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

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

9 A. For me and for others, yes.

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

16 A. Yes, that's my opinion.

17 Q. She may be or she may not be?

18 A. That's true.

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

25 A. That is true.

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

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

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

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

1 sorry.

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

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

24 And kind of similarly --

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

1 ahead.

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

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

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

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

4 A. Yes.

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

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

18 Q. Are you certain?

19 A. I did not see it in her records.

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

1 A. Sure, you can include both.

2 Q. Well, I'm not asking you if we
3 can. I'm saying do you --

4 A. I do.

5 Q. -- include both?

6 A. I do.

7 Q. Okay. Now, in terms of how many
8 years Ms. Tukes is expected to survive, that's
9 something upon which you think, it's your
10 opinion, that we can only speculate, and you
11 put that in your report at page 26, paragraph
12 71, true?

13 A. True.

14 Q. Yes, no?

15 A. True.

16 Q. I didn't hear you if you said a
17 word. You said true?

18 A. Yes.

19 Q. Okay. And then, also, as to any
20 negative impacts to her life expectancy, at
21 this point in your mind are just speculative
22 if somebody were to mention what negative
23 impacts might exist or will exist in the
24 future, it's your opinion, and you put it Page
25 31, paragraph 81, of your report, that would

1 be speculative, true?

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

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

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

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

18 A. Also true, but optimistic at this
19 point.

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

1 matter? That's what you're saying?

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

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

8 A. All right.

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

15 A. Correct.

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

18 A. Correct.

19 Q. All right. And yet you also say
20 you're uncertain why he had to stop work or he
21 did stop work after he had his kidney surgery,
22 true? That you're not certain as -- you're
23 uncertain as to why he chose to stop work or
24 he stopped work, and you express that in Page
25 24, paragraph 57, of your report, right?

1 A. So yes. There were documents in
2 his medical record that he felt under great
3 stress as a result of that. And the stress is
4 real. I'm not discounting that. But having
5 one kidney per se doesn't prevent people from
6 living a full life and an enjoyable productive
7 life.

8 Q. You're not talking about all
9 people, are you? You're talking about some
10 people. Some people with one kidney will act
11 differently than other people. Some may be
12 more disabled. Some may have greater
13 psychological reactions. Some may have
14 additional physical reactions. Some may have
15 comorbidities. You have to look at the
16 individual to be able to say, well, this would
17 prevent them from working. It wouldn't. You
18 can't just take a global estimate and apply
19 that to everybody; isn't that true?

20 A. I think there's parts of that I
21 agree with and a fair amount that I don't
22 agree with.

23 Q. Doctor, when you make an
24 assessment as to one individual, whether that
25 person because of what has happened to them --

1 let's say they had to have a kidney removed
2 and they have chronic kidney disease in the
3 other kidney, take that person. Now, you
4 could say, well, you can survive on one kidney
5 and flourish. Your kidney -- chronic kidney
6 disease in your opinion, Dr. Johnstone, isn't
7 so bad, so having one kidney functioning, you
8 can work, you can play, you can have a quality
9 of life. So you could say that, and that is
10 your opinion in this case about Mr. Mousser,
11 correct?

12 A. Correct.

13 Q. Yeah. But you have to look at
14 Mr. Mousser, not some person in another state
15 who may have enrolled in some study and they
16 may have different health issues than
17 Mr. Mousser. You have to look at Mr. Mousser
18 and his comorbidities, his medical condition,
19 his psychiatric condition, and look at him and
20 say he can or he cannot work, true, for it to
21 be accurate?

22 A. There's still a lot of that that I
23 simply do not agree with.

24 Q. What don't you agree with, Doctor?
25 You think you can apply national statistics to

1 every person, every single individual who has
2 one kidney?

3 A. As a doctor I'm sometimes asked to
4 sign documents so that people can go on
5 disability, and I'm very comfortable doing
6 that. I have patients coming to see me
7 because they have only one kidney. Those
8 patients ask what does this mean for me. And
9 I tell them and write in their medical record
10 that you're not allowed to play rugby, you're
11 not allowed to go sky diving or do anything
12 that would threaten that other kidney.

13 But that, you know, you're 40 or
14 45 years old and you've only just learned that
15 you've had one kidney, keep enjoying your
16 life. So I'm in this clinical situation, and
17 I give advice to people who find they only
18 have one kidney.

19 Q. Do you give that advice to every
20 person who comes to you who has only one
21 kidney no matter what their condition is
22 otherwise?

23 A. I would not sign disability forms
24 saying someone was unable to work only for the
25 reason of having one kidney.

1 Q. Right. But you have to look at
2 the person, if you have that form in front of
3 you, and say what effect having one kidney has
4 had on them, and, for example,
5 psychiatrically, and you also have to look at
6 what other comorbidities they have. You just
7 can't say, because you have one kidney you can
8 work and I'm not signing disability. You
9 can't do that across the board, can you?

10 A. If it's a psychiatric disease
11 problem, then they should be asking and
12 getting disability from their psychiatrist,
13 not from a kidney doctor.

14 Q. That's your answer? I asked you
15 can you apply that which you said you would
16 tell a patient with one kidney, which is go
17 ahead and enjoy your life, no reason you can't
18 work, no reason you can't play, you would say
19 that to everybody who comes to you with one
20 kidney regardless of their overall condition
21 or comorbidities?

22 A. Yes. Can you be -- can you give
23 me an example of something otherwise?

24 Q. Yeah, Mr. Mousser. Have you read
25 the psychiatric records?

1 A. I haven't and shouldn't because
2 I'm not a psychiatrist.

3 Q. Right. Okay.

4 A. And, again, that's a separate
5 reason for disability that is not related to
6 having a single kidney.

7 Q. So, Dr. Johnstone, let's assume
8 you have a patient that has one kidney who has
9 been diagnosed with adjustment disorder,
10 depression, psychiatric issues. You're saying
11 you wouldn't want to know what their medical
12 records say from the psychiatrist because
13 you're a nephrologist, is that what you're
14 testifying to, for your own patients?

15 A. In almost all cases, that medical
16 record would actually be closed to me.

17 Q. Got it. Okay.

18 A. Even if we're sharing a patient, I
19 can't access a patient's psychiatric records.

20 Q. No, but you could ask the patient
21 can I see your records. You would get
22 permission from the patient and a signed HIPAA
23 form and then you'd contact the psychiatrist's
24 office and say your client, our mutual client,
25 our patient, has agreed. And you're saying,

1 no, you're not going to do that because you're
2 a nephrologist, not a psychiatrist?

3 A. No. In your example, if I thought
4 there was something important for care of him
5 as a kidney disease patient, I would and have
6 reached out to psychiatrists. But do I have
7 the right to jump into his record, no, I
8 don't.

9 Q. But nobody said that, Doctor.
10 We're talking about finding out. The point is
11 that you need to look at each person to be
12 able to give an honest and accurate opinion as
13 to whether or not they can work or whether or
14 not their life has been adversely affected;
15 isn't that true?

16 A. I think the way you're phrasing it
17 is very fair.

18 Q. And you say but the cause of his
19 decreased functional capacity for work and
20 life activity is not related to having a
21 single remaining left kidney?

22 A. Correct.

23 Q. Now, first, doesn't that depend on
24 the condition of the single remaining kidney?

25 A. Yes.

1 Q. Doesn't that depend on what other
2 medical and/or psychiatric problems the person
3 has that they're receiving treatment for from
4 other doctors?

5 A. Again, I'm focusing on the kidney.
6 So if the question is the remaining kidney
7 function, I look at the values that correspond
8 to that kidney function. If he happens to be
9 on a medication, and there are a couple in
10 psychiatry that can be toxic to the kidney,
11 then that's a conversation I definitely want
12 to have with him and his treating
13 psychiatrist.

14 If it's a question of just single
15 kidney and the creatinine is fairly low, then
16 it's a good functioning single kidney, and
17 that's true for him.

18 Q. I know that's your opinion. I
19 plan to ask you about that in a few minutes.
20 But, Doctor, you don't just treat a kidney;
21 you're treating a patient that has that
22 kidney, true?

23 A. That's true.

24 Q. And to treat that patient and that
25 kidney properly, you need to know whether that

1 person's heart is okay, whether their brain is
2 okay, whether their liver is okay. You need
3 to know the condition, physically and
4 psychiatrically, of that patient for you to be
5 able to do your job well, true?

6 A. Yes.

7 Q. Because the kidney does not live
8 in isolation; it lives within a human being,
9 true?

10 A. True.

11 Q. Yeah. Now, do you know why
12 Mr. Mousser quit work or was unable to work?
13 From any of his medical records, do you know?

14 A. No.

15 Q. Do you know what he's testified to
16 in his deposition -- strike that.

17 Did you read his deposition?

18 A. I think so, but I can't recall
19 lots of detail.

20 Q. Can you recall any detail from
21 Mr. Mousser's deposition?

22 A. Discussions about getting tested
23 for gross hematuria. I don't think I have --

24 Q. Do you know how many times he --
25 do you know how many times he sat for a

1 deposition, whether it was once, twice, three,
2 four times?

3 A. I don't.

4 Q. Do you have any idea how many
5 times he sat for a deposition?

6 A. No.

7 Q. Okay. Now, are you aware of any
8 determinations by the Veterans Administration
9 after they considered evidence, medical
10 records, and thought about it, do you know
11 what their determination was as to whether or
12 not, after Mr. Mousser's nephrectomy,
13 nephroureterectomy, whether he was able to
14 work or not?

15 A. I don't know.

16 Q. Have you read any documentation
17 from the Veterans Administration as to a
18 decision they made about him in terms of
19 whether he was entitled to disability benefits
20 or not?

21 A. No.

22 Q. All right. Are you aware that the
23 Veterans Administration reached out to a
24 vocational rehab expert who did a vocational
25 rehab examination and report and then

1 supplemented it with a second report? Are you
2 aware that happened --

3 A. No. Again --

4 Q. -- that expert being -- go ahead.
5 I'm sorry.

6 A. Nothing from those VA records, no.

7 Q. All right.

8 MR. MANDELL: Ted, could you get the
9 Veterans Administration decision. It's number
10 32. It's on the list as 32. It would be
11 Exhibit 13.

12 MR. RUZICKA: Yes. I'm marking the VA
13 decision April 8, 2024, as Exhibit 13.

14 (Exhibit 13 was marked.)

15 A. All right.

16 Q. (By Mr. Mandell) Okay. All
17 right, Doctor. Turn to, if you would, please,
18 the third page of that packet, please. Does
19 it identify at the top there Department of
20 Veterans Affairs?

21 A. Page 3 says Appeal to the Board of
22 Veterans Appeals.

23 Q. The third page of that packet,
24 sir?

25 A. Says Appeal to the Board of

1 Veterans Appeals.

2 Q. Okay. I'm going to share a
3 screen, Doctor, and show you what I'm talking
4 about from that exhibit.

5 All right. So can you see on the
6 screen?

7 A. No, sir.

8 Q. Okay. Well, it's coming. Do you
9 see it now?

10 A. All right.

11 Q. It's dated April 8, 2024,
12 Mr. Mousser --

13 A. Yes.

14 Q. -- from the VA? We've made a
15 decision on your VA benefits. Do you see
16 that?

17 A. Yes.

18 Q. All right. Let's go to the third
19 page. Do you see on the page on the screen
20 now, it's Bates stamped 25855, VBA.

21 A. All right.

22 Q. Do you see it says, Decision,
23 Evaluation number one of insomnia with
24 depressive disorder chronic ongoing, paren,
25 previously rated as mood disorder due to

1 general medical condition with major
2 depressive episodes, closed paren, which is
3 currently 70 percent disabling is continued.

4 Number two, entitled to individual
5 unemployability is granted effective
6 October 21st, 2023.

7 Do you see where I read that, sir?

8 A. Yes.

9 Q. Yes?

10 A. Yes.

11 Q. Okay. I can't hear you, but I
12 think you said yes?

13 A. Yes. I'm not sure why it's not
14 going through.

15 Q. Okay. Let's go to the next page.
16 Do you see where it says Evidence on the next
17 page, Bates stamped 25856?

18 A. Yes.

19 Q. And it's got six categories of
20 information, right?

21 A. Yes.

22 Q. Including the very first one which
23 is referred to as the employability
24 evaluation, January 26, 2024. Did you see any
25 of those six documents or categories of

1 documents that are listed under evidence ever?

2 A. If I saw them I would not have
3 felt they were critical for deciding what his
4 kidney function and future chance of
5 progressive kidney disease was.

6 Q. What about for his ability to
7 work, which you said it shouldn't be a problem
8 based on one kidney?

9 A. Again, if he had --

10 Q. Would it be relevant to that?

11 A. -- other reasons for not working
12 that are legitimate, that's fine. But I was
13 -- I was focusing, as I should, on his kidney
14 function and future kidney disease.

15 Q. Doctor, are you aware, from
16 looking at Mr. Mousser's records, or from any
17 source, that it was only after Mr. Mousser had
18 his right kidney removed that he began to have
19 the issues that have prevented him from
20 working? Are you aware of that?

21 A. No.

22 Q. Okay. So look at the next page
23 which says Entitlement to Individual
24 Unemployability. And do you see where in that
25 first paragraph -- could you read that into

1 the record, please, sir.

2 A. Reasons for decision?

3 Q. No. Entitlement to individual
4 employability, number two.

5 A. Entitlement to individual
6 unemployability is granted from October 21,
7 2023, because you are unable to secure or
8 follow a substantially gainful occupation as a
9 result of your service-connected neoplasm of
10 kidney, urothelial cancer, status post right
11 kidney removal and ureter removal with left
12 kidney chronic kidney disease. Recurrent
13 cystitis of the bladder with hematuria, now
14 also claimed as overactive bladder with
15 nocturia. Insomnia with depressive disorder,
16 chronic ongoing. Tinnitus.

17 Q. Right. So according to the VA
18 Mr. Mousser was granted entitlement to
19 individual unemployability for a number of
20 reasons. One reason is as a result of his
21 cancer of his kidney and the fact he had to
22 have his kidney and ureter removed, true?

23 A. True in part.

24 Q. What's not true about it, sir?

25 A. Is this decision based on opinions

1 from his VA kidney doctor, or is it entirely
2 based on opinions from his VA psychiatrist.
3 And if it's the latter, I am not qualified to
4 talk about psychiatry, and the reasons
5 underlying are part of his mental health
6 disorder.

7 Q. Doctor, the VA decision that you
8 just read into the record attributes, in part,
9 Mr. Mousser's inability to work to the fact
10 that he had kidney cancer in his right kidney
11 and he had to have it removed, and his ureter
12 removed. And there are other reasons that you
13 read, also, but that was part of it. Isn't
14 that written there in that decision?

15 A. It is written.

16 Q. Okay. And then the next
17 paragraph, doesn't the first sentence from the
18 VA read, VA examination showed that your
19 service-connected disability impacts your
20 ability to function in an occupational
21 environment?

22 A. Yes.

23 Q. Doesn't it say that?

24 A. Yes.

25 Q. Let's go to the next page, please.

1 And if you look at the next page, which is
2 Bates stamped 25858, doesn't it say in the
3 first -- the second paragraph on that page,
4 Basic eligibility for dependence educational
5 assistance is granted as the evidence shows
6 you currently have a totally disabled
7 service-connected disability or disabilities
8 permanent in nature.

9 Doesn't it say that?

10 A. Yes.

11 Q. And is it your opinion, without
12 your having the benefit of any of the
13 information that the VA based this decision
14 on, that they're wrong, that somehow you're
15 right, that nothing about his kidney and the
16 removal of his kidney means he might not be
17 able to work or shouldn't work? Are you
18 saying they're wrong?

19 A. No, not at all. Someone can have
20 an entirely service connected mental health
21 condition. And, if so, the VA has done the
22 very appropriate thing of giving them service
23 connect -- full service benefits for that
24 mental health condition.

25 Q. Now, Doctor, are you aware when --

1 you say, well, it depends who read this, you
2 know, was it a psychiatrist, and you said I'm
3 not qualified to deal with psychiatry issues.

4 Are you aware that the doctors who
5 have indicated Mr. Mousser's kidney condition
6 impacted his ability to work where Dr. Douglas
7 Jenkins on December 15, 2020, Dr. Hameed, both
8 internal medicine doctors, on May 5th, 2021,
9 Dr. Anthony Martinez -- excuse me, family
10 nurse practitioner Anthony Martinez on
11 November 12th, '21, Melissa Lebron, a family
12 nurse practitioner October 5, '22, and Harry
13 Croft, who is a psychiatrist, also -- all of
14 them, all five of them indicated that
15 Mr. Mousser's kidney condition impacted his
16 ability to work. Are you aware of that?

17 A. I'm not aware of that. And I am
18 not hearing about a kidney doctor.

19 Q. Right. Doctor, do you know who
20 Kelly Sakala is, please?

21 A. No.

22 Q. So she's a vocational rehab expert
23 that the VA asked in January 26, '24, she did
24 -- as a result of their asking, VA
25 commissioned an evaluation, and she did an

1 evaluation and issued a report on January 26,
2 '24. You've never seen that report, have you?

3 A. No.

4 MR. MANDELL: Ted, could you mark as
5 exhibits Kelly Sakala's report and her
6 supplemental report, please.

7 (Exhibits 14-15 were marked.)

8 MR. RUZICKA: I'm marking as
9 Deposition Exhibit 14 the report dated
10 January 26, 2024, and the -- I'm marking as
11 Exhibit 15 the supplemental report dated
12 February 7th, 2025.

13 MR. MANDELL: So that's Exhibits 14
14 and 15.

15 Q. Dr. Johnstone --

16 MR. BU: Sorry. Could you hold on one
17 second?

18 MR. MANDELL: Oh, of course. Of
19 course.

20 MR. BU: All right. Go ahead.

21 Q. (By Mr. Mandell) I'm showing you
22 the conclusion of Ms. Sakala's vocational
23 rehab report dated January 26, '24. And do
24 you see on her signature line is there on this
25 page, Page 27 of the report, Bates stamped

1 8599.

2 So let's look at this conclusion.
3 All right. Number one, Mr. Mousser is unable
4 to perform his past relevant work as an
5 automobile salesperson or sales manager on a
6 sustained full-time competitive basis.

7 Did I read that correctly?

8 A. Yes.

9 Q. All right. Were you even aware of
10 that finding until I just showed it to you?

11 A. I mean, I think I read it in the
12 medical record.

13 Q. You read that Kelly Sakala did an
14 evaluation January 26, 2024, asked by the VA
15 to do it, vocational rehab expert?

16 A. No.

17 Q. And that finding, number one, you
18 read about that in the medical record, sir; is
19 that your testimony?

20 A. No. Again, no.

21 Q. So number two reads, Mr. Mousser
22 is unable to work due to the residuals of his
23 severe service-connected emotional and
24 physical condition.

25 Did you know about that until you

1 just saw it?

2 A. This is the first time I'm reading
3 this report.

4 Q. All right. Read number three,
5 will you, please?

6 A. Mr. Mousser is unable to perform
7 any sedentary, light, medium, heavy, or very
8 heavy work existing in the local or national
9 economy on a sustained full-time regular
10 competitive basis due to the residuals of his
11 service-connected impairments.

12 Q. You can read four and five to
13 yourself, and I want to ask you if you have
14 any disagreement with Kelly Sakala's --
15 Ms. Sakala's report findings as they exist on
16 Page 27.

17 A. I haven't read her report.

18 Q. I'm asking if you have any
19 disagreement with her findings based on what
20 you did read since you've given the opinion
21 that he should be able to work with one
22 kidney.

23 A. My opinion is still the same. One
24 kidney, per se, does not prevent someone from
25 working or living a productive life.

1 Q. Right. But this isn't an issue of
2 one kidney, per se, Doctor. It's an issue of
3 a person, a human being named Frank Mousser.
4 And, in addition to his loss of his kidney and
5 his chronic kidney disease in the other
6 kidney, has other issues that may and do
7 affect him. This is a disability
8 determination, not of a kidney, but of a
9 person, true?

10 A. True.

11 Q. Isn't that true?

12 A. Yes.

13 Q. All right. Are you aware that
14 Ms. Sakala issued a supplement to this opinion
15 in which she renewed her opinion and --
16 reaffirmed her opinion that Mr. Mousser is not
17 employable? Are you aware of that, sir?

18 A. No.

19 Q. Okay. All right. And the second
20 time she gave -- did her renewed report as an
21 expert for the plaintiffs in this case where
22 the first time it was purely at the request of
23 the VA. Are you aware of that?

24 A. No.

25 Q. Doctor, you're not a toxicologist

1 are you?

2 A. No.

3 Q. Not an epidemiologist?

4 A. No.

5 Q. Not an occupational medicine MD?

6 A. No.

7 Q. Now, in your report there's
8 absolutely no mention strike that.

9 You mentioned in your reports for
10 both Ms. Tukes and Mr. Mousser factors such as
11 -- that are risk factors for kidney cancer,
12 true?

13 A. Yes.

14 Q. You mentioned, as to Mr. Mousser,
15 smoking, which I'll talk to you about in a few
16 minutes.

17 You mentioned hypertension for
18 Ms. Tukes, true?

19 A. True.

20 Q. You mentioned obesity I think for
21 Mr. Mousser, true?

22 A. Yes.

23 Q. You mentioned Mr. Mousser's
24 peripheral arterial disease, his
25 cerebrovascular disease that all preexisted.

1 Diabetes.

2 You mentioned a number of risk
3 factors for kidney cancer in your report,
4 right?

5 A. And some of those are listed as
6 risk factors for length of life and quality of
7 life.

8 Q. I'm asking you the question,
9 Doctor, and I'm happy to modify it to add what
10 you said. But you don't -- you mentioned a
11 number of other issues --

12 A. All right.

13 Q. -- without giving an opinion on
14 causation, which you've said you're not doing
15 in this case, but you've mentioned a lot of
16 other issues that are risk factors for kidney
17 cancer or urothelial cancer of the upper tract
18 in the kidney.

19 But one thing you don't mention at
20 all, other than to say Mr. Mousser and
21 Ms. Tukes are claiming that toxins in the
22 water at Camp Lejeune have caused their
23 cancer, you don't mention toxins at all or
24 their exposure to toxins at all as a risk
25 factor for the cause of their kidney cancer

1 and urothelial upper tract cancer; isn't that
2 true?

3 A. I think that's true.

4 Q. Yeah. The concept and facts of
5 the toxic exposures Ms. Tukes had and
6 Mr. Mousser had at Camp Lejeune are absent
7 from your report, right?

8 A. Because, as you point out, I'm not
9 a toxicologist or an epidemiologist, yes.

10 Q. Well, because maybe you only
11 mentioned those things that aren't related to
12 what the plaintiffs are claiming in this
13 lawsuit as the cause of their kidney cancer
14 and you're being an advocate; is that a
15 possibility, Doctor?

16 A. I think I'm mentioning things that
17 I'm familiar with. I am very unfamiliar with
18 the field of toxicology and don't feel myself
19 qualified to be going through toxicologic
20 reports and trying to judge the degree of
21 causation.

22 Q. Yeah. But, Doctor, you've given
23 -- you've alluded to things in your report
24 that you have said you're not giving any
25 opinions on because you're not expert in the

1 area, but you still mention them in your
2 report -- let me withdraw that.

3 Doctor, do you know how many
4 national and international organizations have
5 said that the chemical TCE causes kidney
6 cancer? Are you aware of how many different
7 organizations nationally and internationally
8 have said that?

9 A. No, I don't.

10 Q. And do you know what exposure
11 levels have been identified as to when you
12 could say that TCE is harmful to human health
13 generally and specifically in causing kidney
14 cancer? Do you have any knowledge of that at
15 all, sir?

16 A. The only knowledge I've gleaned is
17 in the few reports I've read. But I'm not
18 able to judge how much exposure someone has
19 had or whether it's mostly, partly, or not
20 causal. It's just not my field.

21 Q. And your answers would be the same
22 for PCE, vinyl chloride, and benzene, in
23 kidney cancer; is that true? You just don't
24 know?

25 A. Benzene at least is in the medical

1 literature that I've read and know a little
2 bit better. For the others it's not a field
3 that's been part of my training, so, no, I
4 don't -- I don't -- I don't know.

5 Q. Doctor, in your report you
6 actually make this comment: My clinical area
7 of expertise is glomerular disease, but I have
8 never placed limits on who I will see in the
9 clinic.

10 And you said that on Page 2. I
11 think it's the fifth paragraph of your report.
12 And I guess my question to you is what do you
13 mean by you've never placed limits on who you
14 will see in your clinic?

15 A. I don't have a specialty clinic
16 only for glomerular disease. And if someone
17 calls -- this was true in Philadelphia, it was
18 true in Pittsburgh, and it's true at Kansas.
19 If someone calls the kidney office and says I
20 have this question about my kidneys, and one
21 of the nurses or administrators reaches out to
22 me and says will you try to see this patient,
23 this is a strange question, I always say, yes,
24 I'll do my best.

25 Q. Doctor, in Kansas do you work at

1 three Fresenius dialysis centers?

2 A. I am currently at two of them.

3 Q. Two of them. Did you work at
4 three until recently?

5 A. No.

6 Q. All right. Well, how long --
7 you've been in Kansas since when, what year?

8 A. About two years.

9 Q. Two years. And the Fresenius
10 dialysis centers, are they affiliated -- are
11 they part of the Kansas University Medical
12 Center?

13 A. Those two are joint ventures with
14 KU. They're not part of the University of
15 Kansas per se.

16 Q. Are they for-profit businesses?

17 A. Fresenius is, yes.

18 Q. And you're -- in attending -- what
19 are the names of those Fresenius centers?

20 A. Fresenius Parallel and Fresenius
21 Lenexa.

22 Q. What about Fresenius Rainbow?
23 You've never worked there as attending
24 nephrologist?

25 A. No.

1 Q. Okay. If you've never worked at
2 Fresenius Rainbow, why is it on your resume
3 that you've worked there since May of 2023 to
4 the present? It's on Page 2 of your resume,
5 the last non-academic appointment.

6 A. I can go there if needed. I am
7 not part of the rotation. Other colleagues in
8 my group go to -- go to Rainbow. As the
9 clinical director, I can be called to fill in
10 for someone in an emergency at any time. I've
11 never had to.

12 Q. So take a look at your resume.
13 It's been marked as an exhibit.

14 A. Six.

15 Q. Take a look at Page 2, sir. Do
16 you see the very last item under non-academic
17 appointments, May 23 to the present, FMC
18 Rainbow, Parallel, and Lenexa, attending
19 nephrologist, right?

20 A. Yes.

21 Q. Why would you put Rainbow on your
22 resume, and you're saying you're an attending
23 nephrologist there, if you've never been
24 there?

25 A. Like I said, as the clinical

1 director I can be called there. I'm
2 privileged there to work if anyone can't. I
3 haven't had to. Other colleagues have covered
4 that particular facility every month.

5 Q. So your testimony is you have a
6 clinical director who has never been there?

7 A. I'm the clinical director of KU
8 Nephrology. And -- and, yes, I've never been
9 to the Fresenius Rainbow site.

10 Q. And yet you put it on your resume
11 as a qualification?

12 A. It's a place where I am certified
13 to work if needed as part of our medical
14 group.

15 Q. How much time per week do you
16 spend at the -- either at or dealing with
17 issues concerning the Fresenius medical
18 centers, whether it's Rainbow, Parallel, or
19 Lenexa? How much time per week?

20 A. So one of us in our group covers
21 each facility as a solo practitioner for that
22 month. In the past year I was at both
23 Parallel and Lenexa for three months. And
24 during those months I probably put in 40 to
25 50-ish, maybe 60 hours of work, within the

1 month.

2 Q. All right. So that's 120 to
3 180 hours in three months approximately?

4 A. It's only for the months where I'm
5 taking the responsibility.

6 Q. Yeah, yeah, for those three
7 months. Right? But I just multiplied three
8 times 40 to 60 hours per month --

9 A. You mean for the year, yes.

10 Q. Well, those three months. You say
11 for three months you were there 40 to 60 hours
12 a month. That's 180 hours for those three
13 months, right?

14 A. Over the course of the year, yes.

15 Q. Yeah, sure. So how does that work
16 that you're the clinical director of Kansas
17 University Medical Center and you can dedicate
18 100 hours -- 180 hours out of, what, three
19 months a year? How do you do that? How do
20 you be medical -- the director of nephrology
21 at Kansas University Medical Center and spend
22 that much time at a for-profit entity?

23 A. I'm confused by your question.

24 Q. Fresenius is a for-profit, right?

25 A. Yes.

1 Q. You spent 180 hours there in a
2 year, right?

3 A. Seeing dialysis patients, yes.

4 Q. Right. But you're not at Kansas
5 University Medical Center working there seeing
6 patients there, being the head of your
7 division there. How is it you can spend
8 180 hours for moonlighting at a for-profit
9 dialysis center?

10 A. It's not moonlighting.

11 Q. By the way, in your resume do you
12 claim that you -- and I might confess I've
13 never seen this in a resume before -- that you
14 actually scored 761 on your nephrology
15 recertification exam in 2017?

16 A. Yes.

17 Q. And you made a point of indicating
18 that was one of the top four scores in the
19 nation I guess in 2017; is that what your
20 reference is?

21 A. Yes.

22 Q. All right. Why would you put in
23 your resume that you received one of the top
24 four scores in the nation in your nephrology
25 recertification exam in 2017? Why would you

1 put that in there?

2 A. It's a point of pride. What's --

3 Q. Yeah. How do you find out? Those
4 results aren't confidential?

5 A. They sent out a distribution of
6 scores across the country. So it looks like a
7 huge graph with bars that create a bell curve.
8 And there's a small bar at the end for people
9 who scored more than 760. And there were only
10 four people in the country who had done that.
11 And I knew my score. So I don't know if the
12 other three scored higher than me, but mine
13 must have been one of the top four scores that
14 year.

15 Q. All right. I don't need to get
16 into it --

17 A. I don't think I need to be ashamed
18 of putting it.

19 Q. Doctor, please don't read anything
20 into the question. I'm just asking why you
21 would put that in a resume.

22 The other times you've listed your
23 scores for board certification, not quite as
24 high, right?

25 A. The internal medicine score uses a

1 different range. I think the top score for
2 that is 300. So 271 is still a good score.
3 It's nothing to sneeze at. It wasn't one of
4 the top four in the country. So, yes, I'm
5 only boasting about the thing that I'm kind of
6 proud of.

7 Q. Yep, got it. Would you agree,
8 Doctor, that the kidneys are a vital organ in
9 a human body?

10 A. Sure.

11 Q. And, in fact, in your first 22
12 pages you spend several pages talking about
13 how critically important the kidneys are in
14 the human body, true?

15 A. True.

16 Q. You talk about how keeping blood
17 in all the cells in our bodies in a stable
18 balance of salts and water is a function of
19 the kidneys and it's a very important
20 function, true?

21 A. True.

22 Q. Can people live without a
23 functioning kidney?

24 A. If they're on dialysis, yes.

25 Q. But then they effectively have a

1 functioning kidney replacement. I'm saying if
2 there's no organ in the body and no way to
3 satisfy the function of the kidneys, will
4 people die every time?

5 A. Yes.

6 Q. It's that important, right?

7 A. Yes.

8 Q. Kidneys not only regulate the
9 balance between salts and water, but they
10 regulate and stabilize water and electrolyte
11 concentrations in our blood, right?

12 A. Yes.

13 Q. Kidneys filter out toxins at the
14 rate of -- I think you wrote 45 gallons of
15 urinary filtrate each day, true?

16 A. That's how much filtrate is made,
17 yes.

18 Q. And it isn't just getting rid of
19 toxins, stabilizing salt, water, making sure
20 the electrolyte balance is there; they're
21 critically important to the brain and to --
22 and, frankly, every part of our body? I mean,
23 kidneys are ultimately important organs in our
24 body, true?

25 A. True.

1 Q. They are not vestigial organs;
2 they're critical to our life and death, true?

3 A. True.

4 Q. So if something happens -- and by
5 the way, of course, we have two kidneys so
6 that, among other things, we have insurance if
7 we lose one, right?

8 A. Exactly, yes.

9 Q. And the danger of losing one
10 kidney, say Mr. Mousser or Ms. Tukes, because
11 of kidney cancer, is that if something goes
12 wrong with the remaining kidney, they don't
13 have that insurance kidney left, true?

14 A. True.

15 Q. And in Ms. Tukes' case, that is a
16 classic example of that. She lost her right
17 kidney due to cancer, and then she lost her
18 left kidney due to cancer; and to stay alive
19 she had to go on dialysis until she got a
20 transplant in the year 2024, true?

21 A. I think true. There were a lot of
22 parts of that question.

23 Q. Is there any part of that question
24 you disagree with?

25 A. She made a choice for when she

1 needed to have those surgeries, but ultimately
2 the -- the result was that she lost both
3 kidneys.

4 Q. Are you aware on the Kansas
5 University Medical Center website that it says
6 the common treatment, or words to that effect,
7 for kidney cancer is surgery? Are you aware
8 that your own employer puts that out on its
9 website?

10 A. I haven't read their website, but
11 I'm sure it's true.

12 Q. Yeah. By the way, dialysis --
13 Ms. Tukes was on dialysis for how long, sir,
14 about nine months or so, maybe a year?

15 A. Yeah, close to a year. Not quite.

16 Q. And you work in dialysis -- well,
17 you're the medical director or the clinical
18 director of dialysis centers. You've --
19 you're well familiar with --

20 A. Not quite.

21 Q. You're well familiar with, on the
22 one hand, it keeps people alive, and, on the
23 other hand, it's like a living hell being in
24 dialysis; would you agree with that?

25 A. It can be. Some people tolerate

1 it very well, but it can be a very hard
2 treatment.

3 Q. In fact, you've cited a doctor --
4 a nurse practitioner who said that she
5 actually mentioned to Ms. Tukes maybe you
6 don't want surgery even if you have cancer
7 because the dialysis is potentially worse than
8 the cancer. Are you familiar with that note
9 that you referenced in your report?

10 A. I think that was one of the
11 University of North Carolina urologists, yes.

12 Q. So briefly would you describe the
13 harm -- potential harm and harm caused to
14 patients like Ms. Tukes who are on dialysis,
15 sir?

16 A. Potential harm -- I mean, it's
17 keeping them alive.

18 Q. Yes, I understand the positive.
19 I'm talking about the negatives of dialysis.
20 The harsh reality of dialysis.

21 A. So dialysis has a number of side
22 effects and a number of risks every treatment.
23 The risks vary with someone's underlying
24 conditions and the side effects vary from
25 patient to patient. Some are quite common,

1 some are rare. Overall most people on
2 dialysis at some point experience symptoms
3 because of their treatment, and it can be --

4 Q. What's the worst side effect you
5 attribute to dialysis? For a patient like
6 Ms. Tukes, what's the worst side effects?

7 A. Severe muscle cramping can be
8 incredibly painful. The itching that some
9 dialysis patients experience can be severe,
10 debilitating. Most dialysis patients feel
11 wiped out after a treatment, on average, for
12 national surveys, from about an hour and a
13 half to 10 hours. And depression is not
14 uncommon.

15 Q. Do you know -- you had mentioned
16 in your report that Ms. Tukes had hemodialysis
17 at DaVita?

18 A. Yes.

19 Q. During the time she was on
20 dialysis, did she ever have peritoneal
21 dialysis?

22 A. I think that was her original
23 plan, but she decided to never go through with
24 it.

25 Q. Did she have hemodialysis at any

1 location other than DaVita?

2 A. She started in the hospital.

3 Q. Okay. You've read all her medical
4 records you say. Did she have -- other than
5 starting at the hospital, yes or no, did she
6 have hemodialysis at any location other than
7 at DaVita?

8 A. I think she was at two different
9 DaVita units. She was at one and then
10 transferred to another at which point her
11 dialysis care was transferred to a different
12 dialysis doctor.

13 Q. Doctor, you read all the records.
14 Are you unaware that she had dialysis at home?
15 Is my telling you that the first time you knew
16 that?

17 A. Yes. I thought she didn't like
18 peritoneal dialysis and turned it down.

19 Q. So would it surprise you to learn
20 that indeed she did have dialysis at home?

21 A. Yes.

22 Q. Yeah. Okay. Would you agree that
23 Mr. Mousser's right kidney had to be removed
24 due to the UTUC high-grade cancer, or do you
25 question that, too?

1 A. I don't question that.

2 Q. You don't mention anything in your
3 report at all about the issue as to whether or
4 not his kidney should have been removed or
5 should not have been removed. That's why I
6 asked you the question, Doctor.

7 But -- let me ask you this.
8 Mr. Mousser has chronic kidney disease; is
9 that true?

10 A. Yes.

11 Q. And when you lose a kidney like he
12 did, when his right kidney was removed, you
13 lose 50 percent of the nephrons, the tubules,
14 in your body, true?

15 A. Yes.

16 Q. And the remaining kidney,
17 depending on its condition, can actually work
18 harder and produce, at least for a period of
19 time, more than 50 percent of the kidney
20 function, true?

21 A. Yes. True.

22 Q. There's a phenomenon called
23 hyperfiltration that helps explain how a
24 single kidney can do that, right?

25 A. Yes. And hypertrophy. Both

1 occur.

2 Q. Neither one can go on generally
3 indefinitely. It can work for a time, but
4 eventually the kidney just can't keep going
5 indefinitely, one kidney, under
6 hyperfiltration or hypertrophy, true?

7 A. Folks who are born with one kidney
8 and who are hyperfiltering the other kidney
9 have a 20 or 30 percent risk of a condition
10 called secondary FSGS in the other -- in their
11 single kidney at about 40 years of age.

12 Q. Okay. So --

13 A. But it takes a while. It takes a
14 couple decades.

15 Q. Was Ms. Tukes born with one
16 kidney?

17 A. No.

18 Q. Was Mr. Mousser born with one
19 kidney?

20 A. No.

21 Q. Okay. So your opinion, if I could
22 summarize it, about the potential need by
23 Mr. Mousser for a kidney transplant in the
24 future, as Dr. Cooper has expressed his
25 conclusion about, your opinion is, well,

1 Mr. Mousser has a good prognosis, that his
2 kidney is in excellent condition, his left
3 kidney, and it's functioning so well that you
4 would actually offer him the opportunity and,
5 to quote you, to graduate from kidney clinic,
6 right?

7 A. Yes.

8 Q. That's your opinion in this case?

9 A. Yes.

10 Q. That any kidney dysfunction in his
11 left kidney is mild, and any negative impact
12 from his having a single kidney, as to his
13 quality of life, any negative impacts are
14 negligible. You put that in your report, too,
15 right?

16 A. Yes.

17 Q. All right. Now, how would you
18 describe to your knowledge, your understanding
19 based on your review allegedly of all of
20 Mr. Mousser's medical records, how would you
21 describe the impact that his having lost his
22 kidney the way he did, what effect that has
23 had on Mr. Mousser, the person? How would you
24 express that, sir?

25 MR. BU: Object to form. You can

1 answer.

2 A. So I'm -- as the kidney doctor
3 reviewing his case, I'm not going to be
4 looking into his mental health or psychiatric
5 records. I'm just looking at his kidney
6 function starting with the contention from Dr.
7 Cooper that, with a creatinine of, it was
8 either 1.6 or 1.9, he had a high risk of
9 either ending up on dialysis or needing a
10 transplant in about 10 years --

11 Q. Is it your testimony under oath
12 that's what Dr. Cooper said?

13 A. -- and it's not true with one
14 kidney.

15 Q. Right. Doctor, let me ask you my
16 question again. You've read Mr. Mousser's
17 medical records. Did you selectively choose
18 not to read his psychiatric records, first of
19 all? You just put them to the side and said
20 I'm not going to look at those because I'm not
21 a psychiatrist? Is that what you did?

22 A. Sort of not germane. In a way
23 none of my business.

24 Q. You're here getting paid \$850 an
25 hour to give an opinion that it's harmful to

1 Mr. Mousser's case, and you're saying it's not
2 your business to look at all of his medical
3 records but to selectively choose which
4 specialties you're going to avoid; is that
5 your testimony?

6 A. With respect, sir, I can spend
7 hours and hours and hours reading parts of
8 medical records that aren't important for me
9 to talk about someone's kidneys. But I try to
10 focus on his kidneys, kidney function, and
11 future risk of progressive kidney disease,
12 because that's the area that I'm being asked
13 to render an opinion as an expert on.

14 So if there's a large part of the
15 medical record that's not germane to that
16 question, then for the sake of saving time and
17 money for the government, I should skip that
18 part and go to the core question.

19 Q. Okay. So you just answered my
20 question. Thank you.

21 Doctor, you have put in your
22 report, and you've just said it's your
23 opinion, that any negative impacts for
24 Mr. Mousser having a single kidney as to his
25 quality of life, any of those negative impacts

1 are negligible. And what you're saying is
2 they're negligible to you because you've put
3 aside a whole category of documents and chosen
4 not to look at them to save the government
5 money. That's not being an advocate, Doctor?

6 A. I don't think I should be doing
7 this just to make money for myself. And I'm
8 trying to serve an expert role and that's as a
9 kidney doctor.

10 Q. Right. How could you possibly say
11 that Mr. -- any negative impacts from
12 Mr. Mousser having a single kidney are
13 negligible when you haven't -- as to his
14 quality of life are negligible when you have
15 selectively decided you're only going to look
16 at those records that deal with the physical
17 condition of his kidney, his remaining kidney,
18 and not whether or not the impact of his
19 losing his right kidney, what impact that was?

20 A. So that question --

21 COURT REPORTER: I'm sorry. Could you
22 start your answer over.

23 A. The question -- so I can think of
24 two different ways to approach it. One is
25 that if I had a mole on my nose and felt it

1 was so disfiguring that I couldn't work and
2 couldn't function, those are real feelings.
3 It could be that a nose doctor would think
4 that there's a treatment and there's something
5 that could be done for that.

6 This is similar. You only have
7 one kidney. I know that there are people who
8 live their entire lives with a kidney. I know
9 that people who receive a transplant by
10 definition have only one kidney.

11 So in and of itself, either being
12 born with one kidney or getting a transplant
13 single kidney doesn't confer the inability to
14 work and enjoy life. If that's happening with
15 him, it's something else. And that something
16 else is not the purview of a kidney doctor.

17 Q. Got it. Does it matter, Doctor,
18 in your opinion how a person loses a kidney,
19 in other words, why they lose a kidney, in
20 terms of the effect on them?

21 A. So I can best speak to the effect
22 on kidney function. If you're asking about
23 the effects on their mental health, I think I
24 should defer that to a mental health expert.

25 Q. Well, Doctor, your -- your opinion

1 on the excellence in condition and function of
2 Mr. Mousser's left kidney, his remaining
3 kidney, what -- you referred to test results
4 before that serve as a basis for you coming to
5 that conclusion. What test results are you
6 talking about?

7 A. Well, it was a combination of
8 creatinine and -- urine albumin and creatinine
9 ratios, best as I can recall.

10 Q. Now, would you agree with me that
11 -- the GFR is a glomerular filtration rate; is
12 that true?

13 A. Yes.

14 Q. And the -- that filtration rate
15 measures the volume of fluids and what's in
16 there, how -- the volume that the glomeruli
17 actually filter during a given period of time;
18 is that true?

19 A. Yes.

20 Q. All right. And that involves
21 getting rid of toxins, reabsorbing things like
22 salt that the body may need and things that
23 would be healthy to the body, true?

24 A. Yes.

25 Q. So the assessment of the -- I'm

1 going to call it GFR just so I don't have to
2 keep repeating the words.

3 But the assessment of GFR is
4 fundamental to clinical practice, public
5 health, and well-being of all American
6 citizens. Do you agree with that?

7 A. Sure.

8 Q. Okay. And what happened in -- and
9 there are different ways to assess and
10 identify the GFR, the glomerular filtration
11 rate, true?

12 A. Yes.

13 Q. And the weight you're relying on
14 for your opinion, like you said, are
15 creatinine and the albumin-creatinine ratio,
16 right, in the urine?

17 A. One of those has to do with the
18 GFR and the other doesn't.

19 Q. The creatinine has to do with the
20 GFR?

21 A. Yes.

22 Q. All right. Now, there are other
23 ways to measure the GFR, and that is to
24 actually measure the GFR and not just estimate
25 it, true?

1 A. True.

2 Q. And the -- if you measure the GFR,
3 there are different ways to do that, that
4 would be the gold standard in terms of
5 accuracy as to the status of the kidney
6 vis-a-vis chronic kidney disease, as compared
7 to estimating the GFR by using creatinine,
8 true?

9 A. True.

10 Q. All right. Now, not everybody
11 uses actual measurements of GFR to find the
12 actual GFR, even though it's the most accurate
13 way to do it, because it takes time and it has
14 expense to it, true?

15 A. And risk, yes.

16 Q. All right. So the cheaper dirty
17 and quicker way of creatinine to indirectly
18 assess GFR, that is, estimate GFR, is more
19 widely used than a direct measurement of GFR,
20 true?

21 A. Yes.

22 Q. And you talk about the risks, but
23 there are countries like Sweden and other
24 countries that have basically
25 institutionalized measuring GFR because it's

1 more accurate than estimating GFR, which is
2 what creatinine does, true?

3 A. No.

4 Q. Okay. So Sweden hasn't done that?

5 A. Not to my knowledge, no.

6 Q. All right. Now, the danger -- or
7 excuse me.

8 What causes creatinine to be less
9 accurate than a measurement of GFR is that it
10 is influenced and can be highly influenced and
11 the creatinine changes, even daily, depending
12 on a number of variables, true?

13 A. It can, yes.

14 Q. Now, creatinine is called an
15 endogenous chemical, because we actually
16 produce it in our body when our muscles break
17 down because it's a by-product of that, true?

18 A. Yes.

19 Q. Right. And the problem with using
20 creatinine to be an accurate measurement of
21 what GFR actually is is it can be highly
22 influenced by age, true?

23 A. True.

24 Q. Sex, meaning gender, true?

25 A. To some degree.

1 Q. Muscle mass, true?

2 A. Absolutely.

3 Q. Body composition, true?

4 A. Not sure how that differs from
5 muscle mass, but I think you're getting at the
6 same thing.

7 Q. Severe chronic illness, if that
8 exists, true?

9 A. Yes.

10 Q. Diet and nutritional habits can
11 affect creatinine and the level of creatinine,
12 true?

13 A. Yes.

14 Q. I mean, if you and I were to go
15 out and have dinner and have big steaks, our
16 creatinine would increase, true?

17 A. In a single day, highly unlikely.

18 Q. All right. Okay. Does red meat
19 increase creatinine?

20 A. In a single day?

21 Q. I didn't say a single day. Does
22 red meat increase creatinine?

23 A. No more so than in equal amounts
24 of chicken or fish.

25 Q. Do tubular secretions increase

1 creatinine?

2 A. They would decrease it.

3 Q. Does protein intake affect the
4 level of creatinine?

5 A. Yes.

6 Q. Would you agree there are many
7 other factors that actually influence
8 creatinine levels at any given time since a
9 blood test is a snapshot at a given point in
10 time; isn't that true?

11 A. Yes.

12 Q. All right. And would you agree
13 that using serum creatinine to estimate GFR
14 often leads to misclassification of patients
15 or potentially puts patients at risk for
16 inappropriate clinical decisions; do you agree
17 with that?

18 A. It can.

19 Q. So possible solutions are they
20 have developed now Cystatin C that is an
21 alternative that is less highly influenced by
22 those same things than creatinine, and the
23 recommendations are, well, if you're going to
24 use it, use it together, if you're going to do
25 an indirect estimation and not just

1 creatinine, true?

2 A. Yes. If you're going to do it, do
3 both. It doesn't need to be --

4 Q. And, again, the most accurate way
5 to assess, we talked about a direct
6 measurement, is actually not using an
7 endogenous chemical, but using what's called
8 exogenous chemical that then is, say, injected
9 into our bodies and that -- whether it's
10 Atehexal, inulin, or others, actually have the
11 ability to accurately, not reasonably or not
12 approximate, but actually accurately determine
13 the GFR, true?

14 A. True.

15 VIDEO TECHNICIAN: Counsel, I need to
16 switch the video when you get a chance.

17 MR. MANDELL: Sure. How much time are
18 we at?

19 VIDEO TECHNICIAN: Well, we're
20 28 minutes over where I was supposed to be.

21 MR. MANDELL: No, no. I'm saying
22 total time out of seven hours, where are we?

23 VIDEO TECHNICIAN: Over five hours.

24 MR. MANDELL: And you're not counting
25 lunch in there, right?

1 VIDEO TECHNICIAN: Yeah, can we go off
2 the record so she doesn't have to type this
3 up?

4 MR. MANDELL: 100 percent we can go
5 off the record.

6 VIDEO TECHNICIAN: Off the record at
7 2:53.

8 (Recess.)

9 VIDEO TECHNICIAN: We are back on the
10 record at 3:03.

11 Q. (By Mr. Mandell) Dr. Johnstone,
12 would our creatinine levels -- by the way,
13 because creatinine levels don't directly
14 measure GFR, when it's an assessment of what
15 GFR is using creatinine, before the letters
16 "GFR," there's a small "e" to indicate it's an
17 estimate; it's not an actual measurement,
18 true?

19 A. Yes.

20 Q. All right. Is creatinine used at
21 all to determine whether or not a kidney is
22 worthy of being donated?

23 A. Yes.

24 Q. Are you sure?

25 A. Yes.

1 Q. Are you sure that -- okay.

2 Doctor, by the way, your reports,
3 both of them, Exhibits 1 and 2, have the
4 University of Kansas Medical Center logo on
5 the top left-hand page of each page, top
6 left-hand corner of each page.

7 A. Right.

8 Q. Are the opinions expressed in your
9 reports for Ms. Tukes and Mr. Mousser, are
10 they your opinions --

11 A. Yes.

12 Q. -- or are they opinions that have
13 been endorsed by the University of Kansas
14 Medical Center, or anyone else there, other
15 than you?

16 A. Entirely my own.

17 Q. Okay. Now, if you look at your
18 report on Page 25 of the Tukes' report,
19 paragraph 65, I'm going to share screen and
20 put it up on the screen, Doctor.

21 So look at paragraph 65, the last
22 full paragraph on Page 25. Do you see that
23 starts, Ms. Tukes underwent kidney
24 transplantation on April 23rd, '24, at East
25 Carolina University, right?

1 A. Yes.

2 Q. Okay. And then at the bottom of
3 that paragraph, you talk about, three days
4 after transplantation, she was discharged with
5 a creatinine of 7.43, which improved to 4.12
6 by the end of the week, which improved to 1.32
7 by May 6th, and reached best creatinine values
8 of 0.96 to 0.97 in July and August of 2024.
9 You say these results meet all, quote, best
10 expectations, right?

11 A. Yes.

12 Q. All right. Let's go to the next
13 page, paragraph 66. When you were -- saw the
14 records, then see that on November 18, 2024,
15 also after the kidney transplant, there's a
16 note from a Dr. McLawhorn that reported a
17 kidney -- a creatinine value that week of
18 1.15, and the baseline was 0.9 to 1.1. So
19 there's been an increase of the creatinine as
20 of November 18th to 1.15, right?

21 A. Correct.

22 Q. But then you make the comment, in
23 a kidney transplantation, creatinine values
24 cannot be translated accurately into an
25 estimated GFR to calculate the stage of

1 chronic kidney disease as is done for native
2 kidneys. Do you see that?

3 A. Yes.

4 Q. Okay. So -- and then you go on to
5 say, but a creatinine of 1.15 in six months
6 post-transplant is considered superb; not just
7 good, but superb, right?

8 A. Yes.

9 Q. So why use creatinine values after
10 transplantation to say they had best values
11 and why use a creatinine value of 1.15 at six
12 months to say it's superb if in a kidney
13 transplant patient creatinine values can't be
14 translated accurately into an estimated GFR to
15 calculate the stage of chronic kidney disease?
16 If you can't use it, why do you use it?

17 A. So two different things in that
18 question. The first is, in the transplant
19 literature, does a given creatinine value for
20 a kidney transplant accurately predict the GFR
21 for that kidney transplant. And the answer is
22 no. And that's a known thing about kidney
23 transplants. So that's why I wrote that part.

24 That doesn't mean the creatinine
25 is useless. It still gives you a good

1 baseline and a good approximation. And if
2 someone with a kidney transplant has a falling
3 creatinine, then their transplant is kicking
4 in and working well. Low numbers are good.
5 And if the numbers begin to increase more than
6 about 30 percent for most transplant centers,
7 they would start to worry about rejection or
8 something else going on, and none of that
9 happened with her.

10 Q. Doctor, when you talk about
11 rejection and early rejection and that's a
12 good sign and you think that means that
13 Ms. Tukes' transplant graft will last, you
14 know, longer than average -- well, strike
15 that.

16 Let me ask this question. Are
17 environmental exposures, including by toxins,
18 considered a risk for the development of
19 chronic kidney disease?

20 A. Yes.

21 Q. Why?

22 A. So the best one known is
23 aristolochic acid. It's an environmental
24 toxin first known as Chinese herb nephropathy
25 and later as Balkan nephropathy.

1 Q. But I didn't ask you for an
2 example. You said that environmental
3 exposures by toxins are considered a risk
4 factor for chronic kidney disease. And I'm
5 asking you why, not for an example, but why do
6 toxins -- why are they considered that? How
7 do they cause chronic kidney disease is my
8 question?

9 A. Well, for the one I mentioned,
10 because they won't all have the same
11 mechanism, the aristolochic acid causes a
12 tubulointerstitial inflammation that leads to
13 chronic slow progressive scarring.

14 Q. Chronic slow progressive scarring
15 of a kidney?

16 A. Yes.

17 Q. Is there a name for that?

18 A. You mean separate from Chinese
19 herb nephropathy and Balkan nephropathy?

20 Q. For a kidney. If a kidney has
21 chronic progressive scarring, does that fall
22 within any diagnosis as to the condition of
23 the kidney or what's happening in the kidney?

24 A. Yes.

25 Q. What is that, sir?

1 A. Tubulointerstitial nephritis.

2 Q. Does -- we know that Mr. Mousser
3 -- well, strike that.

4 At any time based on your review
5 of the records, sir, has Mr. Mousser had
6 nephrosclerosis in one or both of his kidneys?

7 A. Are you referring to
8 nephrosclerosis as a histopathology term?

9 Q. How do you understand that term to
10 be used, sir?

11 A. It can be used in one of two ways.
12 It's used by policies to describe a certain
13 appearance of the kidney under the microscope.
14 And it's sometimes used by clinicians, not
15 very accurately, to describe kidney disease
16 due to we're not sure what in a patient with
17 high blood pressure.

18 Q. What is nephrosclerosis?

19 A. It's, on histopathology, referring
20 to onion skinning -- a form of vascular
21 disease of the small vessels within the kidney
22 that leads to progressive dropout of entire
23 nephrons, including at the level of the
24 glomeruli.

25 Q. What is it when the clinicians

1 will use it to describe kidney disease?

2 A. Absent a kidney biopsy, it is
3 sometimes used, not very accurately, to
4 describe kidney disease we don't precisely
5 know what from in a patient with high blood
6 pressure.

7 Q. How does it manifest -- how does a
8 kidney disease that is part of or leads to a
9 diagnosis of nephrosclerosis, how does that
10 kidney disease manifest itself in the kidney?

11 A. We would see a rising creatinine
12 over time, and usually a bland urinalysis with
13 a bland urine microscopic sediment. And the
14 kidneys, on imaging, would often gradually
15 become smaller in size as they shrink with
16 progressive fibrosis.

17 Q. When you say bland urinalysis, can
18 you operationally define the word bland for
19 me?

20 A. When we're looking at a patient's
21 urine under the microscope, we're trying to
22 find features that are potentially alarming
23 and indicate the need for a kidney biopsy.
24 And if the urine has none of those features at
25 all, and often very few cells, then it is a

1 bland urine.

2 Q. Okay. So let's take kidney
3 disease -- excuse me, nephrosclerosis that you
4 described clinicians sometimes using -- I
5 think you made have said often inaccurately,
6 to describe kidney disease.

7 So in that context of
8 nephrosclerosis, based on your review of all
9 of Mr. Mousser's medical records, did he --
10 has he ever had that in one or both of his
11 kidneys?

12 A. So he could have had evidence of
13 nephrosclerosis on pathology from his
14 nephrectomy, because one of the causes -- two
15 of -- I guess he has two or three of the
16 causes, of nephrosclerosis on histopathology
17 are smoking, diabetes, and heart disease, all
18 of which lead to a similar appearance of those
19 kidney arteries on a kidney biopsy. But does
20 he have a progressive rising of creatinine of
21 the other kidney? Not at this time
22 fortunately.

23 Q. Okay. So that's how the
24 clinicians -- so did he ever -- did any
25 clinician ever diagnose him with

1 nephrosclerosis based on your review of the
2 records?

3 A. I don't recall.

4 Q. Okay. Now, you just referred
5 again to you'd see a progressive rising of the
6 creatinine in the remaining kidney.

7 A. Uh-huh. Yes.

8 Q. Still you're putting that reliance
9 on creatinine knowing, at least as to its
10 identifying GFR, it's a -- it can be a very
11 inaccurate estimation of it, true?

12 A. It's a good tool, but not perfect,
13 yes.

14 Q. It's more than not perfect. It's
15 often inaccurate and -- because it's
16 influenced by so many different factors other
17 than what the GFR is or other than whether
18 there's chronic kidney disease. And we talked
19 about a few of them, true?

20 A. I don't agree with it the way
21 you've stated it, no.

22 Q. Okay. Now, you had talked about,
23 when clinicians look at it, that can be often
24 inaccurate, right? That is whether there's
25 nephrosclerosis there or not.

1 A. Nephrosclerosis, yes.

2 Q. That's what I'm talking about.

3 A. That's not a very precise
4 diagnosis.

5 Q. Right, I got it, in terms of
6 clinicians.

7 A. Yeah.

8 Q. Is a histopathologic diagnosis or
9 finding of nephrosclerosis more accurate or
10 exact than, say, a clinician saying that that
11 might exist?

12 A. I mean, the histopathology is
13 simply what's seen under the microscope. It
14 is what it is.

15 Q. All right. So did Mr. Mousser
16 ever have nephrosclerosis of one or both of
17 his kidneys? Can you answer that question?

18 A. He certainly could have. I don't
19 recall the full pathology report after his
20 nephrectomy.

21 Q. Now, you had mentioned that
22 Mr. Mousser had two or three of the known risk
23 factors for causing -- by the way -- excuse
24 me. I'm sorry.

25 If you said this, I apologize.

1 Can you tell me what nephrosclerosis is
2 precisely?

3 A. I think we've talked about this
4 before. It has both a histopathologic
5 diagnosis and a clinical diagnosis.

6 Q. I'm talking about the effect on
7 the kidney. Does it adversely change the
8 kidney, biologically, medically, anatomically,
9 in a negative way; and, if it does, how?

10 A. So if referring to the
11 histopathologic diagnosis, if you have
12 progressive narrowing of the arteries within
13 the kidneys, then you begin to have decreased
14 blood supply to the glomeruli and then to the
15 tubules, they become ischemic, they begin to
16 die and drop out. So it leads to a
17 progressive kidney disease over time with
18 higher creatinine and eventually the potential
19 for loss of kidney function.

20 Q. Is it your testimony you can't
21 have nephrosclerosis unless you have higher
22 creatinine levels?

23 A. Not quite.

24 Q. Okay. Well, so what would your
25 answer be? Can you have nephrosclerosis

1 without having higher creatinine levels?

2 A. Yes, you can have the
3 histopathologic diagnosis of nephrosclerosis.
4 But if your creatinine is good, showing that
5 you have overall good kidney function, then
6 the nephrosclerosis can't be very severe
7 clinically.

8 Q. And by the way, the way -- inexact
9 as it may be, the way creatinine in -- like as
10 you said, allows you to assess kidney
11 function, is that if the glomeruli tubules are
12 harmed or damaged, they can't filter as much
13 creatinine out of the blood, and so you'd have
14 a higher creatinine in the blood; is that a
15 fair statement?

16 A. I think so.

17 Q. Yeah, okay. So if you would --

18 MR. MANDELL: Ted, if you could get
19 the pathology report from October 20th, 2020,
20 from the nephrectomy done in which
21 Mr. Mousser's right kidney was removed.

22 Let's put it on the screen. And we'll
23 mark that as the next exhibit, please.

24 MR. RUZICKA: What number on the
25 index?

1 MR. MANDELL: It's 20 -- no. 28 on
2 the index. But it will be exhibit number --

3 MR. BU: I think we're on 16.

4 MR. MANDELL: Did you say 16, Dedric?

5 MR. RUZICKA: Yeah, 16. I'm marking
6 as Exhibit 16 the pathology report.

7 (Exhibit 16 was marked.)

8 Q. Okay. So can you see on the
9 screen the pathology report that has been
10 marked as 16, Dr. Johnstone?

11 A. Yes.

12 Q. All right. And it's dated October
13 -- all right. It's dated -- or it was
14 obtained October 20, 2020, which is the date
15 the nephrectomy was done, correct?

16 A. 29 October 2020.

17 Q. Right. Okay. And this is the
18 surgical pathology report from that surgery?

19 A. Yes.

20 Q. Okay. Now, do you see in this
21 pathology report at the bottom of this page
22 that's on the screen where it says Additional
23 Findings?

24 A. Yes.

25 Q. And it says non-neoplastic renal

1 tissue.

2 A. Yes.

3 Q. What does it say?

4 A. Nephrosclerosis, chronic
5 pyelonephritis, hydroureter, iron and Fontana
6 Masson stains performed.

7 Q. Now, according to the pathology
8 report of the kidney that was removed, the
9 right kidney removed from Mr. Mousser
10 October 20th, 2020, that right kidney had
11 nephrosclerosis in it, true?

12 A. Yes.

13 Q. All right. So that's an exact --
14 not often inaccurate, as the clinician might
15 have been, but an exact finding by pathology
16 of the right kidney specimen, true?

17 A. True.

18 Q. Again, I'm sorry. I didn't hear
19 you did you say true, sir? I'm sorry.

20 A. Yes.

21 Q. Okay. Now, is it -- you're not
22 surprised by that, are you, since the risk
23 factors you talked about, that is, smoking,
24 diabetes, and heart disease, at some point in
25 Mr. Mousser's life, and as to diabetes and

1 heart disease, existed up to the removal of
2 his kidney, true?

3 A. True. It's a very common finding
4 on kidney pathology.

5 Q. But you're not surprised by it
6 because those risk factors, particularly
7 diabetes and heart disease, existed inside --
8 the results of that existed inside
9 Mr. Mousser's kidney, correct?

10 A. And the finding can also occur
11 with age in the absence of those risk factors.
12 It's a fairly common finding in a subset of
13 the kidney tissue in most nephrectomies for
14 folks his age.

15 Q. Does the fact that it's a common
16 finding according to you mean it's not -- that
17 it's a good thing, that it's a positive
18 finding?

19 A. No.

20 Q. Does the fact that you say it's
21 common mean that it's not a finding that shows
22 some harm has been done to the kidney?

23 A. No. It means you need to
24 correlate it with an assessment of the global
25 kidney function.

1 Q. Right. So does Mr. Mousser still
2 have diabetes?

3 A. Gosh, I -- I can't say for certain
4 yes or no right now. I think he probably
5 does, but I don't know.

6 Q. Okay. What is the basis of your
7 opinion that you think he probably still has
8 diabetes now?

9 A. I don't remember his most recent
10 medication list. And if he's on diabetic
11 medications, then he's certainly getting
12 treated for diabetes.

13 Q. Okay. So you don't know one way
14 or the other whether he has diabetes now,
15 right, as you sit there?

16 A. I can't recall, no.

17 Q. Does he still have heart disease?

18 A. To the best of my knowledge, a
19 heart doctor wouldn't say it goes away or it
20 disappears entirely. So he's continued to
21 have persistent heart disease for the rest of
22 his life; it's just medically managed.

23 Q. Okay. So how does diabetes harm
24 the kidney so that it would lead to a
25 condition like nephrosclerosis?

1 A. So there are a series of classical
2 findings of diabetes in the glomeruli. This
3 is different. So this is the association
4 between diabetes and vascular disease, and
5 vascular disease doesn't tend to happen just
6 in the arteries of the heart. It will happen
7 throughout the body.

8 And the kidney gets one-fifth of
9 the blood supply from the heart every second.
10 So if there's vascular disease in the heart,
11 there's a highly likely finding of vascular
12 disease or nephrosclerosis within the kidney.

13 Q. Right. And would you agree that
14 the -- with those risk factors Mr. Mousser has
15 -- has and has had and that -- and the finding
16 of nephrosclerosis in his right kidney when it
17 was removed likely means he has
18 nephrosclerosis in his left kidney as well
19 since that's --

20 A. Yes.

21 Q. -- receiving blood from the heart
22 and diabetes still has the same effect?

23 A. Yes.

24 Q. Okay. So would you agree that
25 comorbidities such as diabetes -- and by the

1 way -- strike that. Let me just take half a
2 step back.

3 The heart disease Mr. Mousser has
4 had in the past and continues till today, can
5 you describe that heart disease by diagnosis
6 or diagnoses?

7 A. I'd have to look back at the
8 Mousser report for the summary that I took.

9 Q. Okay. So Mr. Mousser -- well,
10 actually why don't we do that. Why don't you
11 take a look at your report and identify for
12 us, if you would, please, what heart disease
13 he has. And I'm including in that what
14 peripheral arterial disease he has.

15 A. Well, coronary artery disease for
16 which he underwent percutaneous coronary
17 intervention times four. That either means
18 angioplasty or stents within the arteries of
19 the heart.

20 Q. He had a CABG times four. Are you
21 aware of that?

22 A. That's what the next line says, as
23 well as coronary artery bypass graft surgery,
24 four vessel, about four years ago.

25 Q. Now, that's the vascular disease,

1 or do you consider that cardiovascular?

2 A. It's all part of the vasculature.

3 Q. Okay. Now, you've told us how
4 diabetes harms the kidney. How does that kind
5 of cardiovascular disease, peripheral artery
6 disease, too, how does that adversely affect a
7 kidney?

8 A. So it's -- with regard to
9 nephrosclerosis, it's the same process.
10 Decreased kidney flow, shrinkage of small
11 vessels within the kidney, eventually ischemia
12 to individual glomeruli and tubules, and then
13 dropout of nephron after nephron.

14 Q. All right. So because of the
15 diabetes and the heart disease -- strike that.

16 The diabetes and the heart
17 disease, peripheral arterial disease, they
18 don't just have a snapshot one time adverse
19 effect on the kidney, true, meaning that the
20 longer that vascular disease and peripheral
21 artery disease and diabetes exists, the
22 greater potential harm there is to the kidney,
23 true?

24 A. That's true. And it also depends
25 on how well those disease processes are

1 controlled.

2 Q. So both up to and including the
3 date on which Mr. Mousser had his right kidney
4 removed and up until today, cerebrovascular
5 disease, peripheral artery disease, and
6 diabetes is still present and adversely
7 affecting Mr. Mousser's left kidney, true?

8 A. True.

9 Q. All right. And I think you just
10 testified a few minutes ago that Mr. Mousser
11 -- Mr. Mousser likely has nephrosclerosis in
12 his left kidney as well, true?

13 A. Yes.

14 Q. Okay. So the fact that
15 Mr. Mousser has those comorbidities of heart
16 disease and diabetes and that he has
17 nephrosclerosis in his left kidney, if they
18 progress he doesn't have his right kidney
19 anymore, because he had to have it removed due
20 to having cancer, true?

21 A. True.

22 Q. Is there a reason, Dr. Johnstone,
23 that in your report for Mr. Mousser you don't
24 mention at all that he has nephrosclerosis in
25 his left kidney?

1 A. Well, I think the answer goes back
2 to what I said a few minutes ago. If you have
3 nephrosclerosis in your left kidney, but the
4 assessment of your total kidney function based
5 on serum creatinine is really pretty darn
6 good, then that nephrosclerosis can't be
7 severe.

8 And we know that his creatinine
9 was coming down into -- I'd have to check. I
10 think it was in the range of 1.3 or maybe even
11 1.2, lower than it was after he had the kidney
12 removed. So his kidney is not getting worse.
13 His account is appropriately undergoing
14 hypertrophy and hyperfiltration and at least
15 at this time has pretty darn good function.

16 Q. To the point where you would
17 graduate him from kidney clinic, right?

18 A. If he -- especially if he has a
19 good PCP who can remain in contact with me, so
20 that if something changes in two years, four
21 years, eight years, that PCP can then reach
22 back out and say, hey, it looks like things
23 are changing, can you take a look at him
24 again.

25 Q. Do you consider insomnia to be a

1 psychiatric issue?

2 A. You know, I don't know. It's not
3 something I think of as primarily a kidney
4 issue.

5 Q. I'm just asking, do you -- okay,
6 so you don't know. All right. Does
7 Mr. Mousser have insomnia?

8 A. I think I've read that in his
9 medical record.

10 Q. By the way, how long has
11 Mr. Mousser likely had nephrosclerosis in his
12 left kidney?

13 A. Likely just as long as in the
14 right kidney.

15 Q. How long was that?

16 A. Because you can really only tell
17 on biopsy or pathology. It's likely that it
18 has been present years before he underwent
19 nephrectomy, but I can't say for how long.

20 Q. Okay. What is your understanding
21 of what Mr. Mousser's smoking history was?

22 A. I read a couple of clinic notes
23 that discussed his smoking history I think
24 while he was still -- while he was still a
25 Marine. I think it might have been in

1 relation to the gross hematuria.

2 Q. What is your memory as to what
3 that history was in those clinic notes you
4 just referred to?

5 A. I think he had an evaluation once
6 while he was stationed overseas, and then
7 years later a second evaluation somewhere in
8 the US.

9 Q. I'm just asking you what was his
10 smoking history. Can you tell me how many
11 packs a day he smoked for how long?

12 A. Oh, I don't remember.

13 Q. Okay. Do you have any knowledge,
14 sir, of what the scientific and medical
15 literature indicates happens when you stop
16 smoking, whether -- what happens with that
17 smoking history being a risk factor for kidney
18 cancer?

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

21 Q. (By Mr. Mandell) Do you
22 understand my question, sir? Smoking is a
23 risk factor for kidney cancer, true?

24 A. Yes.

25 Q. All right. Smoking is a risk

1 factor for damage to the kidneys such as
2 nephrosclerosis? You've already said that,
3 true?

4 A. True.

5 Q. So if you stop smoking, what is
6 your understanding as to smoking being a risk
7 factor for harm to the kidney, including
8 nephrosclerosis and/or kidney cancer?

9 A. Without knowing the details off
10 the top of my head, my guess is that the risks
11 would -- that the earlier you quit the better;
12 and that the risks would gradually abate over
13 time; but that if you've had significant
14 damage to the kidney, it can't re-grow.

15 Q. I just, if I could, you -- in
16 terms of how long Ms. Tukes' kidney transplant
17 is expected to last in terms of being
18 functional and not failing, your report
19 indicates you think it is 10 to 12 years with
20 wide variation. And Dr. Cooper, you said,
21 said 13 years.

22 So do you consider that to be a
23 difference -- a big difference in opinion, 10
24 to 12 years versus 13 years?

25 A. To clarify, the 10 to 12 years I

1 was talking about is the average duration for
2 a deceased donor kidney transplant in this
3 country.

4 Q. Right. That's what Ms. Tukes got,
5 isn't it, a deceased donor kidney transplant,
6 or do you not know?

7 A. I do know. Your statement was
8 that I was predicting hers would last 10 to
9 12 years, and that's not what I've said.

10 Q. Did you -- do you agree that a
11 deceased donor kidney transplant is expected
12 to last about 10 to 12 years with wide
13 variation?

14 A. Yes.

15 Q. Okay. Now, you say that
16 Ms. Tukes' -- you think her kidney transplant
17 is going to last longer than 10 to 12 years,
18 because you say she doesn't have diabetes, she
19 doesn't have cerebrovascular disease, she's
20 never smoked, am I correct?

21 A. The major risks are actually
22 different than those.

23 Q. What are they?

24 A. Whether or not someone has delayed
25 graft function and then whether or not someone

1 has acute rejection, followed by what is their
2 transplant allograft function roughly judged
3 by serum creatinine at one year.

4 Q. You focused in your report, and
5 you just said it again, acute rejection.
6 Isn't it with -- a significant issue with
7 kidney transplants and whether they -- how
8 long they last before they fail, isn't chronic
9 rejection a significant issue that has to be
10 considered and not just acute rejection?

11 A. That's true but we're talking
12 about within the first year. And if you've
13 had no acute rejection within the first year,
14 your long-term prognosis is better. She
15 hasn't, so her prognosis is expected to be
16 better than the average.

17 Q. Now, where -- what learned study
18 are you -- or article in the peer-reviewed
19 medical literature are you relying on for your
20 statement that says the fact she hasn't had an
21 acute rejection in the first year means she's
22 less likely to have a chronic rejection in the
23 future?

24 MR. BU: Object to form. You can --

25 Q. What study -- what are you using

1 as a basis for that opinion in terms of any
2 learned treatises, medical literature, and in
3 peer-viewed journals, not journals people had
4 to pay for to get articles in?

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

7 A. So, once again, I didn't pay to
8 get my article in --

9 Q. (By Mr. Mandell) Yeah, I wasn't
10 referring to you, sir. I was referring to
11 journals like Current Therapeutic Research and
12 other journals that pharmaceutical companies
13 do pay to get articles in.

14 A. So I would turn to the end of my
15 general introductory section. The article
16 from Harry Herron in the New England Journal
17 of Medicine. And then the -- the KDOQI
18 clinical guidelines for care of kidney
19 transplant patients.

20 Q. All right. Are you aware, by the
21 way, that Dr. Jayaram testified in his
22 deposition that he -- that a kidney transplant
23 is expected to last 10 to 15 years, and he was
24 referring to Ms. Tukes' transplant, and that
25 she will likely need a second kidney

1 transplant?

2 A. I did not see that in Dr.
3 Jayaram's. And I think he's a medical
4 oncologist.

5 Q. So you didn't see that in his
6 testimony, okay.

7 By the way, you mentioned that
8 when Dr. Cooper -- you're saying he said
9 13 years graft survival. And you're -- on
10 Page 29 and 31 in your Tukes' report -- and,
11 in fact, let's go there. Let's go to the --
12 your conclusion in Tukes' report on Page 31.

13 So look at Paragraph 82, sir, on
14 Page 31 of your Tukes' report. It is also
15 quite speculative, about halfway down in that
16 paragraph you said, to predict her transplant
17 will fail in 13 years at the median time cited
18 by Dr. Cooper, and then you continue on why
19 you feel that way.

20 And you also mention that -- the
21 same thing about the median time cited by Dr.
22 Cooper on Page 29 of your report -- that
23 report.

24 So I'm asking you where did you
25 get the information that Dr. Cooper -- strike

1 that actually.

2 What's your understanding as to
3 the difference between the median and the
4 mean? How would you define that difference?
5 I mean generally, not just estimates.

6 A. The -- sure. The mean of 100
7 numbers would be derived by adding them all up
8 together and dividing by 100. The median
9 would be looking at those 100 numbers in a
10 sequence and picking the 50th number, which
11 could be slightly higher or slightly lower
12 than the mean. They're both approximations of
13 what's the middle of the pack.

14 Q. So the mean is the average, right?

15 A. Correct.

16 Q. And the median is just basically
17 the number, if you have 10 numbers, in between
18 the fifth and sixth number. Or, if you have
19 11 numbers, it would be number -- the sixth
20 number. It's the number that's halfway, where
21 half the numbers are below it and half the
22 numbers are above it, right?

23 A. Correct.

24 Q. Now, where did you obtain
25 information that Dr. Cooper was talking about

1 the median? Where does he say that in his
2 report anywhere? And I'll submit to you you
3 got it wrong. He talked about the mean, not
4 the median.

5 A. All right. Then I wrote it down
6 wrong. I apologize.

7 Q. No need to apologize, Doctor.
8 There's a big difference between the median
9 and the mean, isn't there?

10 A. Depends. There can be a very
11 small difference.

12 Q. Right. And there could be a huge
13 difference, right?

14 A. In this case, if it's between 10
15 to 12 years versus 13 years, I don't think I'd
16 characterize that as huge.

17 Q. Okay. So, Doctor, you did say 10
18 to 12 years with wide variation. But let me
19 ask you this question. You make a comment in
20 your report that, because so many people in
21 that New England Journal of Medicine study, I
22 think it was figure 3, had graft rejection in
23 the first year, that using the median that
24 would skew the numbers so that Dr. Cooper
25 would be wrong about the number he used. And

1 I want to ask you --

2 A. Median or the mean, sure.

3 Q. Well, you said the median is what
4 you said in your report.

5 Let me just ask you, using that,
6 if there were, say, 11 numbers and a
7 disproportionate number of rejections, say,
8 five, were in the first year, but numbers
9 seven, eight, nine, 10 and 11 were 10th year,
10 12th year, 15th year, 20 year. It really
11 doesn't matter to the median how many
12 transplants failed in the first year because
13 you're not averaging. They're not entitled to
14 the equal weight of what, you said, divide by
15 10 or divide by 100. All that really matters
16 is what's the -- what's the -- what are the
17 two numbers that the mean falls in between.
18 Isn't that true?

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

21 A. I think we're mixing up a couple
22 of things.

23 Q. Doctor --

24 MR. MANDELL: Ted, could you get the
25 New England Journal of Medicine article,

1 Long-Term Survival After Kidney
2 Transplantation. It's item number 42 on that
3 list. And let's mark it as the next exhibit.

4 MR. RUZICKA: I'm marking the New
5 England Journal of Medicine article as
6 Exhibit 17.

7 (Exhibit 17 was marked.)

8 Q. Doctor, before I get there, I just
9 want to ask you just a couple questions. I'm
10 sorry.

11 MR. BU: Sorry, Mark, before you go
12 ahead, there are two stapled packets. Is this
13 all just one exhibit?

14 MR. MANDELL: Yeah. Yeah.

15 MR. BU: Thank you, Mark.

16 MR. MANDELL: In fact, you know what
17 we could do, Nathan, the article can be one
18 exhibit and the appendix can be -- like it can
19 be 17-A and 17-B or something like that, just
20 to identify it. Okay?

21 MR. BU: Okay.

22 MR. MANDELL: Thank you.

23 Q. (By Mr. Mandell) Doctor, when
24 Ms. Tukes got her kidney there were several
25 cautionary predictive risk factors associated

1 with it in addition to being a deceased donor
2 kidney as opposed to a living person's kidney?

3 A. Yes.

4 Q. Isn't that true?

5 A. Yes.

6 Q. All right. So the kidney -- donor
7 kidney had an elevated KDPI of 62, right?

8 A. Yes.

9 Q. Now, a KDPI is a kidney donor
10 profile index, correct?

11 A. Yes.

12 Q. And what they do is there are 10
13 donor variables that are used to determine the
14 quality of the deceased donors and the kidney,
15 right?

16 A. Correct.

17 Q. And they include things like is
18 there hypertension, is there hepatitis C, how
19 did the donor die, that kind of stuff --

20 A. Exactly.

21 Q. -- right?

22 A. Yes.

23 Q. And the range of the KDPI goes
24 from one to 100?

25 A. Yes.

1 Q. One is the best, 100 is the worst?

2 A. Yes.

3 Q. And there are four stages, or four
4 grades. A is one through 20, that's the best,
5 B is 21 to 55, C is 55 to 85, and D is the
6 worst at 86 to 100, right?

7 A. Yes.

8 Q. So 62, that's in grade C, that's
9 not a good grade, is it, when donating a
10 kidney?

11 A. It's not great.

12 MR. BU: Let Mr. Mandell finish his
13 question before you respond.

14 Q. (By Mr. Mandell) Now, there was a
15 prolonged cold ischemia time of 17 hours and
16 31 minutes, and a visible lower pole ischemia
17 at the time of transplant. So they were not
18 positive predictive factors, they were
19 cautionary factors, that said, Ms. Tukes,
20 you're not getting the best kidney,
21 colloquially, true?

22 A. I completely agree.

23 Q. So let's go to the article because
24 I just want to ask you a few questions about
25 it.

1 A. Sure.

2 Q. First, on Page 27, paragraph 72,
3 of your Tukes' report, you make the statement
4 that, from the general introduction section
5 above, it's in the fifth line or fourth line
6 -- fifth line, deceased donor kidney
7 transplant grafts have about 70 percent chance
8 of working after 10 years. Do you see that,
9 sir?

10 A. Yes.

11 Q. Okay. Now, in the donor -- excuse
12 me. In the general introduction section, you
13 cite to this article that has just been marked
14 -- is it 18-A and B, or what number is it?

15 A. 17.

16 Q. 17-A and B, okay. So 17-A. So
17 you cite figure 3D and -- if we can go to
18 figure 3D, it's on Page 736 of the article.
19 Do you see it in front of you, sir?

20 A. Yes.

21 Q. Okay. And if you look at that
22 article and that figure -- actually in your
23 general introduction, I apologize, you refer
24 to figure 2, not figure 3. So I think we need
25 to go there for this point. But if you look

1 at figure 2 --

2 A. All right.

3 Q. -- which is the only reference to
4 this article you make in the general
5 introduction, you should be looking at 2D,
6 which is the graft survival from a deceased
7 donor, right?

8 A. Yes.

9 Q. Now, if you look at the most
10 recent data from graph 2D for 10 years
11 post-transplant, that actually shows the rate
12 of graft survival is around 55 percent for the
13 208 -- or 2008 to 2011 cohort; isn't that
14 correct?

15 A. That's not the most recent data.

16 Q. Well, it's the most recent data
17 for 10 years, true? The 2012 to 2015 does not
18 extend out 10 years. Since your statement
19 said 70 percent for 10 years, I went to 2008
20 to 2011 which goes halfway between 10 and
21 15 years, correct?

22 A. Correct.

23 Q. And at 10 years the useful life of
24 the graft survival number is really like
25 50 percent on graph 2D, not 70 percent, true?

1 A. It was for that four-year era.

2 Q. That's right. And that's the most
3 recent era that deals with 10-year survival,
4 because if you go to the 2002, 2004, 2007 for
5 10 years, it's about the same? It's actually
6 lower --

7 A. It's lower --

8 Q. -- than 50 percent?

9 A. And that's one of the points that
10 Harry Herron and group were making is that --

11 Q. But I'm talking about the point
12 you were making. This is not a 70 percent
13 graft survival at 10 years in this article you
14 cited us to. It's 50 percent if you use 2008
15 to 2011. It's like 40 percent if you use 2004
16 to 2007.

17 My point is that it's 20 to
18 30 percent lower graft survival at 10 years
19 than you said in your report, which you said
20 70 percent; isn't that true?

21 A. No. The current projection is
22 that, since graft survival tends to improve
23 slightly in every four-year cohort with
24 improvements to transplantation medicine, and
25 that's why each of these curves looks like

1 they're slightly better over time. That's
2 because of improvements in transplant
3 algorithms and --

4 Q. But you knew that when you wrote
5 your report, and you still said 70 percent --

6 A. That's the projected --

7 Q. -- and yet for 10-year survival --
8 okay.

9 So, Doctor, there is also an
10 appendix to this article that, if you look at
11 the appendix in terms of Figure 1, for 10-year
12 survival of the graft, the most recent data,
13 that is, the 2008-2011 that I used, is
14 53.62 percent, almost 20 percent less than
15 what you said in your report; isn't that true?

16 A. For that four-year era, yes.

17 Q. But you're citing this article and
18 you're citing that graph and you --

19 A. But we've got more recent
20 transplant.

21 Q. But you cited this article?

22 A. Yes.

23 Q. You're trying to say this article
24 supports, and you cited to it in your brief --
25 in your report, and you're wrong. You way

1 overstated how -- the percentage by -- what I
2 just showed you, by 20 percent or more; isn't
3 that true?

4 A. No, sir. You're misunderstanding
5 the figure.

6 MR. BU: And you do need to wait for
7 Mr. Mandell to finish his question before you
8 respond.

9 Q. (By Mr. Mandell) Okay. So,
10 Doctor, in this article, same article, look at
11 Page 731 of the article. Look in the
12 right-hand column. Look about halfway down.
13 It says, During the first year after
14 transplantation most graft losses were due to
15 technical issues and vascular complications.
16 41 percent of graft losses for technical
17 issues and vascular complications, followed by
18 acute rejection, 17 percent, and then
19 glomerulonephritis, 3 percent.

20 It then goes on to say, beyond one
21 year, which is where Ms. Tukes is now, it said
22 most graft losses were due to chronic
23 rejection, 63 percent, and glomerulonephritis
24 of 6 percent. Did I read that correctly?

25 A. Correct.

1 Q. So beyond the first year, it isn't
2 like chronic rejection doesn't happen or it
3 almost never happens. 63 percent of graft
4 losses after the first year are due to chronic
5 rejection, true?

6 A. I agree.

7 Q. Now, when you have somebody who is
8 older, rejection is not the only thing you're
9 concerned about with a transplant of a kidney,
10 true?

11 A. True.

12 Q. And, by the way, do you know what
13 age the studies that assessed what the risks
14 are to a patient who'd had a transplant
15 surgery who is older, is in terms of chronic
16 rejection and the other bad issues that could
17 happen, how they defined older? What -- how
18 of studies actually -- what age they put on
19 older --

20 MR. BU: Object to form.

21 Q. -- to make those assessments, sir?

22 MR. BU: I'm sorry. I'm going to
23 object to form. You can answer.

24 Q. (By Mr. Mandell) Go ahead. Do
25 you know how the studies define older?

1 A. Okay. In most studies it's
2 probably age over 60. Some will have age over
3 70.

4 Q. Now, what's the biggest potential
5 danger to a patient over 60 who has had a
6 kidney transplant surgery after one year?

7 A. As age goes higher, it's going to
8 be death with functional graft.

9 Q. And what condition causes that
10 death most of the time?

11 A. Cardiovascular disease.

12 Q. Are there any other causes?

13 A. The second would probably be
14 infections, sepsis.

15 Q. Okay. So one thing that happens
16 with older people is their immune system is
17 weaker than it was when they were younger, and
18 so in the first year they may not have as much
19 acute rejection because their immune system
20 just isn't as strong, true?

21 A. True.

22 Q. But because their immune system
23 isn't as strong and because they're on
24 medications, immunosuppression medications, to
25 try to prevent rejection, they are more

1 susceptible to life-threatening and dangerous
2 infections, true?

3 A. True. That's also why some older
4 patients are treated with lower levels of
5 immunosuppressant.

6 Q. Now, you also say in your report
7 that the rate of graft loss at the year --
8 first year post one is 5 percent. And then
9 you say that the chance Ms. Tukes' transplant
10 graft will stop working per year is about
11 5 percent.

12 And I'd like to ask you, where in
13 this, either figure 2 or figure 3 in the New
14 England Journal of Medicine article,
15 Exhibit 17-A, or the appendix, 17-B, is any
16 attempt to measure the per year graft loss and
17 that it's 5 percent? Where is that in any of
18 these grafts, either 2D or 3D, since those are
19 the sections that deal with greater graft loss
20 from a deceased donor.

21 So my question is show me where it
22 says -- show us where it says that they're
23 trying to measure per year graft loss.

24 A. So in figure 3, the rate
25 percentage, rate of graft loss deceased donor,

1 that is a rate per year.

2 Q. You said the first year is five
3 percent. Show me where every it's 5 percent
4 loss. They don't measure per year graft loss
5 at 5 percent, do they?

6 A. I don't think I said it was
7 5 percent in the first year. The overall rate
8 of graft loss in the first year will be higher
9 because that's the riskiest year.

10 Q. Your report will stand as to what
11 you said about the 5 percent at one year. But
12 my question to you is, where in that graph
13 does it indicate that every single year the
14 rate of graft loss is 5 percent?

15 A. So most of those rates that we're
16 looking at, especially for recent years, are
17 somewhere between 4 and 6 percent.

18 Q. You're saying at which line or
19 lines?

20 A. Figure 3 --

21 Q. Blue line?

22 A. Figure 3D.

23 Q. Yeah. Which lines?

24 A. The blue line looking at the rate
25 of loss in the first year in folks who were

1 transplanted in 2016 to 2018 is already at or
2 below 6 percent. And the rate of graft loss
3 after the first year, if you go year one
4 through year five, and this is people
5 transplanted between 2010 and 2014, is already
6 somewhere in the 4 percent range, mid-fours.

7 MR. MANDELL: Dedric, could I ask you
8 how much time is left, please?

9 VIDEO TECHNICIAN: So we had two
10 hours, and we're at an hour 13, so 50 minutes
11 left.

12 MR. MANDELL: How much? I'm sorry.
13 Five-zero?

14 VIDEO TECHNICIAN: Yes.

15 MR. MANDELL: Okay. Thank you very
16 much.

17 MR. BU: Dedric, do you need to switch
18 out the video?

19 VIDEO TECHNICIAN: I'm going to need
20 to, but in a little bit, unless he wants to do
21 it now. Do you want to take a moment now for
22 me to just switch the tape, the video?

23 MR. MANDELL: Whatever is best for
24 you, Dedric.

25 VIDEO TECHNICIAN: Let's just do it

1 now while we're at a break point here. So
2 we're off the record at 4:15.

3 (Recess.)

4 VIDEO TECHNICIAN: We are back on the
5 record at 4:21.

6 Q. (By Mr. Mandell) All right. Dr.
7 Johnstone, in your report, the Tukes' report,
8 you made some comments about whether age is a
9 factor in eligibility or candidacy for a
10 transplant. And I'm specifically referring,
11 for example, to Page 29 of your report,
12 paragraph 77.

13 And you make the comment
14 particularly -- and tell me -- are you there,
15 sir? Because I'll wait for you to get there.

16 A. 77? Which one?

17 Q. Paragraph 77. Page 29, sir.

18 A. Yep, I'm there.

19 Q. Okay. Thank you. You say there
20 is -- in the third line, There is no standard
21 age limit for kidney transplantation. And if
22 she remains quite healthy, she may be a good
23 candidate. But then you say, In the
24 literature on kidney transplantation in older
25 adults, the consistent, and then you put in

1 quotes, you're quoting, the consistent theme
2 is that chronologic age is substantially less
3 important than physiologic age in the nature
4 and severity of any coexisting conditions, and
5 then you cite to an article by GA Knoll,
6 Kidney Transplantation, in the footnote, In
7 the Older Adult, true?

8 A. True.

9 Q. Okay. So do you know how old
10 Ms. Tukes will be -- well, how old is she now,
11 do you know?

12 A. I think it was 59 going on 60.

13 MR. BU: You may need to speak up, Dr.
14 Johnstone.

15 A. I think it was 59 going on 60.

16 Q. (By Mr. Mandell) Okay. And so in
17 12 to 15 years she'll be in her mid-70s --

18 A. Yes.

19 Q. -- early, mid-70s? Okay.

20 Now, with that article, that is
21 the Knoll article, I'm going to put it on
22 screen share so we can see it.

23 MR. MANDELL: Ted, can you mark that
24 as the next exhibit, the Knoll article.

25 MR. RUZICKA: Yes, I'm marking it as

1 Exhibit 18.

2 (Exhibit 18 was marked.)

3 Q. (By Mr. Mandell) So, Doctor, can
4 you see the beginning of that article on the
5 screen?

6 A. Yes.

7 Q. And on the first page it does have
8 that reference similar to your report -- in
9 your report at the bottom of the right-hand
10 column that says, Although no guideline
11 reports an upper age limit for
12 transplantation, the consistent theme is that
13 chronologic age is substantially less
14 important than physiologic age in the nature
15 and severity of any coexisting conditions.

16 Do you see where I read that from,
17 sir?

18 A. Yes.

19 Q. Now, if you take a look at the
20 beginning of the abstract, let's start there.
21 It talks about the end stage renal disease
22 population is aging and nearly half of all new
23 patients are older than 65 and a third are
24 actually older than 70.

25 And then it says, Assessing the

1 possibility of transplantation for older
2 patients with end stage renal disease often
3 involves contemplating more complex issues,
4 including cognitive impairment, decreased
5 functional status, and frailty, which makes
6 selecting appropriate candidates more
7 difficult.

8 All right. So I read that
9 correctly first, correct?

10 A. Yes.

11 Q. All right. Now, cognitive
12 impairment, is that something outside the
13 scope of a nephrologist, so you would ignore
14 that like you would psychiatric issues?

15 A. I don't ignore, either, sir.

16 Q. Well, I thought you said you put
17 it aside, you don't read it. What is that, if
18 not ignoring it, as to psychiatric issues,
19 sir?

20 A. I think you're misclassifying what
21 I've said.

22 Q. Well, the record will stand on
23 itself.

24 A. That's fine.

25 Q. What about cognitive impairment is

1 that something you pay attention to as a
2 neurologist -- a nephrologist or not?

3 A. I am not a neurologist. So I pay
4 attention to it, but it's not my area of
5 expertise.

6 Q. And then it says, older patients
7 -- older transplant patients have decreased
8 patient and transplant survival compared with
9 younger recipients. So it says, for example,
10 75 percent of deceased donor transplant
11 recipients, age 30 to 49 years, are alive
12 after five years compared to only 61 percent
13 for those older than 65.

14 Did I read that correctly?

15 A. Yes.

16 Q. A little further down, it says,
17 Older transplant recipients experienced more
18 infectious complications and less acute
19 rejection, but the risk of transplant loss
20 from rejection is increased compared with
21 younger patients.

22 Do you agree with that statement?

23 A. I -- I think it's correct. It's
24 what's listed in the literature of -- from
25 experts on transplantation in older adults.

1 Q. Then it continues on, These
2 immunologic issues, along with the fact that
3 older patients often are excluded from
4 transplant trials, have made selecting an
5 ideal immunosuppressive regimen challenging.

6 Do you agree that older patients
7 often are excluded from transplant trials just
8 because of their age?

9 A. They have been, yes. Do I agree
10 with that practice, no.

11 Q. And then the next page, Page 791,
12 just above the heading patient survival, it
13 reads, "Given the strong influence of age on
14 transplantation outcomes, it is not surprising
15 that older recipients have decreased patient
16 in transplant survival rates compared with
17 younger recipients.

18 Is that an accurate statement,
19 Doctor?

20 A. Yes.

21 Q. And then on Page 796, the last
22 page of the narrative, in the right-hand
23 column where it talks -- the heading is, in
24 the left column, Evaluation Issues in the
25 Elderly. It says, although -- in the

1 right-hand column and the last paragraph,
2 about halfway down, it says, Although most
3 data focused on patient survival, transplant
4 survival, and infections, elderly patients
5 have a limited reserve and major complications
6 can lead to loss of mobility, cognitive
7 decline, and even a loss of independence.

8 Is that an accurate statement,
9 sir?

10 A. Absolutely.

11 Q. In the records have you observed
12 any comments concerning Ms. Tukes' reaction
13 emotionally to what she has gone through
14 because of the kidney cancer she has
15 experienced that resulted in a loss of both of
16 her kidneys and dialysis and a transplant?

17 A. No specific overview, no.

18 Q. Okay. How do you -- how would you
19 describe your understanding as to the
20 emotional reaction experienced by Ms. Tukes to
21 having cancer in both her kidneys, removal of
22 both her kidneys, being on dialysis, and
23 having kidney transplant? What's your
24 understanding of that reaction?

25 A. I think it's been a very hard road

1 for her. I think it was very hard to hear
2 about kidney cancer for her, to want the
3 cancers out as soon as possible. I think she
4 had a hard time on dialysis. And I think, but
5 am not certain, that she's doing a lot better
6 now that she has a functional kidney
7 transplant.

8 Q. Dr. Johnstone, you mentioned on
9 Page 28 of your report in the Tukes case,
10 Paragraph 75, you talk about, to minimize the
11 risks of chronic rejection and medication
12 toxicity from one year onward, Ms. Tukes will
13 require monitoring, and then you go on with
14 some detail as follows.

15 So I'd like you to go through
16 subparagraphs A through H, and I've put it up
17 on the screen. 28.

18 All right. I'd like you to go
19 three each of these subparagraphs, A through
20 H, and explain why you feel those -- that
21 monitoring and those future treatments are
22 necessary.

23 A. So regular clinical visits every
24 six months with a nephrologist or transplant
25 specialist.

1 Q. Why is that necessary?

2 A. That was my training during
3 fellowship. It's the recommendation of the
4 KDOQI guideline and is part of general
5 practice, meaning if not most transplant
6 centers. It's important to give the patient
7 the opportunity to ask questions and for the
8 doctor and the team to review blood pressure,
9 functional status, overall infection issues,
10 overall transplant allograft function.

11 And like clinical visits for
12 people who have chronic kidney disease, try to
13 make any adjustments to medications or to the
14 kind of personal monitoring that a patient
15 does at home in terms of diet and blood
16 pressure that can help them do as well as
17 possible.

18 Q. What about subparagraph B, blood
19 tests every one to three months, why is that
20 necessary?

21 A. So your blood tests are monitoring
22 kidney function, electrolyte disorders. So
23 kidney function you're looking for transplant
24 rejection. Electrolyte disorders can arise
25 either by themselves or because of the

1 transplant medications, so hyperkalemia
2 acidosis and such like.

3 Q. How about section C, urinalysis
4 every month, why is that necessary?

5 A. So a urinalysis can detect the
6 onset of protein in the urine, which is for
7 folks who had hypernephritis, one of the signs
8 of occurrence. In folks who after a few years
9 start to be at risk for chronic transplant
10 rejection, one of the hallmarks of that is
11 progressive protein in the urine. And then
12 you can also detect infections which can
13 sometimes have minimal symptoms in the urine
14 but still need -- still need treatment.

15 Q. How about D, periodic renal
16 ultrasounds, why are they necessary?

17 A. So for a couple of reasons. The
18 first is that it's possible to detect changes
19 in the echogenicity of an ultrasound that can
20 correlate with changes in kidney function,
21 either from rejection, infection, or allergic
22 reactions to medications. It's also possible
23 to detect kidney masses, essentially kidney
24 cancers that can arise within a transplanted
25 kidney. And the surveillance allows you to

1 detect those early on.

2 And then sometimes you're able to
3 detect new onset of blockages in either the
4 arteries that go to the kidneys, veins that
5 come away, or the ureter that comes away. And
6 that can be detected before the onset of very
7 overt trouble.

8 Q. Okay. How about the medications,
9 including prednisone, et cetera. Why are they
10 necessary?

11 A. So everyone with a transplant
12 allograft needs some degree of
13 immunosuppression to reduce the risk of
14 rejection and to encourage a state of
15 tolerance. And the medications listed are the
16 ones that are most commonly used in the United
17 States at this time. And this is the regimen
18 that's she's getting from Carolina University.

19 Q. How about screening for the virus
20 and the HLA antibodies at one year and then
21 annually, why is that necessary?

22 A. So BK virus is an opportunistic
23 virus. It really mainly arises in folks who
24 are on immunosuppressant medications. If
25 present at high degrees in the kidney, it can

1 contribute to transplant graft failure. So
2 it's good to try to screen for that. And
3 then, if it's present, make adjustments to
4 help that virus go away.

5 HLA antibodies are ways to screen
6 for antibodies that the patient, the donor --
7 I'm sorry, the patient is making against the
8 donor kidney and can lead to chronic
9 transplant rejection. So in both cases, a
10 transplant doctor could see that test result
11 and then adjust the immunosuppression and then
12 keep monitoring.

13 Q. How about monitoring fasting lipid
14 levels, why is that necessary?

15 A. Especially for people who had
16 either diabetes or cardiovascular disease.
17 But, in general, with transplant patients,
18 there is a risk of hyperlipidemia and -- and
19 that can arise because of the transplant
20 medications themselves.

21 So if it's happening, you want to
22 help detect it early on, get them on statins,
23 get them on the appropriate diet to lower
24 their cholesterol, sometimes add additional
25 medications. Because lower levels of fasting

1 lipids will lead to a slower rate of
2 atherosclerotic disease throughout their body,
3 lower rates of heart disease, stroke, and loss
4 of their transplant kidney.

5 Q. And then finally, what about
6 cancer screening, why is that necessary, in
7 subparagraph H?

8 A. So necessary for all of us, but
9 more so for folks who have a transplant. When
10 you are suppressing your immune system, you're
11 also suppressing your body's natural
12 surveillance for cancer. So transplant folks
13 have an increased incidence of -- of cancer,
14 especially of the skin. And so surveillance
15 is suggested as part of their routine
16 transplant follow-up.

17 Q. In your report you speak of
18 Ms. Tukes demonstrating atypical early -- in
19 your report you speak of Ms. Tukes
20 demonstrating atypical early bifurcation of
21 renal arteries, 2.1 centimeter from
22 bifurcation.

23 So first question is, why do you
24 believe this to be atypical?

25 A. I think that's the wording in the

1 radiology report from the VA. I don't
2 remember which kidney it was on. But it's an
3 anatomic variant of her vasculature.

4 Q. Do you believe that to be
5 causative or contributory at all to her kidney
6 problems?

7 A. Not causal or contributory.

8 Q. You had mentioned earlier that you
9 have worked on other cases in the past for
10 Versed, or Versed. What cases are you
11 referring to, sir?

12 A. I think they were involved with
13 two or three of the cases in Pittsburgh and
14 one or two of the cases in Philadelphia for
15 which I was an expert witness.

16 Q. What was the subject matter of
17 those cases? What kind of cases were they?

18 A. In Pittsburgh, one of them was a
19 patient on lithium who was concerned that she
20 developed kidney disease.

21 A second was a patient who had
22 been transported from one small hospital to
23 another with circulatory shock, on the verge
24 of death, and the transport was -- hoped would
25 allow that person to have a special form of

1 dialysis, and they died en route.

2 Q. So that was -- the first one was a
3 suit against who or which entity?

4 A. I think the treating psychiatrist.

5 Q. Okay. And you were retained to
6 testify as an expert on behalf of who,
7 plaintiff or defendant?

8 A. I think defendant.

9 Q. And the transport from one small
10 hospital to another, that case, were you
11 working for the plaintiff's lawyer or the
12 defense lawyer?

13 A. Defense lawyer.

14 Q. Okay. Any other Versed cases?

15 A. I think there was a third in
16 Pittsburgh that I'm not recalling at the
17 moment and -- yeah, I think it was a -- maybe
18 it was a different company in Philadelphia.

19 Q. Have you worked on any other cases
20 in addition to the Camp Lejeune cases and
21 those cases, the two you just described, the
22 lithium and the transport case, and maybe a
23 third case in Pittsburgh or the two cases in
24 Philadelphia.

25 Have you worked on any other

1 cases, to review them, et cetera, testify, or
2 anything, as an expert?

3 A. Somewhere between a half dozen and
4 a dozen in total. And probably closer to a
5 half a dozen.

6 Q. Okay. And what kind of cases?

7 A. Some of them had to do with --

8 Q. Were they environmental toxins?

9 A. No.

10 Q. Okay. What kind of cases?

11 A. I think adverse events on dialysis
12 for a couple of them.

13 Q. Okay. And who generally were the
14 defendants, the hospital or dialysis center?
15 Who would be the defendants in those cases?

16 A. I forget if it was the dialysis
17 center or -- I think it was the physician
18 involved.

19 Q. And were you working on behalf of
20 the patient or the plaintiff or the defendant?

21 A. Defendant for both of the dialysis
22 cases that I recall.

23 Q. Okay. In all of your work as an
24 expert witness in medical-legal work, has it
25 always been on behalf of the defendant or

1 defendants?

2 A. I think so. That's who's
3 approached me.

4 Q. Okay. Have you ever testified
5 before in a deposition or at trial?

6 A. This is my first time as an expert
7 witness in a deposition.

8 Q. Have you ever testified at trial?

9 A. No.

10 Q. Okay. Just so I'm clear,
11 100 percent of your work as an expert witness
12 has been on behalf of the defense; is that
13 true?

14 A. I think so. One of the cases in
15 Philly might have been for prosecution. I
16 can't recall.

17 Q. Meaning in a criminal case?

18 A. I don't think it's criminal. I
19 think it was probably a civil case.

20 Q. Okay. As you sit here now, to the
21 extent that you remember the cases you worked
22 on, 100 percent were on behalf of the defense;
23 is that true?

24 A. I think so.

25 Q. Okay.

1 MR. MANDELL: Nathan, I have no
2 further questions.

3 MR. BU: Do you mind if we take a
4 10-minute break? I'll talk to my co-counsel.

5 MR. MANDELL: Sure, of course.

6 VIDEO TECHNICIAN: That will put us
7 off the record at 4:50.

8 (Recess.)

9 VIDEO TECHNICIAN: We are back on the
10 record at 4:57.

11 EXAMINATION

12 BY MR. BU:

13 Q. So, Dr. Johnstone, can you tell us
14 a little bit about your clinical practice and
15 your experience treating patients who have
16 chronic kidney disease.

17 A. Been in practice since about 2007.
18 Fellowship up until 2006 -- or I guess I've
19 been in practice since then. I'm currently
20 the clinical director at University of Kansas,
21 so in that role I see patients in the
22 outpatient clinic twice a week.

23 And then about three months, four
24 months a year, four months a year, I take care
25 of patients in the hospital, all around the

1 hospital. And then for about three months a
2 year, I go to an outpatient dialysis center.

3 And the rest of the time is spent
4 with a combination of meetings,
5 administration, teaching of students, teaching
6 of residents, teaching of fellows, and quality
7 improvement throughout the hospital.

8 Q. Do you see patients who are either
9 on dialysis or may need dialysis in the
10 future?

11 A. Yes, both.

12 Q. When you're thinking about whether
13 a patient may need dialysis in the future,
14 what are the factors you normally consider in
15 your practice?

16 A. The likelihood that their kidney
17 disease will progress in the relatively near
18 future. And then I try to incorporate in that
19 some idea of their comorbidities, their
20 quality of life, and what their goals are.

21 Q. And when you think about the
22 progression of kidney disease and its
23 likelihood, are there -- I guess what data
24 would you consider in making that
25 determination?

1 A. So the first thing I always try to
2 do is to find the cause. I think once I know
3 the cause, I can design a better treatment
4 plan. And then as a generalization, there is
5 a prediction equation, the kidney failure risk
6 equation. It's best for common forms of
7 kidney disease. It's imperfect but okay for
8 other causes of kidney disease. And it can be
9 used to predict the likelihood that that
10 patient will end up needing dialysis either in
11 two years or five years.

12 Q. What are the inputs for the kidney
13 failure risk equation?

14 A. They have a couple of different
15 iterations. But the weight of it is on age,
16 serum creatinine, and the amount of albumin
17 that's leaking from their blood into their
18 urine. Some iterations also include
19 phosphorous or albumin or gender. It doesn't
20 have to.

21 Q. Are these kidney failure risk
22 equations widely used by nephrologists?

23 A. Yes, increasingly so.

24 Q. The various factors that we just
25 discussed, did you consider these for your

1 report in Mr. Mousser's case?

2 A. I did.

3 Q. So you considered his age?

4 A. Yes.

5 Q. His serum creatinine?

6 A. Yes.

7 Q. His albumin?

8 A. Yes.

9 Q. Mr. Mandell asked you some
10 questions about Mr. Mousser's voc rehab. Do
11 you believe that's relevant to determining the
12 likelihood that Mr. Mousser will need dialysis
13 in the future?

14 A. I don't think it's directly
15 relevant.

16 Q. Why not?

17 A. Again, something new, some
18 surprise, can always come up in someone's
19 life. I could be hit by a car, develop some
20 critical viral infection in the next week that
21 puts me on dialysis.

22 But if you're just asking will I
23 end up on dialysis in five or 10 years, you'd
24 base it on the facts and clinical
25 characteristics you see in front of you.

1 And when I looked in his record
2 and I found his current -- most current serum
3 creatinines, not one, but several. And then,
4 not one, but several checks of his urine
5 looking to see if albumin is leaking into the
6 urine. All of those together are fairly
7 reassuring.

8 Q. Mr. Mandell also showed you or
9 referenced some of Mr. Mousser's psychiatric
10 records. Do you recall that?

11 A. Yes.

12 Q. Do you find those relevant to your
13 opinion about Mr. Mousser's potential need for
14 dialysis in the future?

15 A. I don't.

16 Q. And why not?

17 A. So I'm not trying to make light of
18 mental health. It's simply a different
19 disease with different doctors and different
20 considerations.

21 Q. And --

22 A. When I'm asked what's the
23 likelihood he's going to end up on dialysis,
24 it's just dealing with those -- those factors
25 that go into the kidney failure risk equation

1 and to thinking about the cause of why he has
2 the kidney disease that he has at present.

3 Q. Mr. Mandell also referenced a
4 bladder cancer recurrence. Do you recall
5 that?

6 A. Yes.

7 Q. Do you find that relevant to your
8 opinions about Mr. Mousser's potential need
9 for dialysis in the future?

10 A. That's a tricky one. It may or
11 may not be. I just don't have any information
12 about the extent of that cancer, what's going
13 to have to be done. And, as far as I know,
14 maybe -- it still isn't known this month. I
15 don't -- I know that from the last data that I
16 had in the kidney function of his remaining
17 kidney was really very good for a single
18 kidney.

19 Could that change, yes. Was there
20 any evidence it was changing so far, no. All
21 the evidence was still making me very
22 optimistic about the health of that one
23 kidney.

24 Q. When you say could have changed,
25 yes, what are you referring to?

1 A. Oh, gosh. I mean, in the worst
2 case scenarios, someone could require a full
3 cystectomy, which means removal of the entire
4 bladder. If that occurs then there are
5 urologists who are very, very good at taking a
6 segment of ileum and using that to create an
7 artificial ureter so that that left kidney
8 could still drain to the outside.

9 But even though that might retain
10 the function of that left kidney, it would be
11 a change in lifestyle for him, and it would
12 require another surgery. Depending on the
13 extent of his bladder cancer, it could require
14 chemotherapy. Most often that's local and
15 doesn't affect the kidney. But it depends on
16 the extent of out cancer within the bladder.

17 In the -- early bladder cancer is
18 actually pretty amenable to treatment by a
19 urologist just within the kidney. So the
20 other end of the spectrum is that it could be
21 really easy to treat and not affect his kidney
22 at all in any way.

23 Q. Is the recurrence itself reason to
24 think that Mr. Mousser is likely to need
25 dialysis in the future?

1 A. I guess so. But, again, the
2 caveats are what kind of recurrence, can it be
3 treated with local means, are they able to
4 resect it, get negative margins, and have a
5 likely cure, is it amenable to BCG local
6 therapy. I'd have to know a lot more. And
7 I'm not even sure it's known yet about what's
8 going to happen with his disease.

9 Q. I think Mr. Mandell also asked you
10 some questions about the standards you applied
11 in your report. Are the standards you applied
12 in your report the standards you would apply
13 in your normal medical practice?

14 A. Yes.

15 MR. MANDELL: Objection.

16 A. Yes. And I do this all the time
17 with using estimates of likelihood of
18 progression. And I -- I allow patients the
19 opportunity to graduate from my clinic all the
20 time. If an occasional patient says, no, I
21 want to see you in six months, I say okay.
22 I'm not going to turn them away.

23 But I give them the opportunity to
24 graduate. And some patients are delighted to
25 have that opportunity. And they know they're

1 going to go back to their primary care
2 providers and still have their kidney function
3 looked at every six months or every year. And
4 they know that if -- if things change, their
5 primary care provider will reach out to me
6 right away.

7 Q. You had mentioned having some
8 difficulty accessing some records from DOJ.
9 Were there any missing records -- or any
10 records you felt were missing that you were
11 not able to access by the time you issued your
12 reports in April?

13 A. I don't think so. It's just the
14 CORA database is huge and it took a while to
15 get permission to finally access it. But once
16 I was in and learned how to go through
17 everything and find Tukes and Mousser, I think
18 -- there were just a huge number of files
19 there. I think everything was complete.

20 Q. Thinking about Ms. Tukes'
21 predictions regarding graft survival, what do
22 we know about her current medical condition
23 that might be relevant to predicting her graft
24 survival?

25 A. So I completely agree that the

1 kidney she got had a higher risk of rejection
2 and failure initially. And what I was struck
3 by is that so far she is defying all the odds.

4 So she had a kidney with a pretty
5 high KDPI, prolonged cold ischemia time. If
6 I'm remembering correctly, I think it was a
7 four match, and it had a purplish-looking, I
8 think, inferior pole, which isn't even
9 officially on the predictions because that's
10 not very common.

11 So four bad things and yet -- and
12 you can tell this in -- in the notes from the
13 Carolina transplant group. You can tell how
14 delighted they are, because doctors get really
15 happy when things go well. And at all of
16 those November follow-up notes, they are very
17 happy with how -- how good her kidney function
18 is, how she didn't have any delayed graft
19 function, no episodes of rejection.

20 That she had some mild viremia,
21 but that it went away with gentle reduction of
22 her transplant medications. So it allowed her
23 own immune system to sort of attack and kill
24 the virus without causing rejection. And so
25 they got her into a nice balance. So it

1 sounds like they did a very good job of
2 getting that balance.

3 And one of the next big predictors
4 for long-term outcome is what's your
5 transplant kidney function like at one year.
6 And with all those negative predictors, you
7 might have said I'm not so sure it's going to
8 be that great at one year; and, yet, as far as
9 I could get the data for, she was getting
10 close to a year and had very good kidney
11 allograft function, which means -- again,
12 overall we predict she should be better than
13 both the mean and median for deceased donor
14 kidney transplants in this country.

15 MR. MANDELL: I just want to move to
16 strike that answer as nonresponsive to the
17 question. Go ahead, though.

18 Q. (By Mr. Bu) You also were asked
19 some questions about a 5 percent probability
20 of rejection. Do you recall those?

21 A. Per year, yes. Yeah.

22 Q. And is that for every year after a
23 transplant?

24 A. It's not really the -- so the
25 first year is going to be the highest. And

1 then it will start to go down. Overall, the
2 rate per year is about five. The further you
3 get out, the lower it will be per year. And
4 at the same time as you're looking at that
5 rate decrease every year, it doesn't go to
6 zero ever.

7 But we end up having a new -- a
8 new graph for every four-year block, because,
9 with small advances in transplant medicine,
10 the rates per year keep improving. They come
11 up with new ways for induction, which is what
12 you do immediately once the patient is on the
13 operating table. So basiliximab didn't exist
14 20 years ago.

15 We get better with knowing where
16 the right level should be for the transplant
17 medications and how to detect it and what
18 assay should be used. Tacrolimus didn't even
19 exist 20 years ago. It was -- it was just --
20 just coming on the market at that time.

21 The Myfortic that she takes, that
22 started in about 2006. So transplant outcomes
23 before that even going to be a little bit
24 worse. We use lower amounts of prednisone now
25 to minimize the chance of long-term

1 complications from prednisone. So it's not
2 that it's easy. It's that, so far with her
3 transplant, she's doing extremely well. She's
4 beating the curve.

5 MR. MANDELL: So I move to strike that
6 answer as nonresponsive. And I object to the
7 question based on a lack of foundation and
8 form.

9 Q. (By Mr. Bu) You were also asked
10 some questions about a 70 percent graft
11 survival rate at ten years. Do you recall
12 that?

13 A. Yes.

14 Q. Why do you think 70 percent is an
15 appropriate figure?

16 MR. MANDELL: Objection. Go ahead.
17 You can answer, Doctor.

18 A. I think from looking at that
19 figure that we were looking at, Harry Herron's
20 point was that, again, the graphs are getting
21 a little better every year. And if you
22 extrapolate from the data that we have, the
23 estimated 10-year rate for current transplants
24 is about 70 percent.

25 Q. When measuring kidney function is

1 eGFR commonly used?

2 A. Yes.

3 Q. Why is eGFR commonly used?

4 A. Serum creatinine is easy to
5 measure and detect. There are a number of
6 caveats, and so I think about those caveats
7 whenever I'm looking at an individual patient
8 to decide if I think that serum creatinine is
9 accurate.

10 When trying to look at eGFR, its
11 creatinine is stable for several days. It
12 can't be a single measurement. But if it is
13 stable for several days and you're at what we
14 call the steady state, then the eGFR, the
15 estimated glomerular filtration rate, is a
16 pretty good test.

17 Q. When you were discussing
18 Ms. Tukes' need for future care, were there
19 any guidelines that you consulted?

20 A. So I think the main guideline that
21 I looked at was the KDIGO guideline on care of
22 kidney transplant patients. The second
23 article was Harry Herron's New England Journal
24 paper on long-term survival of the kidney
25 transplant patient.

1 Q. And what is KDIGO?

2 A. It's a global forum for coming out
3 with guidelines based on as much evidence as
4 we have for care of different kinds of kidney
5 disease. So Kidney Disease Improving Global
6 Outcomes. And it involves a couple of kidney
7 doctors from every region around the world.

8 MR. BU: Thank you, Dr. Johnstone.
9 That's it for me, Mark.

10 MR. MANDELL: I don't have any further
11 questions. Thank you very much, Doctor.

12 VIDEO TECHNICIAN: What about read and
13 sign?

14 MR. BU: Yes. You can send it to DOJ.

15 VIDEO TECHNICIAN: All right. That
16 will conclude the deposition at 5:18.

17 (The deposition concluded at 5:18 p.m. CST)

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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

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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
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:	_____	: _____
:	_____	: _____
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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.



STACY L. DECKER, CSR, CCR
CCR No. 858
CSR No. 1540

&	205:10 240:19	140:22 141:11	130 3:16,17
& 2:4,7 3:18,19 3:22	240:23,25	141:21 143:2	13872 295:23
0	241:8,12,17	144:2,4,11	14 3:7,8,21
0.9 218:18	243:23 245:17	145:5,20 146:5	180:9,13
0.96 218:8	246:14,17	149:1,3 245:19	14-15 180:7
0.97 218:8	247:9,15	247:6,9	140 3:18,19
02906 2:5	249:12 251:8	11-12 140:12	14th 127:17,20
06/20/2025	252:10,17,18	11/26/2018	15 3:22 121:6
294:3	252:19,20,23	75:9	154:14 179:7
1	253:3,5,13,18	1100 2:7,16	180:11,14
1 2:4 3:7 13:25	254:7,11 278:4	293:4	243:23 252:21
14:3,11,14,14	281:23 290:23	12 3:19 140:14	262:17
14:24 23:11	100 118:9,13	140:15,18	1540 295:25
136:20 137:7	141:7 192:18	141:2,11,21	1553 77:8
142:24 217:3	216:4 245:6,8	143:2 144:2,4	15th 247:10
254:11	245:9 247:15	144:11 145:6	16 3:23 106:14
1-2 14:1	249:24 250:1,6	145:20 146:5	106:19 107:4
1.1. 218:18	277:11,22	148:1 149:1,4	229:3,4,5,6,7
1.15 218:18,20	1000 99:12,18	154:14 240:19	229:10
219:5,11	100:4,7,15,16	240:24,25	16th 108:24
1.2 237:11	100:22 101:7,9	241:9,12,17	115:12
1.3 237:10	101:24 102:5,9	246:15,18	17 10:14 31:17
1.32 218:6	102:19 103:2,6	262:17	248:6,7,19,19
1.6 205:8	104:17,17	120 3:15 192:2	250:15 251:15
1.9 205:8	105:5,17,21	12:00 124:21	251:16,16
10 3:17 58:11	108 3:14	12:29 140:8	255:18 258:15
58:16 59:17	10:47 74:4	12th 179:11	258:15
68:14 108:22	10:53 74:7	247:10	170 121:21
130:25 131:3,9	10th 57:25 58:3	13 3:20 153:9	172 3:20
135:16 154:13	58:16,20 59:5	154:13 172:11	17a 4:2
156:4 200:13	66:9,19 68:15	172:13,14	17b 4:4
	127:18 247:9	240:21,24	18 4:5 46:2,3,4
	11 3:18 115:12	244:9,17	46:16,21 47:4
	140:14,15,18	246:15 260:10	47:25 49:14,24

51:4 218:14 251:14 263:1,2 180 3:21,22 192:3,12,18 193:1,8 18th 218:20 19 26:4 36:9 19th 65:7,10 114:12,22 122:4 1:04 140:11 1:30 140:4	2001 45:18 2002 253:4 2004 253:4,15 20044 2:16 293:4 2006 278:18 289:22 2007 253:4,16 278:17 2008 252:13,19 253:14 2008-2011 254:13 2009 135:18 2010 260:5 2011 252:13,20 253:15 2012 252:17 2013 99:23 2014 260:5 2015 252:17 2016 260:1 2017 193:15,19 193:25 2018 74:18 75:4,21 76:9 76:24 78:4,22 84:20 85:22 147:3,7 260:1 2020 179:7 228:19 229:14 229:16 230:10 2021 179:8	2022 106:14 107:4 108:24 2023 174:6 176:7 190:3 2024 65:7 66:19 98:25 172:13 173:11 174:24 180:10 181:14 197:20 218:8,14 2025 1:12 5:11 23:25 25:4 26:15 29:11,15 29:20 30:2,5 30:13 31:1,7 32:21 37:19 51:9,11,21,25 52:12 56:5,11 56:16 58:17,20 59:5,17 92:18 96:24 122:21 123:13 125:22 180:12 293:2 293:10 295:22 208 252:13 20th 5:11 64:15 228:19 230:10 21 176:6 179:11 250:5 219 2:10 21st 128:11,18 174:6 22 3:9,10 106:19 118:8	119:6,13 125:8 137:11,15 179:12 195:11 229 3:23 23 74:9 83:3 95:11,15 96:4 97:6 119:12 146:12 190:17 23rd 124:19 127:6 217:24 24 106:10,16 118:23 162:25 179:23 180:2 180:23 217:24 248 4:3,4 24th 147:3 25 116:21 124:19 217:18 217:22 25855 173:20 25856 174:17 25858 178:2 26 15:2,15 74:18 75:4,21 76:9,24 78:4 78:22 84:19 85:22 118:19 147:7 160:11 161:10 174:24 179:23 180:1 180:10,23 181:14 263 4:6
2			
2 3:8 13:25 14:4,14,15,24 98:17 131:22 131:22,23 132:2,21 133:8 137:7 142:24 188:10 190:4 190:15 217:3 251:24 252:1 258:13 2.1 273:21 20 1:12 117:25 124:21 203:9 229:1,14 247:10 250:4 253:17 254:14 255:2 289:14 289:19 293:10 294:20			

26th 116:21 27 147:8 180:25 182:16 251:2 270 122:10 271 195:2 278 3:4 27th 115:13 120:3,3,25 121:21 126:24 28 147:11,12,14 215:20 229:1 268:9,17 281 140:23 141:1 29 77:4 121:17 155:13,22 229:16 244:10 244:22 261:11 261:17 2930 2:7 29440 2:11 29th 60:4,5,7 61:13 64:12 67:11 69:3,10 69:17 72:17 73:2,14 121:4 2:00 122:22 2:53 216:7 2d 252:5,10,25 258:18 2nd 125:22,24 125:25 126:15	3 3 3:9 22:20 23:1,5 31:10 31:22,22 98:17 109:3 131:22 131:24 132:2 133:23 172:21 246:22 251:24 255:19 258:13 258:24 259:20 3-4 22:24 30 75:11 78:18 79:24 85:5 121:10,18 123:1 152:3 203:9 220:6 253:18 265:11 293:16 300 195:2 308 147:9 309 147:13,25 148:4 30th 121:8 122:8 31 119:11,16 150:25 151:2 151:15,22 160:25 244:10 244:12,14 250:16 31st 122:8 32 172:10,10	339 135:20 35,000 117:25 363 136:12 3:03 216:10 3:20 124:21 3d 251:17,18 258:18 259:22 4 4 3:10 22:20 23:2 26:4 27:3 31:10 121:17 259:17 260:6 4.12 218:5 4/26/18 147:15 40 165:13 191:24 192:8 192:11 203:11 253:15 400 1:15 41 255:16 42 248:2 435 86:17 441 77:8,13,14 45 23:7,15 24:4 24:9,10 36:4 37:20 92:19 93:15 131:12 136:3,9 165:14 196:14 49 265:11 4:15 261:2 4:21 261:5	4:50 278:7 4:57 278:10
			5 5 3:11 25:2 76:5,6,19 138:3 179:12 258:8,11,17 259:3,5,7,11,14 288:19 50 191:25 202:13,19 252:25 253:8 253:14 260:10 500 117:21 50th 245:10 53 95:15,17 96:4 53.62 254:14 55 146:18,24 250:5,5 252:12 56 74:11 75:3 83:4 57 162:25 59 108:17,19,22 262:12,15 5:00 1:14 122:25 123:12 123:20 5:18 292:16,17 5th 1:16 26:15 28:24 29:11,15 29:20,22 30:2 30:5,10,13,21

31:1,7 32:21 33:9,21 38:3 38:10 51:21,25 52:12 56:5,10 56:16 59:21 65:7,8 92:17 92:18 93:18 96:24 122:21 122:23 123:13 124:12 126:25 179:8	6th 218:7	8	9th 1:16
	7	8 3:15 37:19 120:13,14 172:13 173:11 80,000 118:4 81 160:25 82 141:2 147:8 150:25 151:4,5 151:16,22 244:13 85 250:5 850 116:25 117:14,20 118:3 205:24 858 295:24 8599 181:1 86 250:6 897 1:5 5:15 8:00 122:22 8th 23:25 27:8 73:8 92:8,9 98:7	a a.m. 122:22 abate 240:12 ability 37:12 51:19 59:1 162:7 175:6 177:20 179:6 179:16 215:11 able 34:17 68:6 69:6,11 72:18 143:5 149:12 163:16 168:12 170:5 171:13 178:17 182:21 187:18 271:2 285:3 286:11 above 245:22 251:5 266:12 293:10,16 absence 231:11 absent 186:6 223:2 absolute 80:2 absolutely 47:17 50:25 103:24 184:8 213:2 267:10 abstract 263:20 academic 190:5 190:16 access 143:4 144:17,20,24
6	7 3:13 108:11 108:13 136:3,8 293:2 7.43 218:5 70 174:3 251:7 252:19,25 253:12,20 254:5 257:3 263:24 290:10 290:14,24 70s 262:17,19 71 160:12 161:10 72 251:2 731 255:11 736 251:18 749,000 116:23 75 265:10 268:10 76 3:11 760 194:9 761 193:14 77 155:13,23 261:12,16,17 791 266:11 796 266:21 7:23 1:5 5:15 7th 92:7 180:12 295:21	9 9 3:16 130:22 131:8 9-10 130:20 9/13/22 86:12 9/16 120:21 9/27 120:21 99 3:12 9:00 1:13 9:14 5:12	
6 3:3,12 98:25 99:1 135:12 156:4 255:24 259:17 260:2 60 106:10,16 191:25 192:8 192:11 257:2,5 262:12,15 61 265:12 62 249:7 250:8 63 108:19 109:2 110:16 110:20 255:23 256:3 64105 2:8 65 217:19,21 263:23 265:13 66 218:13 68 15:3,15,17 16:2 19:18,19 19:22			

145:2,8 148:22 149:11 167:19 286:11,15 accessing 286:8 account 41:1 237:13 accounting 56:23 124:4 126:13 accuracy 211:5 accurate 8:3 57:21 58:8,11 58:13 81:4,8 116:10 139:21 144:7 164:21 168:12 211:12 212:1,9,20 215:4 226:9 266:18 267:8 291:9 accurately 26:19 56:23 112:7 215:11 215:12 218:24 219:14,20 222:15 223:3 accusing 40:4 acid 220:23 221:11 acidosis 270:2 act 112:23 113:17 163:10 action 294:16 295:19	activity 168:20 actual 20:1 104:12 134:23 142:6,14 144:1 145:21 147:17 148:9 149:2 211:11,12 216:17 actually 13:2 15:5 16:7 19:21 23:8 24:9 31:22 35:18 36:22 53:15 55:25 76:14 83:9 92:13,20 102:19 114:23 123:21 126:3 136:8,21 148:2 149:19,20 152:1 167:16 188:6 193:14 199:5 202:17 204:4 209:17 210:24 212:15 212:21 214:7 215:6,10,12 234:10 241:21 245:1 251:22 252:11 253:5 256:18 263:24 284:18 acute 242:1,5 242:10,13,21	255:18 257:19 265:18 add 32:22 81:8 138:23,23 139:10 185:9 272:24 adding 245:7 addition 32:9 36:19 47:24 59:16 61:3,20 71:12 111:13 153:1 183:4 249:1 275:20 additional 89:14 132:20 143:8 163:14 229:22 272:24 address 52:15 91:13 293:15 addressed 91:20 addresses 31:17 78:20 109:4 adjust 272:11 adjustment 167:9 adjustments 269:13 272:3 adjuvant 107:1 107:11 109:5 109:10,12,14 109:14,24 110:25 111:3	administration 171:8,17,23 172:9 279:5 administrators 188:21 admit 84:21 adult 4:6 262:7 adults 261:25 265:25 advances 289:9 adverse 235:18 276:11 adversely 168:14 227:7 235:6 236:6 advice 86:3 165:17,19 advocate 8:11 8:16 42:22 52:25 53:4 79:21,25 186:14 207:5 advocated 40:15 50:24 107:22 affairs 172:20 affect 183:7 213:11 214:3 235:6 284:15 284:21 affected 168:14 affecting 236:7 affiliated 50:6 50:8 189:10
---	---	--	--

affiliation 5:17	256:6 265:22	allograft 242:2	answer 10:11
affix 294:16	266:6,9 286:25	269:10 271:12	11:18 19:7
afternoon 1:14	agreed 5:1	288:11	37:25 38:13
37:9	55:15 111:3	allow 41:5,6	46:7 51:18
age 6:4 158:19	167:25	274:25 285:18	59:1,14 60:10
203:11 212:22	ahead 9:20	allowed 165:10	61:8,15 62:3,4
231:11,14	11:24 15:12	165:11 287:22	62:6,6 63:2,7
256:13,18	28:6 54:17	allows 228:10	64:25 65:15
257:2,2,7	62:13 98:5,5	270:25	67:3 68:7,21
261:8,21 262:2	133:4 158:1	alluded 186:23	69:7,11,13
262:3 263:11	166:17 172:4	alternative	71:14,25 73:11
263:13,14	180:20 248:12	214:21	85:12 86:1
265:11 266:8	256:24 288:17	amenable	97:22 102:13
266:13 280:15	290:16	284:18 285:5	110:5 113:7,20
281:3	aim 40:21	american 210:5	123:19 150:16
aging 263:22	ajkd 4:5	amount 39:16	156:18,21
ago 17:21 25:6	alarming	58:9 75:17	166:14 205:1
55:11 64:13,16	223:22	118:3 122:19	207:22 219:21
80:23 234:24	albumin 209:8	163:21 280:16	226:17 227:25
236:10 237:2	210:15 280:16	amounts	237:1 239:20
289:14,19	280:19 281:7	213:23 289:24	243:6 247:20
agree 7:8 8:1,5	282:5	analogy 137:25	256:23 288:16
8:9,13,15,19,24	alert 41:1	anatomic 274:3	290:6,17
9:2,7 10:15	algorithms	anatomically	answered 9:21
34:5,8 42:5	254:3	227:8	68:24 206:19
43:7 150:3,8	alive 197:18	anesthesiolog...	answering 93:8
163:21,22	198:22 199:17	88:16	answers 7:20
164:23,24	265:11	angioplasty	109:13 187:21
195:7 198:24	allegedly 39:16	234:18	anthony 179:9
201:22 209:10	204:19	annually	179:10
210:6 214:6,12	alleles 101:1	271:21	antibodies
214:16 225:20	allen 132:13,15	anonymous	271:20 272:5,6
233:13,24	allergic 270:21	101:21	any's 135:10
241:10 250:22			

anybody 34:3 51:8,15 81:23 96:25 102:9 anymore 236:19 apol1 100:25 apologize 226:25 246:6,7 251:23 appeal 172:21 172:25 appeals 172:22 173:1 appearance 222:13 224:18 appendix 22:9 156:4 248:18 254:10,11 258:15 applied 113:2 285:10,11 apply 163:18 164:25 166:15 285:12 appointment 190:5 appointments 190:17 approach 7:17 7:19 9:13 207:24 approached 70:24 277:3	appropriate 51:11,25 52:14 178:22 264:6 272:23 290:15 appropriately 237:13 approximate 29:18 215:12 approximately 192:3 approximation 220:1 approximatio... 245:12 april 23:25 27:8 37:19 73:8 92:7,7,9 98:7 127:17,18 127:20 146:20 147:4,7 172:13 173:11 217:24 286:12 area 40:5,8 41:25 80:24 93:24 107:17 187:1 188:6 206:12 265:4 areas 109:22 argument 82:3 arguments 9:5 arises 271:23 aristoloctic 220:23 221:11	arterial 184:24 234:14 235:17 arteries 224:19 227:12 233:6 234:18 271:4 273:21 artery 234:15 234:23 235:5 235:21 236:5 article 4:2,5 99:12,19,20 100:5,21,25 101:9,13,16,18 101:25 102:7,9 102:19 103:2 104:2,8,11,16 104:25 105:2,5 105:18,20 106:2 242:18 243:8,15 247:25 248:5 248:17 250:23 251:13,18,22 252:4 253:13 254:10,17,21 254:23 255:10 255:10,11 258:14 262:5 262:20,21,24 263:4 291:23 articles 100:13 100:19,20 103:12,16,21 105:18 135:14	243:4,13 artificial 137:8 284:7 ashamed 194:17 aside 207:3 264:17 asked 57:9 64:10 67:23 68:23 126:23 140:13 165:3 166:14 179:23 181:14 202:6 206:12 281:9 282:22 285:9 288:18 290:9 asking 6:12 24:7 35:6 38:2 57:1 61:21,22 62:5 79:20 146:2,3 151:12 154:5 160:2 166:11 179:24 182:18 185:8 194:20 208:22 221:5 238:5 239:9 244:24 281:22 aspect 62:7 63:19,19 72:24 73:3 aspects 154:2 assay 289:18
---	---	--	---

assertion 151:10 assertions 152:7 assess 135:25 210:9 211:18 215:5 228:10 assessed 256:13 assessing 263:25 assessment 163:24 209:25 210:3 216:14 231:24 237:4 assessments 256:21 assign 157:4 assigned 157:8 assistance 178:5 assistants 138:10 assisted 161:15 associate 55:14 associated 248:25 association 85:6 129:16,20 233:3 assume 6:22 11:22 20:1 22:21 167:7 assuming 96:23	assure 33:14 atehexal 215:10 atherosclerotic 273:2 attached 52:20 53:17 attack 287:23 attempt 154:17 258:16 attending 189:18,23 190:18,22 attention 265:1 265:4 293:17 attorney 34:14 91:10 109:7 110:1 295:16 attorney's 1:15 attorneys 2:15 5:16 10:13 51:17 68:3 70:21 91:4 115:2 128:24 295:18 attribute 57:20 84:7 200:5 attributed 58:10,13 attributes 177:8 attribution 38:8,11	atypical 273:18 273:20,24 august 218:8 auto 162:14 automobile 36:20 181:5 available 27:17 28:17 91:15 average 154:4 154:19 157:11 157:21,22 158:19,25 200:11 220:14 241:1 242:16 245:14 averaging 247:13 avoid 206:4 awards 99:11 aware 43:16 49:6 52:18,23 63:18 77:6 88:2,18,21 90:10,10 92:16 103:5,7 104:21 104:23,24 105:3,4,17,22 113:9,14 115:19 116:3,6 116:20 127:25 128:4,8 145:24 171:7,22 172:2 175:15,20 178:25 179:4	179:16,17 181:9 183:13 183:17,23 187:6 198:4,7 234:21 243:20 b b 248:19 250:5 251:14,16 258:15 269:18 back 33:14 38:16,17 56:1 59:20 74:6 77:15 92:12 112:5 133:20 140:10 145:10 152:12 153:17 155:3 216:9 234:2,7 237:1 237:22 261:4 278:9 286:1 background 18:25 19:16 43:23 120:5 121:1,5,9 124:6,7,11 126:16 143:17 bad 83:16 164:7 256:16 287:11 balance 112:17 119:5 195:18 196:9,20 287:25 288:2
---	---	---	---

balkan 220:25 221:19 bar 194:8 bars 194:7 base 136:2 281:24 based 8:21 20:9 54:5,15,18 72:9,10 73:6 77:22 81:15 82:3 83:18 92:1 93:23 98:2 152:20 153:18,25 154:18 175:8 176:25 177:2 178:13 182:19 204:19 222:4 224:8 225:1 237:4 290:7 292:3 baseline 218:18 220:1 bash 2:20 basic 155:6 178:4 basically 211:24 245:16 basiliximab 289:13 basing 143:9 basis 111:21 135:9 144:5 145:17 181:6	182:10 209:4 232:6 243:1 bates 77:8 86:15,16 136:6 147:8,12 173:20 174:17 178:2 180:25 bcg 285:5 bear 71:3 73:6 bearing 95:9 beating 290:4 began 45:20 175:18 beginning 23:12 24:23 27:13 75:6 82:12 122:14 122:16 125:5 136:19 263:4 263:20 begins 119:12 122:19 152:3 behalf 275:6 276:19,25 277:12,22 belief 82:3 believe 7:21,21 7:22 12:6 13:6 38:17 44:8,11 52:10 53:6,25 70:16 157:9,14 273:24 274:4 281:11	believed 51:23 bell 2:10 12:25 115:21 134:15 134:18 136:17 194:7 belllegalgroup 2:11 benefit 178:12 benefits 3:20 171:19 173:15 178:23 benign 87:1 benzene 187:22 187:25 berg 86:12 best 6:17 7:5,23 7:24 11:10 51:18 59:1 71:17 104:18 132:9 188:24 208:21 209:9 218:7,9 219:10 220:22 232:18 250:1,4,20 260:23 280:6 bethune 2:7 better 157:21 188:2 240:11 242:14,16 254:1 268:5 280:3 288:12 289:15 290:21 beyond 61:16 61:18 62:2	255:20 256:1 bias 8:7 bifurcation 273:20,22 big 97:15,19 213:15 240:23 246:8 288:3 biggest 257:4 bilateral 111:23 bill 56:5 64:6 123:6 125:23 billing 3:15 56:16,19 57:18 57:24 58:7 60:3,5 61:12 63:14,24 66:9 114:13,21 115:11,19 119:18 120:1,4 120:8,15,17 125:5 127:7 128:11 bills 114:22 127:1 biologically 227:8 biopsy 148:12 223:2,23 224:19 238:17 bird 132:10 bit 188:2 260:20 278:14 289:23
---	---	---	--

bk 271:22	196:2,22,24	bringing 27:23	180:16,20
black 24:14	202:14 209:22	brought 73:6	204:25 229:3
26:8	209:23 212:16	bu 2:13 3:4	239:19 242:24
bladder 48:1	213:3 233:7	5:18,18 9:18	243:5 247:19
90:25 92:23	273:2	10:10 11:2,17	248:11,15,21
93:14,20,25	body's 273:11	14:2 15:4,8,11	250:12 255:6
95:6,8,8 96:16	boisclair 2:4	16:22 27:25	256:20,22
176:13,14	bold 24:14 26:7	33:17,19 34:5	260:17 262:13
283:4 284:4,13	77:12 84:25	34:21 35:9,17	278:3,12
284:16,17	book 106:7	35:20 36:5	288:18 290:9
bland 223:12	born 203:7,15	37:5 38:2,14	292:8,14 293:3
223:13,17,18	203:18 208:12	40:25 41:5,7,9	293:8
224:1	bottom 23:15	51:13,16 52:2	business
block 289:8	23:24 77:12	56:4 58:22	205:23 206:2
blockages	86:22 140:24	59:11 60:8,18	businesses
271:3	141:20 152:3	61:7,14,21	189:16
blood 195:16	218:2 229:21	62:10,12,15	bypass 234:23
196:11 214:9	263:9	63:1,8,13 64:2	c
222:17 223:5	bove's 134:13	64:5,24 65:12	c 2:1 12:12
227:14 228:13	box 137:2	65:20,25 66:11	214:20 249:18
228:14 233:9	144:20	66:17,24 67:4	250:5,8 270:3
233:21 269:8	brain 170:1	68:1,16 69:5	295:1,1
269:15,18,21	196:21	69:18 71:13,24	c.s.r. 293:21
280:17	break 73:21,24	76:3 77:5,10	cabg 234:20
blue 259:21,24	74:3 212:16	77:15 85:11,25	calculate
board 166:9	261:1 278:4	86:15,18 91:3	218:25 219:15
172:21,25	brief 55:12	91:22 93:1	call 19:16
194:23	57:3,11,17	102:12 105:11	25:12,16,19
boasting 195:5	254:24	113:6,19	56:6 57:8,15
bodies 195:17	briefly 15:5	115:17 120:23	57:16,19,23
215:9	113:24 199:12	123:18 125:19	58:2,10,16
body 22:5	bring 32:25	128:22 139:24	59:4,16 63:9
46:14,14 47:6	71:3 77:1	143:13,19	65:2,3 66:10
49:23 195:9,14	108:6	149:23 156:20	

67:23,25 68:24 98:12 101:6 114:19 123:22 124:17 126:6 210:1 291:14 called 19:21 70:1 87:9 88:1 94:10 96:16 105:17 113:25 136:14 137:2 141:18 144:19 149:21 159:16 190:9 191:1 202:22 203:10 212:14 215:7 calls 60:2 66:6 188:17,19 camille 2:14 5:23 camille.d.joh... 2:17 camp 1:5,21 5:14 61:3,19 62:7,17,20,24 63:12 65:5 71:11,21 72:6 111:21 112:21 112:22 113:16 185:22 186:6 275:20 293:6 294:2 cancer 39:5,24 40:12 41:22 43:10,14,14	47:16,17 75:13 78:20 80:9,12 80:17,21 81:3 81:12,25 82:19 83:20 84:24,25 85:7,15,18,24 86:7 87:6,17 87:25 88:1,5,6 88:11,12,13,13 88:23,24,25 90:12,19,22,24 91:14,21 92:24 93:11,15,20,22 93:25 94:6,23 95:2,4,6,7,8,8 95:19 96:3,10 96:14 97:7,24 106:23 107:14 109:17,22 110:17 111:22 176:10,21 177:10 184:11 185:3,17,17,23 185:25 186:1 186:13 187:6 187:14,23 197:11,17,18 198:7 199:6,8 201:24 236:20 239:18,23 240:8 267:14 267:21 268:2 273:6,12,13 283:4,12	284:13,16,17 cancers 38:22 39:10,15 42:15 42:19 77:23 80:16 268:3 270:24 candidacy 261:9 candidate 44:20,25 45:7 45:16 49:16 153:4 155:11 155:14,21 156:10 158:3 261:23 candidates 264:6 capacity 162:13 168:19 car 281:19 carcinoma 94:25 95:24 96:7,9 97:2,6 97:10 146:23 cardiovascular 158:10,17 235:1,5 257:11 272:16 care 12:8,12,13 21:2,15 22:10 30:1 32:10,12 32:13 35:4,5 36:15,16 40:14 51:9,24 52:10	52:13,19 53:1 53:5,7,12,16,17 53:20,25 54:15 54:23 55:2,9 55:14 56:6 89:15 127:23 156:2,12 161:15 168:4 201:11 243:18 278:24 286:1,5 291:18,21 292:4 cared 148:11 148:13 carolina 1:1,21 2:11 12:8 17:22 18:1 29:3 84:17 199:11 217:25 271:18 287:13 carson 2:14 case 5:15 6:12 9:13 10:2,9 12:2 13:6,23 13:24 15:24 17:7 21:10 27:8 31:11,12 31:16 32:16 33:10 34:3 39:4,8 56:4 68:12 71:1,6 71:10,21,22,23 72:19 73:16 74:10 81:14
--	---	--	---

92:8 109:19	127:9 167:15	cautionary	120:8 159:10
112:12 113:18	272:9 274:9,10	248:25 250:19	159:11,18
113:23 116:14	274:13,14,17	caveats 285:2	162:22 222:12
116:25 118:2	274:17 275:14	291:6,6	232:3 268:5
118:13 119:2,3	275:19,20,21	cc 293:24	certainly 43:10
119:20 123:5,7	275:23 276:1,6	ccr 5:5 295:24	49:18 138:16
123:11 127:2	276:10,15,22	295:24	145:22 226:18
128:17 129:25	277:14,21	cell 80:16	232:11
130:6,17,17	categories	106:25 107:1	certificate
132:15,17	31:20 48:25	146:22	294:1
134:20 135:9	88:5,10 174:19	cells 96:14	certification
138:14 139:22	174:25	195:17 223:25	89:15 194:23
141:5,6,12	category 136:4	center 48:20	certified 1:17
145:18,22	207:3	49:4,9 87:25	1:17 2:25 5:5
164:10 183:21	causal 187:20	88:1,1,2,4,6,12	191:12 295:2,4
185:15 197:15	274:7	88:13,23 89:22	certify 294:15
204:8 205:3	causation	189:12 192:17	295:5,15
206:1 246:14	36:14 113:18	192:21 193:5,9	cetera 31:13
268:9 275:10	185:14 186:21	198:5 217:4,14	124:9 126:19
275:22,23	causative 274:5	276:14,17	159:8 271:9
277:17,19	cause 1:18	279:2	276:1
281:1 284:2	80:21 168:18	center's 88:7	challenging
293:10	185:25 186:13	centers 48:13	266:5
cases 6:12 11:1	221:7 280:2,3	189:1,10,19	chance 79:7,14
12:3 55:1	283:1	191:18 198:18	79:17,23 81:6
60:22,24,25	caused 38:22	220:6 269:6	81:21 82:9
61:4,5,19 62:8	39:4,9 111:22	centimeter	83:19 84:22
62:25 63:12	185:22 199:13	273:21	175:4 215:16
65:6 66:22	causes 187:5	cerebrovascu...	251:7 258:9
69:25 70:17	212:8 221:11	184:25 236:4	289:25
71:9,11,12	224:14,16	241:19	change 54:14
72:2,12 112:12	257:9,12 280:8	certain 1:18	73:21,25 74:2
112:22 113:4	causing 187:13	14:21 32:24	116:23 138:22
115:10 118:15	226:23 287:24	80:3 93:9	139:19 140:3

227:7 283:19 284:11 286:4 294:4 changed 82:17 283:24 changes 212:11 237:20 270:18 270:20 293:12 changing 237:23 283:20 characteristics 281:25 characterize 119:24 246:16 charge 117:18 charging 117:5 chart 144:17 cheaper 211:16 check 237:9 checked 102:10 checks 282:4 chemical 187:5 212:15 215:7,8 chemotherapi... 109:20 110:22 chemotherapy 109:16,18 110:12,18 111:4 284:14 chicago 12:6,17 12:24 chicken 213:24 chief 116:4,10	chinese 220:24 221:18 chloride 187:22 choice 197:25 cholesterol 272:24 choose 101:13 119:24 205:17 206:3 chose 162:23 chosen 207:3 christine 104:6 104:9 chronic 121:15 137:20,23 164:2,5 173:24 176:12,16 183:5 202:8 211:6 213:7 219:1,15 220:19 221:4,7 221:13,14,21 225:18 230:4 242:8,22 255:22 256:2,4 256:15 268:11 269:12 270:9 272:8 278:16 chronologic 262:2 263:13 chronologies 136:16 chronology 3:18,19 136:13	147:6 circulatory 274:23 cite 106:12 145:16 154:20 251:13,17 262:5 cited 153:9 199:3 244:17 244:21 253:14 254:21,24 citing 254:17 254:18 citizens 210:6 city 2:8 civil 277:19 ckd 121:15,17 claim 193:12 claimed 176:14 claiming 185:21 186:12 claims 9:5 82:25 clarification 61:23 clarified 55:24 clarify 240:25 clarifying 110:2 classic 197:16 classical 233:1 clayton 104:7,9 104:25	clear 9:24 37:1 52:16 69:18 80:16 106:25 277:10 clearance 115:14,24 116:12 120:2 120:22 cleared 15:22 client 167:24 167:24 clinic 30:17 188:9,14,15 204:5 237:17 238:22 239:3 278:22 285:19 clinical 24:5 83:18 94:11,17 95:3 122:17 138:25 154:3 165:16 188:6 190:9,25 191:6 191:7 192:16 198:17 210:4 214:16 227:5 243:18 268:23 269:11 278:14 278:20 281:24 clinically 80:13 228:7 clinician 224:25 226:10 230:14
---	--	--	--

clinicians 222:14,25 224:4,24 225:23 226:6	comb 103:15 combination 82:21 209:7 279:4	committed 39:25 committee 48:15	266:16 compendium 136:11
close 23:14 149:5 152:10 198:15 288:10	come 54:13 104:5 142:25 145:19 147:25	common 158:9 198:6 199:25 231:3,12,15,21	competence 43:24 competing 112:17
closed 167:16 174:2	271:5 281:18 289:10	280:6 287:10 commonly 271:16 291:1,3	competitive 181:6 182:10 complete 137:3
closer 276:4	comes 139:1 152:9 165:20	communicate 51:8,14,22	137:5 286:19 completed 134:7
club 106:7,8	166:19 271:5 comfortable 165:5	communication 81:22	completely 250:22 286:25
cmo 10:14	coming 165:6 173:8 209:4	communicati... 28:2 31:25	complex 264:3
coexisting 262:4 263:15	237:9 289:20 292:2	51:16 59:12 65:13,17 66:1	complications 255:15,17
coffee 137:25	comment 7:1 44:19 57:2	66:2,4,25 68:2 68:5,17,20	265:18 267:5 290:1
cognitive 264:4 264:11,25	82:23 188:6 218:22 246:19	69:19,22 72:25 91:7 93:3,6	composition 213:3
267:6	261:13 commented 44:2,6,14	comorbidities 92:22 163:15	compounds 136:1
cohort 252:13 253:23	comments 39:19 45:12,14	164:18 166:6 166:21 233:25	comprehensive 137:23 139:21
cold 250:15 287:5	45:15 146:7,8 261:8 267:12	236:15 279:19 companies 243:12	comprised 48:15
collaborate 90:4	commission 294:24	company 70:1 275:18	concentrations 196:11
colleagues 100:2 190:7	commissioned 179:25	compared 134:23 211:6	concept 186:4
191:3		265:8,12,20	concepts 137:18
collection 144:18			
colloquially 250:21			
column 255:12 263:10 266:23			
266:24 267:1			

concerned 256:9 274:19	286:22	237:25 240:22	17:13 18:20
concerning 14:15,16 29:25 30:3,14 37:21 39:4 52:19 53:8 54:2 55:2 62:24 65:5 75:3 119:15 127:2,9 191:17 267:12	conditions 199:24 262:4 263:15 confer 208:13 confess 193:12 confidential 194:4 confidentiality 34:24 37:4 confirmed 95:23 96:5 confirms 87:3 confused 103:18 192:23 confusion 102:3 congress 113:16 congressional 113:15 conjunction 48:10 connect 178:23 connected 41:4 176:9 177:19 178:7,20 181:23 182:11 connecticut 129:19 consider 47:9 86:6 89:9 94:4 109:9,15 110:3 110:6 235:1	279:14,24 280:25 considerations 282:20 considered 3:16,17 30:4 98:15 99:13,15 99:23 108:1 130:9,16,22,25 131:2,8,12 132:7 134:11 135:8,13 171:9 219:6 220:18 221:3,6 242:10 281:3 consistent 92:10 261:25 262:1 263:12 consult 26:16 35:22 36:11 consultant 61:2 89:3,8 consultation 24:19 25:23 35:25 consultations 26:12 consulted 291:19 consulting 63:3 70:16 contact 11:25 12:2 16:20	19:15 21:8 25:16 55:23,25 57:10 58:1,5 58:14 67:7,14 67:17 68:9 69:10,17,25 116:2 167:23 237:19 contacts 10:6 10:23 11:8,14 contaminated 111:21 contamination 61:4,19 62:8 62:25 63:12 65:6 71:11,21 112:22 contemplating 264:3 content 59:3 139:18 contention 205:6 contents 23:9 23:10,12,16,19 24:8 35:6 131:18 context 224:7 contingent 156:8 continue 244:18

continued 4:1 174:3 232:20	58:23,25 72:25 73:3 91:4 128:24	correct 15:24 15:25 16:4,5 16:21 17:16 18:13 20:23 25:6 26:24,25 41:16,19 45:2 45:10 46:9,23 74:25 75:7 77:9 85:10 87:6,7 106:3 107:7 110:4 119:8,17 121:6 121:7,11 122:14,23,24 123:3 132:1 152:4 162:15 162:18 164:11 164:12 168:22 218:21 229:15 231:9 241:20 245:15,23 249:10,16 252:14,21,22 255:25 264:9 265:23 295:13	287:6 correlate 101:2 231:24 270:20 correspond 169:7 corresponden... 31:25 corresponding 23:15 council 135:18 counsel 5:2,3 34:23 73:20 129:16 215:15 278:4 295:16 295:18 counselor 74:17,23 75:9 78:5 81:6 85:21 86:11 counselor's 81:22 86:3 counting 215:24 countries 211:23,24 country 157:22 194:6,10 195:4 241:3 288:14 county 294:23 295:21 couple 66:15 169:9 203:14 238:22 247:21 248:9 270:17
continues 109:16 122:12 234:4 266:1	convey 80:10 cooper 44:23 132:12,13,16 132:17 152:13 153:10 203:24 205:7,12 240:20 244:8 244:18,22,25 245:25 246:24	cooper's 151:10,13,25 152:6 157:9 coordinated 9:14,25 10:2 coordinating 115:4 copy 77:2 92:9 293:9,12 cora 75:18 116:15 123:24 127:11 134:24 137:1 143:5 144:21,24 145:3,8,9 148:7,7 149:12 286:14 core 206:18 corner 77:13 141:21 217:6 coronary 234:15,16,23	
contract 116:22 117:5			
contribute 272:1			
contributed 128:5			
contributory 274:5,7			
controlled 236:1			
conversation 16:10,11 17:8 18:11,15 20:21 21:2,4,16 22:1 24:25 26:1 28:9,15,24 31:7 32:20 33:8,21,24 34:6,9 35:10 35:11,19 36:8 37:2 38:5,10 56:9 67:21 69:3 82:12 108:23 115:2 169:11			
conversations 10:12 11:19 16:25 31:18 33:8 52:3,6			

276:12 280:14 292:6 course 7:12,14 29:6 130:14 180:18,19 192:14 197:5 278:5 court 1:1,17,20 2:25 5:5 6:1 14:2 37:12 52:16 76:4 207:21 295:2 covered 191:3 covers 191:20 cramping 200:7 create 42:18 194:7 284:6 creatinine 169:15 205:7 209:8,8 210:15 210:15,19 211:7,17 212:2 212:8,11,14,20 213:11,11,16 213:19,22 214:1,4,8,13,22 215:1 216:12 216:13,15,20 218:5,7,17,19 218:23 219:5,9 219:11,13,19 219:24 220:3 223:11 224:20	225:6,9 227:18 227:22 228:1,4 228:9,13,14 237:5,8 242:3 280:16 281:5 291:4,8,11 creatinines 282:3 credo 7:16,18 criminal 277:17,18 criteria 99:7 101:12 critical 32:4 107:13,16,19 107:20 133:15 157:19 175:3 197:2 281:20 critically 195:13 196:21 criticism 42:19 croft 179:13 cross 34:14 35:2 csr 295:24,25 cst 292:17 cure 285:5 current 54:5 78:9,23 79:4,6 79:11,15 80:5 97:3 154:3 156:9 243:11 253:21 282:2,2 286:22 290:23	currently 174:3 178:6 189:2 278:19 curve 194:7 290:4 curves 253:25 cut 81:9 cv 1:5 3:12 5:15 98:24 99:9 cystatin 214:20 cystectomy 284:3 cystitis 176:13 cytopatholog... 88:15 cytotoxic 109:19 110:19 111:4	daniel 86:11 darn 237:5,15 data 3:16,17 7:22 153:25 252:10,15,16 254:12 267:3 279:23 283:15 288:9 290:22 database 75:18 123:25 127:11 127:16 137:1 143:5 149:12 286:14 date 5:11 21:8 25:1 57:19,25 117:23 127:11 144:16 147:10 147:15 148:10 148:14,21 157:4 229:14 236:3 294:3,18 dated 75:21 76:24 86:12 173:11 180:9 180:11,23 229:12,13 dates 30:8 121:17 122:7 148:9 davis 2:7 davita 29:5 200:17 201:1,7 201:9
		d	
		d 2:14 3:1 26:13 250:5 270:15 d.c. 2:16 293:4 daily 212:11 damage 240:1 240:14 damaged 228:12 danger 197:9 212:6 257:5 dangerous 258:1	

day 1:14 66:17 120:6 196:15 213:17,20,21 239:11 294:20 295:22 days 58:1 115:12 218:3 291:11,13 293:16 dbjlaw.net 2:8 deal 28:20 70:15 118:22 156:13 179:3 207:16 258:19 dealing 191:16 282:24 deals 253:3 dear 293:8 death 197:2 257:8,10 274:24 debilitating 200:10 decades 203:14 deceased 241:2 241:5,11 249:1 249:14 251:6 252:6 258:20 258:25 265:10 288:13 december 65:7 65:7,8,10 122:2,4,8 127:12 144:25	179:7 decide 49:19,25 80:2 100:11 291:8 decided 200:23 207:15 deciding 175:3 decision 48:4,8 48:14 49:17 50:20,23,23 51:2 171:18 172:9,13 173:15,22 176:2,25 177:7 177:14 178:13 decisions 50:19 214:16 decker 1:16 2:24 5:5 293:20,21 295:2,24 decks 66:12,15 66:18,18,20 declination 84:10 decline 267:7 declined 83:2,8 83:14,24 84:3 84:8,9,14 decrease 214:2 289:5 decreased 168:19 227:13 235:10 264:4	265:7 266:15 dedicate 192:17 dedric 2:22 229:4 260:7,17 260:24 defendant 2:12 275:7,8 276:20 276:21,25 defendants 5:3 276:14,15 277:1 defense 8:7,16 9:4,15 10:1,3,9 10:25 11:1,7 12:2 17:7 21:9 37:3 61:2 79:22 80:1 129:9,16,20 130:6 149:21 275:12,13 277:12,22 defer 49:16 97:20 208:24 define 223:18 245:4 256:25 defined 256:17 defining 31:23 definitely 19:10 132:12 140:20 148:17 169:11 definition 208:10	defying 287:3 degree 186:20 212:25 271:12 degrees 271:25 delayed 157:18 241:24 287:18 deliberately 82:1,4 delighted 285:24 287:14 demonstrating 273:18,20 denied 62:1 dennis 115:14 115:23,24 dense 134:1 deny 41:5 department 2:15 32:24 59:19 60:1 61:1 172:19 293:3 depend 168:23 169:1 dependence 178:4 depending 202:17 212:11 284:12 depends 179:1 235:24 246:10 284:15 depo 3:13
---	---	--	--

deponent 14:5 77:14 105:15 140:1	describe 20:10 36:7 65:25 199:12 204:18 204:21 222:12 222:15 223:1,4 224:6 234:5 267:19	289:17 291:5 detected 271:6 determination 171:11 183:8 279:25 determinations 171:8 determine 215:12 216:21 249:13 determining 281:11 develop 90:6 281:19 developed 214:20 274:20 development 220:18 device 41:2 dhs 115:17 diabetes 158:10 158:16 159:9 159:13,16,21 159:22 185:1 224:17 230:24 230:25 231:7 232:2,8,12,14 232:23 233:2,4 233:22,25 235:4,15,16,21 236:6,16 241:18 272:16 diabetic 232:10	diagnose 224:25 diagnosed 94:5 167:9 diagnoses 82:19 234:6 diagnosis 92:23 93:14,20 146:22 221:22 223:9 226:4,8 227:5,5,11 228:3 234:5 dialysis 29:5 54:15,20 111:23 151:7 151:11,19 152:19 153:17 154:24 155:3 189:1,10 193:3 193:9 195:24 197:19 198:12 198:13,16,18 198:24 199:7 199:14,19,20 199:21 200:2,5 200:9,10,20,21 201:11,12,14 201:18,20 205:9 267:16 267:22 268:4 275:1 276:11 276:14,16,21 279:2,9,9,13 280:10 281:12
deposition 1:11 5:4,13 14:23 37:13 39:9 57:13 72:21 107:25 108:3,7 108:11,18 109:3 111:14 113:11 126:5,5 126:15 128:12 128:17 129:5 129:10 130:22 170:16,17,21 171:1,5 180:9 243:22 277:5,7 292:16,17 293:9 294:2,15 294:16	described 20:16,20 25:16 25:21 90:24,24 95:6 97:2,9,11 97:12 224:4 275:21 describes 48:24 describing 30:19 57:10 97:8 description 47:12 56:3,11 design 101:21 102:21,22 280:3 desired 293:13 detail 90:21 126:12 141:16 170:19,20 268:14 details 31:4 90:13,20 93:25 95:7 134:4 240:9 detect 79:6,15 270:5,12,18,23 271:1,3 272:22	depositions 30:15 123:9 124:8 125:10 126:18 134:10 134:14,20,22 135:6 depression 167:10 200:13 depressive 173:24 174:2 176:15 deps 293:1 derived 245:7	

281:21,23 282:14,23 283:9 284:25 die 196:4 227:16 249:19 died 275:1 diet 213:10 269:15 272:23 difference 47:18 97:15,20 143:22 149:6 240:23,23 245:3,4 246:8 246:11,13 different 11:7 23:18 29:6,7 30:22 36:24 39:12 42:11 49:21 69:15 82:20 87:15 97:9 104:14,15 135:1 136:1,1 164:16 187:6 195:1 201:8,11 207:24 210:9 211:3 219:17 225:16 233:3 241:22 275:18 280:14 282:18 282:19,19 292:4 differently 163:11	differs 213:4 difficult 116:17 127:10 264:7 difficulty 286:8 dinner 213:15 direct 44:12 95:9 211:19 215:5 direction 295:12 directly 117:5 216:13 281:14 director 190:9 191:1,6,7 192:16,20 198:17,18 278:20 dirty 211:16 disabilities 178:7 disability 165:5 165:23 166:8 166:12 167:5 171:19 177:19 178:7 183:7 disabled 163:12 178:6 disabling 174:3 disagree 10:16 17:2 44:23 45:9 53:18 197:24 disagreed 81:20	disagreement 182:14,19 disappears 232:20 discharged 218:4 disclose 35:19 58:25 66:3 68:4,19 69:21 91:6 93:5 128:23 disclosed 10:2 10:18 27:7 31:10,18 32:7 32:17 33:22 35:12 37:19 63:17 discounting 163:4 discrepancies 149:8 discuss 10:19 95:18 115:14 discussed 34:9 35:24 38:3 45:13 59:10,22 92:23 93:14,18 115:22 238:23 280:25 discussing 56:6 57:19 291:17 discussion 16:18 27:24 58:20 59:24	75:11 106:22 discussions 10:7,23 11:9 11:14 68:11 170:22 disease 24:19 26:12 40:22 54:7 68:25 72:5 87:16 93:24 94:2,3 95:10 97:4 98:10 121:15 137:20,24 158:9,10,14,17 164:2,6 166:10 168:5 175:5,14 176:12 183:5 184:24,25 188:7,16 202:8 206:11 211:6 219:1,15 220:19 221:4,7 222:15,21 223:1,4,8,10 224:3,6,17 225:18 227:17 230:24 231:1,7 232:17,21 233:4,5,10,12 234:3,5,12,14 234:15,25 235:5,6,15,17 235:17,20,21 235:25 236:5,5
---	--	--	---

236:16 241:19	22:25 23:3	163:23 164:24	142:19 151:24
257:11 263:21	38:18 40:21	165:3 166:13	documentation
264:2 269:12	41:12 42:9	168:9 169:20	12:23 30:25
272:16 273:2,3	45:11,23 47:12	172:17 173:3	171:16
274:20 278:16	51:6 55:22	175:15 177:1,7	documents
279:17,22	57:24 59:20	178:25 179:18	30:13,20
280:7,8 282:19	64:9 65:4,19	179:19 183:2	106:24 124:25
283:2 285:8	66:8 67:7 68:7	183:25 185:9	125:6 127:8,19
292:5,5	68:13,22 69:23	186:15,22	130:10 131:19
diseases 87:16	77:17 79:20	187:3 188:5,25	136:4,22,24,25
disfiguring	80:4,19 83:23	194:19 195:8	137:4 142:16
208:1	84:17 86:21	199:3 201:12	163:1 165:4
disorder 167:9	87:8,19 89:9	201:13 202:6	174:25 175:1
173:24,25	89:12 90:15	205:2,15	207:3
176:15 177:6	92:16 93:12	206:21 207:5,9	doing 7:6 40:1
disorders	94:4,9,14	208:3,16,17,25	49:17 61:11
269:22,24	95:11 96:13	217:2,20	62:18 63:11,15
disproportion...	98:11 99:3	220:10 232:19	66:13 107:14
247:7	101:15 102:5	246:7,17	109:23 110:7
dispute 146:9	102:11,17	247:23 248:8	110:12,25
disrespect 7:2	103:1,5,10,19	248:23 254:9	124:2 128:21
distribution	103:25 104:5	255:10 263:3	165:5 185:14
194:5	105:16 106:9	266:19 269:8	207:6 268:5
district 1:1,1	107:21 110:3,6	272:10 290:17	290:3
1:19,20	112:11 120:1	292:11	doj 10:12,13
dive 146:1	120:17 122:20	doctors 35:2	20:14 51:16
divide 247:14	124:19 125:3	47:11 48:25	58:23 59:13
247:15	125:23 127:17	50:12 67:15,18	60:6,11,17
dividing 245:8	128:6 131:3,5	88:23 106:8	61:6,11,13,25
diving 165:11	135:12 136:3	169:4 179:4,8	62:18 63:11,18
division 1:2	137:6 140:17	282:19 287:14	63:19 64:19
193:7	143:23 145:15	292:7	65:13 66:10,25
doctor 7:9 9:21	147:22 150:2	document	67:24 68:2,17
14:8,13 15:14	152:1,14 154:5	82:18 131:7	69:20 71:15

91:4,9 93:3	19:22 20:2,5	65:12 67:8,8,8	205:12 216:11
109:7 110:1	20:16,21,22	67:21,21 68:9	218:16 229:10
114:3 115:2,13	21:1,2,4,14,24	68:9,14 72:15	236:22 240:20
115:24 116:14	22:2,18,22	72:16,16 73:1	243:21 244:2,8
116:21 117:5	23:10 24:11,20	73:1,1 74:8	244:18,21,25
117:11 123:21	24:21,25 25:1	76:3,21 77:10	245:25 246:24
124:1 128:24	25:15,19,20,22	87:12 89:18	261:6 262:13
129:6,7 130:2	25:25 26:13,13	91:3,22 92:19	268:8 278:13
131:24 133:22	26:15,17,18	92:20 93:1,7	292:8
286:8 292:14	27:3,4,6,19,25	93:12,18,19	draft 138:9
doj's 37:7	28:15,15,24,25	96:23 98:21	drafts 21:22
don 67:1	31:8 32:6,10	105:11 106:12	drain 284:8
donated 216:22	32:11,14,16,19	106:18,23	drop 227:16
donating 250:9	32:19,22,25,25	107:9,10,13,24	dropout 222:22
donor 90:3	33:2,3,4,14	108:7,11,17,24	235:13
241:2,5,11	34:4,11,18,18	109:2,9,13	due 82:19,21
249:1,6,9,13,19	35:2,12,21,23	110:5,11	95:19 157:17
251:6,11 252:7	35:23 36:10,11	116:20 120:11	173:25 181:22
258:20,25	36:12,18 37:14	120:15 123:19	182:10 197:17
265:10 272:6,8	37:18,20,25	126:5 127:23	197:18 201:24
288:13	38:4,8,11,15	127:25 128:2,7	222:16 236:19
donors 249:14	39:22,22 42:9	129:13,25	255:14,22
douglas 179:6	43:8 44:23	130:1,1 132:12	256:4
downgraded	45:12 51:6,22	132:13,15,16	duly 6:4 295:6
86:25	51:22 52:8,9	133:24,24	duncan 1:11
dozen 276:3,4,5	52:10,19,21	134:5,13	5:13 6:3 24:21
dr 3:13,15 5:13	53:12,15,18	139:25 149:23	26:18 35:23
6:9 10:11,22	55:20 56:10,10	151:9,13,24	293:9 294:2,15
11:17,24 13:3	56:15,15 57:2	152:6,13	294:18
13:10,22 15:18	57:2,11,11	153:10 156:1,6	duration
15:23 16:4,7	58:1,2,5,15,22	157:9 164:6	154:20 157:11
16:11,18,20,24	59:11,16,22,23	167:7 179:6,7	157:20 241:1
17:8,8,13,18,25	60:8,18 61:24	179:9 180:15	dysfunction
18:10 19:13,20	63:24 64:25	203:24 205:6	204:10

e	effective 174:5	electronically 92:7	enclosures 293:24
e 1:15 2:1,1 3:1	effectively 195:25	elevated 249:7	encounter 75:3
12:12 216:16	effects 199:22	eligibility 178:4	encourage 271:14
295:1,1	199:24 200:6	261:9	endogenous 212:15 215:7
earlier 56:25	208:23	eligible 44:24	endorsed 33:1
240:11 274:8	effort 7:5 9:14	else's 143:9	217:13
early 64:6	9:25	email 10:7	ends 79:7
96:24 154:1	efforts 115:13	11:15 116:19	england 103:11
157:19 220:11	115:23 120:2	emailing 116:13	103:20,22
262:19 271:1	egfr 291:1,3,10	emails 10:24	243:16 246:21
272:22 273:18	291:14	emanate 143:25	247:25 248:5
273:20 284:17	eight 119:14	emergency 190:10	258:14 291:23
ease 14:24	237:21 247:9	emotional 181:23 267:20	enjoy 166:17
easier 14:21	either 6:16 23:4	emotionally 267:13	208:14
east 217:24	25:13 38:19	employability 3:21,22 174:23	enjoyable 163:6
eastern 1:1,20	43:17 47:1	176:4	enjoying 165:15
easy 284:21	66:5 117:8	employable 183:17	enrolled 164:15
290:2 291:4	123:16 126:22	employee 295:16,17	enrolling 83:2
echogenicity 270:19	132:10 137:9	employer 198:8	83:8,24 84:8,9
economy 182:9	139:1,10,12	employment 36:19	enrollment 84:14
edit 139:15	151:20 159:21	enabled 112:20	entering 56:20
editing 122:9	159:24 191:16	enclosed 293:9	entire 20:11
122:16	205:8,9 208:11	293:10	50:16,23
educational 178:4	234:17 258:13		144:21 208:8
effect 57:4,12	258:18 264:15		222:22 284:3
166:3 198:6	269:25 270:21		entirely 107:6
200:4 204:22	271:3 272:16		137:12,13
208:20,21	279:8 280:10		177:1 178:20
227:6 233:22	elderly 266:25		
235:19	267:4		
	electrolyte 196:10,20		
	269:22,24		

217:16 232:20 entitled 171:19 174:4 247:13 entitlement 175:23 176:3,5 176:18 entity 192:22 275:3 entries 23:20 65:8 119:18 142:23,25 entry 23:16 56:5 58:2 61:12 64:18 121:4 124:12 124:12 127:18 environment 177:21 environmental 82:22 220:17 220:23 221:2 276:8 eo 63:15,21,25 64:7 65:5,9,10 66:21 122:3,5 122:5 epidemiologist 184:3 186:9 episodes 157:15 174:2 287:19 equal 54:7,9 213:23 247:14	equally 150:15 equation 280:5 280:6,13 282:25 equations 280:22 equipoise 112:13,15 era 253:1,3 254:16 errata 293:11 293:13,15 error 105:8 errors 139:16 escalated 115:17 120:23 especially 237:18 259:16 272:15 273:14 espousing 8:11 essentially 270:23 estimate 163:18 210:24 211:18 214:13 216:17 estimated 218:25 219:14 290:23 291:15 estimates 245:5 285:17 estimating 211:7 212:1	estimation 214:25 225:11 et 31:13 124:9 126:19 159:8 271:9 276:1 ethically 71:4 evaluation 3:21 23:23 90:1 173:23 174:24 179:25 180:1 181:14 239:5,7 266:24 evaluations 90:3 events 276:11 eventually 111:24 115:17 120:22 203:4 227:18 235:11 everybody 163:19 166:19 211:10 evidence 7:24 83:6 161:23 171:9 174:16 175:1 178:5 224:12 283:20 283:21 292:3 exact 56:21 126:12 226:10 230:13,15 exactly 29:21 60:2 114:9 124:2,11	132:11 197:8 249:20 exam 193:15,25 examination 3:2 6:7 171:25 177:18 278:11 examine 35:2 examined 1:12 examining 7:22 34:14 example 44:3 47:15 73:10 135:11 154:21 166:4,23 168:3 197:16 221:2,5 261:11 265:9 excellence 209:1 excellent 54:11 157:14 204:2 exception 33:16 63:14 exchange 10:7 10:7 exchanges 10:23 11:9,15 excluded 266:3 266:7 excuse 30:10 87:21 131:24 179:9 212:7 224:3 226:23 251:11
--	--	---	--

exhibit 14:3,4 14:11,14,15 23:1,2,5 26:4 27:3 76:5,6,18 76:19,22 98:22 98:25 99:1 108:8,11,13 120:12,13,14 130:22 131:3,8 131:9 140:22 141:2 143:2 144:2,11 147:25 172:11 172:13,14 173:4 180:9,11 190:13 228:23 229:2,6,7 248:3,6,7,13,18 258:15 262:24 263:1,2 exhibits 3:6 4:1 13:25 14:1,14 22:20,24 31:10 130:18,20 137:7 140:12 140:14,18 141:11,21 142:24 144:3 145:5,20 146:5 149:1 180:5,7 180:13 217:3 exist 34:24 155:4 160:23 160:23 182:15	226:11 289:13 289:19 existed 18:18 231:1,7,8 existence 33:21 34:6 existing 182:8 exists 213:8 235:21 exogenous 215:8 expectancy 160:20 expectations 218:10 expected 32:9 157:20 160:8 240:17 241:11 242:15 243:23 expense 211:14 experience 43:23 72:11 200:2,9 278:15 experienced 265:17 267:15 267:20 experiences 73:7 expert 12:2 16:3 17:6,12 18:12 34:25 39:3 54:25 60:6,7,16,17 61:2,13 63:3,8	64:10,17,19,22 64:23 67:9 69:3,4,17 70:4 70:16,21 72:17 73:2,13 113:24 123:4 126:18 130:2 131:21 132:2,6 145:13 171:24 172:4 179:22 181:15 183:21 186:25 206:13 207:8 208:24 274:15 275:6 276:2,24 277:6,11 expertise 9:9 9:10 40:5,8 42:1 80:24 93:24 107:16 188:7 265:5 experts 9:15 10:1,9,13 11:1 11:7,13,20 16:20,25 21:9 21:9 24:20 26:13 28:2 31:19 32:3,6 32:18 33:11,25 34:13,15 37:3 51:17 52:4,6 58:24 59:13 67:7 68:3,18 69:20 91:5 93:3 129:8,9	129:24 130:5 131:23,24 133:9,22 265:25 expires 294:24 explain 153:10 202:23 268:20 explained 22:1 110:11 explanation 43:16 exposure 185:24 187:10 187:18 exposures 186:5 220:17 221:3 express 8:20 161:16 162:24 204:24 expressed 9:16 41:20 162:16 203:24 217:8 expressing 20:8 expressly 5:8 extend 252:18 extensive 16:14 29:17 extent 31:17 61:15 65:16 69:1 101:7 128:22 145:18 277:21 283:12 284:13,16
---	--	---	--

extractions 137:3 extrapolate 290:22 extremely 44:17 290:3	225:16 226:23 230:23 231:6 231:11 233:14 248:25 250:18 250:19 279:14 280:24 282:24	144:8 163:21 168:17 228:15 fairly 56:23 137:22 169:15 231:12 282:6 fall 129:19 221:21 falling 220:2 falls 247:17 familiar 87:8 141:9 149:9 186:17 198:19 198:21 199:8 family 82:19 179:9,11 far 153:1,3 283:13,20 287:3 288:8 290:2 fast 134:25 155:2 fasting 272:13 272:25 favoring 112:18 features 158:22 223:22,24 february 116:21 122:13 122:14,21,23 123:13 124:12 124:19 125:6 126:25 127:6 180:12	fee 106:1 116:25 feel 186:18 200:10 244:19 268:20 feelings 208:2 feels 140:25 fees 105:18 fellows 279:6 fellowship 47:3 269:3 278:18 felt 163:2 175:3 207:25 286:10 fibrosis 223:16 field 87:15 186:18 187:20 188:2 fifth 84:24 188:11 233:8 245:18 251:5,6 figure 246:22 251:17,18,22 251:24,24 252:1 254:11 255:5 258:13 258:13,24 259:20,22 290:15,19 filed 73:8 92:6 92:8,14 98:6 files 286:18 filings 112:6 fill 190:9
f	facts 3:16,17 7:21 8:25 9:3 186:4 281:24 faculty 99:12 99:18 100:4,7 100:15,22 101:7,8,24 102:5,9,19 103:2,6 104:17 105:5,17,21 fail 150:10,19 151:6,11,18 152:18 153:9 153:16 154:11 154:13 155:2 242:8 244:17 failed 116:18 247:12 failing 240:18 failure 154:2 156:9 272:1 280:5,13,21 282:25 287:2 fair 6:23,24 8:2 19:25 22:16 24:6,6 71:1,6 81:18 87:18 90:6 133:7		
f 104:17 295:1 facility 191:4 191:21 fact 8:13,22 37:22 47:25 84:2 87:24 93:21 94:25 101:17,24 102:1 131:17 132:8 145:16 147:1 150:24 152:9 162:9 176:21 177:9 195:11 199:3 231:15,20 236:14 242:20 244:11 248:16 266:2 factor 159:24 185:25 221:4 239:17,23 240:1,7 261:9 factors 82:22 154:1 184:10 184:11 185:3,6 185:16 214:7			

filter 196:13 209:17 228:12 filtrate 196:15 196:16 filtration 209:11,14 210:10 291:15 final 28:19 48:3 50:20,22 51:1 finally 144:20 273:5 286:15 financial 24:4 financially 295:18 find 85:6 94:13 104:11 134:25 136:7,8 165:17 194:3 211:11 223:22 280:2 282:12 283:7 286:17 293:9 finder 70:5 113:24 finding 134:22 168:10 181:10 181:17 226:9 230:15 231:3 231:10,12,16 231:18,21 233:11,15 findings 148:9 182:15,19 229:23 233:2	fine 19:19 77:20 84:16 115:1 175:12 264:24 finish 91:23 105:13 139:25 250:12 255:7 finished 45:17 92:3,6 finishing 98:2 first 6:4 12:9 16:19 20:5 23:10,22 24:2 26:14 27:11 31:21 36:4 78:21 83:9 85:14 90:9,15 109:11 110:8 114:21 116:24 118:8 119:6,13 120:17 123:6 123:10,15 127:14 128:9 136:10,20 137:1 143:4 145:25 151:4 158:8 168:23 174:22 175:25 177:17 178:3 182:2 183:22 195:11 201:15 205:18 219:18 220:24 242:12 242:13,21	246:23 247:8 247:12 251:2 255:13 256:1,4 257:18 258:8 259:2,7,8,25 260:3 263:7 264:9 270:18 273:23 275:2 277:6 280:1 288:25 295:6 295:10 fish 213:24 fit 9:4 five 23:19 29:7 57:15,25 179:14 182:12 215:23 247:8 259:2 260:4,13 265:12 280:11 281:23 289:2 floor 1:16 flourish 164:5 flow 235:10 fluids 209:15 fmc 190:17 focus 206:10 focused 127:14 242:4 267:3 focusing 169:5 175:13 foia 115:16 folder 76:1 folks 203:7 231:14 259:25	270:7,8 271:23 273:9,12 follow 7:19 86:6 176:8 273:16 287:16 followed 29:5 66:7 242:1 255:17 following 7:24 152:5,9 follows 6:6 268:14 fontana 230:5 footnote 262:6 foregoing 294:15 forget 276:16 form 9:18 10:10 16:23 31:24 61:7 68:1 69:14 71:13,24 102:12 113:6 113:19 123:18 125:19 140:19 156:20 166:2 167:23 204:25 222:20 239:19 242:24 243:5 247:19 256:20 256:23 274:25 290:8 format 25:11 141:14,19
---	---	--	--

142:15,19 144:19 145:24 149:10 formats 144:15 forms 165:23 280:6 forth 72:21 145:10 295:9 fortunately 224:22 forum 292:2 found 38:22 70:20 73:4 94:6,24 96:22 282:2 foundation 73:15 85:11,25 290:7 four 11:11,13 22:22 24:24 29:6 30:22 36:6 37:21 118:21,22 119:4 149:19 171:2 182:12 193:18,24 194:10,13 195:4 234:17 234:20,24,24 237:20 250:3,3 253:1,23 254:16 278:23 278:24 287:7 287:11 289:8	fours 260:6 fourth 77:20 251:5 frailty 264:5 frank 23:23 94:11 136:22 183:3 frankly 196:22 fresenius 189:1 189:9,17,19,20 189:20,22 190:2 191:9,17 192:24 front 14:8 37:18 99:3 166:2 251:19 281:25 fryar 55:1,14 fryar's 36:16 55:7 fsgs 203:10 full 24:7 68:25 83:1 139:21 144:20 163:6 178:23 181:6 182:9 217:22 226:19 284:2 function 54:6 54:12,19 98:9 107:23 157:15 157:18 169:7,8 175:4,14 177:20 195:18 195:20 196:3	202:20 205:6 206:10 208:2 208:22 209:1 227:19 228:5 228:11 231:25 237:4,15 241:25 242:2 269:10,22,23 270:20 283:16 284:10 286:2 287:17,19 288:5,11 290:25 functional 40:22 168:19 240:18 257:8 264:5 268:6 269:9 functioning 39:17 40:13 42:15 164:7 169:16 195:23 196:1 204:3 fundamental 210:4 funding 116:22 further 265:16 278:2 289:2 292:10 295:15 future 44:21 52:25 53:5,8 53:16,21 54:1 54:6,14 55:15 139:8 150:14	155:12,20 156:8,10 158:4 160:24 161:5,7 161:14,14 162:3 175:4,14 203:24 206:11 242:23 268:21 279:10,13,18 281:13 282:14 283:9 284:25 291:18 g ga 262:5 gabaran 126:6 gainful 176:8 gallons 196:14 garand 2:14 garbarini 74:24 75:22 76:9 78:4 126:6 gender 212:24 280:19 gene 75:11 78:18 79:24 82:20,24 83:8 83:15,25 85:5 86:25 general 33:16 72:5,7 119:21 120:5 121:1,5 121:8,9 124:5 124:7,10
--	--	--	--

126:16 137:18 174:1 243:15 251:4,12,23 252:4 269:4 272:17 generalization 280:4 generalizations 72:1,4 generally 62:11 63:13 187:13 203:2 245:5 276:13 generic 125:7 genes 78:15 82:20 83:2 genetic 74:17 74:22 75:8 78:5,13 81:5 81:21 82:21 85:21 86:11 geneticist 12:7 17:14,20,21 20:22 55:24 58:3,5,11,21 59:7,16 86:12 genetics 76:2 85:7 genitourinary 88:1,13,23 genome 83:1 gentle 287:21 georgetown 2:11	germane 43:6 205:22 206:15 getting 41:1 116:11 125:2,3 149:13 154:18 166:12 170:22 196:18 205:24 208:12 209:21 213:5 232:11 237:12 250:20 271:18 288:2,9 290:20 gfr 209:11 210:1,3,10,18 210:20,23,24 211:2,7,11,12 211:18,18,19 211:25 212:1,9 212:21 214:13 215:13 216:14 216:15,16 218:25 219:14 219:20 225:10 225:17 give 73:9,16 109:17,21 110:17,23 135:11 137:19 141:17 153:14 155:7 156:17 161:25 165:17 165:19 166:22 168:12 205:25 269:6 285:23	given 114:10 137:16 182:20 186:22 209:17 214:8,9 219:19 266:13 295:8 295:13 gives 219:25 giving 63:2 178:22 185:13 186:24 gleaned 187:16 global 163:18 231:24 292:2,5 glomerular 188:7,16 209:11 210:10 291:15 glomeruli 209:16 222:24 227:14 228:11 233:2 235:12 glomerulone... 255:19,23 glomeruloscl... 101:2 go 9:20 11:24 14:22 15:11 28:6 32:15 40:10 50:10,15 54:17 56:1 62:13 65:22 94:12 98:5,5 127:15 133:3 133:20 140:7	145:13 148:12 153:10,17 155:3 157:25 165:4,11 166:16 172:4 173:18 174:15 177:25 180:20 190:6,8,8 197:19 200:23 203:2 206:18 213:14 216:1,4 218:12 219:4 244:11,11 248:11 250:23 251:17,25 253:4 256:24 260:3 268:13 268:15,18 271:4 272:4 279:2 282:25 286:1,16 287:15 288:17 289:1,5 290:16 goals 279:20 goes 32:1 36:12 50:10 98:17 110:21 197:11 232:19 237:1 249:23 252:20 255:20 257:7 going 6:22 9:18 10:10 16:22 32:25 35:4 37:10,24 38:13
--	--	---	---

44:15 51:13 52:2,8 59:13 59:20 60:11 61:14 63:6 64:9,24 65:15 68:1 75:20 77:15 80:3 86:13 93:4 112:5 123:23 128:24 132:25 134:25 135:22 140:5 142:13 143:14 144:12 145:10 154:10 155:1 157:25 158:18 159:5 168:1 173:2 174:14 186:19 203:4 205:3,20 206:4 207:15 210:1 214:23 214:24 215:2 217:19 220:8 241:17 256:22 257:7 260:19 262:12,15,21 282:23 283:12 285:8,22 286:1 288:7,25 289:23 gold 211:4 golkow 293:1 golkow.com 293:1	good 14:10 44:25 54:20 87:3 99:5 153:4 155:10 155:14 158:7 158:21 161:24 169:16 195:2 204:1 219:7,25 220:1,4,12 225:12 228:4,5 231:17 237:6 237:15,19 250:9 261:22 272:2 283:17 284:5 287:17 288:1,10 291:16 googled 102:6 gosh 232:3 284:1 government 206:17 207:4 gradation 104:21 grade 95:23 96:6 106:25 201:24 250:8,9 graded 104:25 grades 104:16 250:4 gradually 223:14 240:12 graduate 204:5 237:17 285:19	285:24 graft 157:18 220:13 234:23 241:25 244:9 246:22 252:6 252:12,24 253:13,18,22 254:12 255:14 255:16,22 256:3 257:8 258:7,10,19,23 258:25 259:4,8 259:14 260:2 272:1 286:21 286:23 287:18 290:10 grafts 251:7 258:18 grammatical 139:16 grant 82:10 granted 174:5 176:6,18 178:5 graph 194:7 252:10,25 254:18 258:16 259:12 289:8 graphs 290:20 great 7:8 28:20 70:15 110:1 119:20 163:2 250:11 288:8 greater 163:12 235:22 258:19	gross 170:23 239:1 grossly 35:7 group 2:10 5:21,22 6:11 50:11,23 56:6 57:19 58:2,10 58:16 59:4 65:9,10 66:7 67:24 89:3 100:9 103:14 122:3,5 190:8 191:14,20 253:10 287:13 grow 240:14 growing 80:15 guess 7:16 69:12 81:10 98:22 117:24 144:9 188:12 193:19 224:15 240:10 278:18 279:23 285:1 guideline 263:10 269:4 291:20,21 guidelines 86:7 243:18 291:19 292:3 guys 140:4 h h 268:16,20 273:7
---	---	---	--

habits 213:10	197:4 239:15	health 40:14	heavy 182:7,8
half 50:12 81:9	239:16 256:3	76:7 150:14	hell 198:23
200:13 234:1	257:15	158:7 164:16	help 7:23 22:14
245:21,21	happy 10:18	177:5 178:20	114:14 116:16
263:22 276:3,5	13:8 21:12	178:24 187:12	116:19 138:8
halfway 26:8	31:15 33:12	205:4 208:23	269:16 272:4
74:15,15 78:6	139:2 140:5	208:24 210:5	272:22
244:15 245:20	147:1 156:3	282:18 283:22	helping 50:18
252:20 255:12	185:9 287:15	healthier	helps 202:23
267:2	287:17	158:18	hematuria
hallmarks	hard 199:1	healthy 42:20	170:23 176:13
270:10	267:25 268:1,4	158:12 209:23	239:1
hameed 179:7	harder 40:17	261:22	hemodialysis
hand 77:13	202:18	hear 9:21 15:7	156:2,7,13
141:21 198:22	harm 199:13	15:20 18:14,17	200:16,25
198:23 217:5,6	199:13,13,16	18:22 19:6	201:6
255:12 263:9	231:22 232:23	63:22 91:8	hepatitis
266:22 267:1	235:22 240:7	143:17,21	249:18
295:20	harmed 228:12	147:19 160:16	herb 220:24
handing 22:25	harmful 187:12	174:11 230:18	221:19
131:3	205:25	268:1	hereditary
happen 54:10	harms 235:4	heard 19:10,14	75:12 78:19
139:7 144:23	harry 154:20	20:10 73:12	80:8,11,17
233:5,6 256:2	179:12 243:16	90:23 91:1,2	81:2,12,25
256:17 285:8	253:10 290:19	116:24	83:19 84:23
happened	291:23	hearing 179:18	85:17,23
32:20 71:20	harsh 199:20	heart 170:1	herron 154:20
163:25 172:2	head 58:6	224:17 230:24	243:16 253:10
210:8 220:9	116:6 193:6	231:1,7 232:17	herron's
happening	240:10	232:19,21	290:19 291:23
208:14 221:23	heading 25:21	233:6,9,10,21	hey 237:22
272:21	26:7 84:25	234:3,5,12,19	high 95:23 96:6
happens	266:12,23	235:15,16	194:24 201:24
161:22 169:8		236:15 273:3	205:8 222:17

223:5 271:25 287:5 higher 194:12 227:18,21 228:1,14 245:11 257:7 259:8 287:1 highest 288:25 highlight 100:12 103:17 highly 57:15 212:10,21 213:17 214:21 233:11 hilby 26:16,21 27:4 28:16,25 35:22 36:10 hipaa 167:22 hired 69:24,24 70:25 71:2 72:9 112:11 113:23 114:23 115:7,9 123:14 hiring 114:3 histopathologic 226:8 227:4,11 228:3 histopathology 222:8,19 224:16 226:12 history 77:22 94:11,17 95:3 238:21,23 239:3,10,17	hit 281:19 hla 271:20 272:5 hold 180:16 holidays 145:1 home 201:14 201:20 269:15 honest 8:2 81:4 81:7 114:17 168:12 honestly 64:21 71:3 honor 99:13,15 99:16,23 101:7 101:8 102:16 honors 98:12 98:15 99:8,10 hope 7:3 36:25 149:7 161:21 hoped 274:24 hopefully 137:22 horrible 54:13 hospital 142:5 201:2,5 274:22 275:10 276:14 278:25 279:1,7 hour 57:21,23 115:18 117:1 117:14 118:3 121:5 200:12 205:25 260:10 hours 1:13 118:13 120:6,9	121:1 122:22 124:20 128:13 191:25 192:3,8 192:11,12,18 192:18 193:1,8 200:13 206:7,7 206:7 215:22 215:23 250:15 260:10 huge 75:17 194:7 246:12 246:16 286:14 286:18 huh 74:19 77:25 99:21 120:24 225:7 human 12:7 20:22 46:12,14 48:2 49:23 80:16 170:8 183:3 187:12 195:9,14 hundreds 29:1 29:9,14 hydroureter 230:5 hyperfiltering 203:8 hyperfiltration 202:23 203:6 237:14 hyperkalemia 270:1	hyperlipidemia 272:18 hypernephritis 270:7 hypertension 184:17 249:18 hypertrophy 202:25 203:6 237:14 hypothesis 81:11 i idea 18:24 80:3 171:4 279:19 ideal 266:5 identical 118:9 119:6 identified 10:1 17:7,20 54:25 60:16 66:10 74:10 88:6 126:9 128:1 130:11 187:11 identifies 26:23 33:5 48:24 107:10 108:23 identify 11:12 19:17 53:16 56:9,13 72:19 172:19 210:10 234:11 248:20 identifying 36:13 225:10
--	---	---	---

ignore 264:13 264:15 ignoring 264:18 ileum 284:6 illness 54:13 213:7 imaging 223:14 immediately 289:12 immune 257:16 257:19,22 273:10 287:23 immunologic 266:2 immunosupp... 258:5 271:24 immunosupp... 157:17 257:24 271:13 272:11 immunosupp... 266:5 immunothera... 110:22 immunothera... 109:20 impact 204:11 204:21 207:18 207:19 impacted 179:6 179:15 impacts 160:20 160:23 177:19 204:13 206:23	206:25 207:11 impairment 264:4,12,25 impairments 182:11 imperfect 280:7 implication 61:24 important 7:10 7:15 168:4 195:13,19 196:6,21,23 206:8 262:3 263:14 269:6 impression 42:18 improve 253:22 improved 218:5,6 improvement 279:7 improvements 253:24 254:2 improving 289:10 292:5 inability 177:9 208:13 inaccurate 148:14,21 225:11,15,24 230:14	inaccurately 224:5 inappropriate 214:16 incidence 273:13 include 65:16 93:21 97:23 138:13 160:1,5 249:17 280:18 included 22:10 56:15 59:22 75:10,18 106:22 including 29:3 36:14,14,15 50:14 52:12 61:4 66:11 115:15,16 119:22 128:17 147:10 174:22 220:17 222:23 234:13 236:2 240:7 264:4 271:9 inconsistencies 148:25 incorporate 279:18 incorporated 28:19 incorporating 122:17	incorrect 45:3 increase 213:16 213:19,22,25 218:19 220:5 increased 265:20 273:13 increasingly 280:23 incredibly 200:8 indefinitely 203:3,5 independence 267:7 index 4:4 228:25 229:2 249:10 indiana 18:6 101:1 indicate 124:20 127:7 128:5 216:16 223:23 259:13 293:12 indicated 111:8 179:5,14 indicates 24:24 25:22 27:3 84:4 85:16 114:7,13 128:12 239:15 240:19 indicating 131:18 193:17
--	---	---	---

indirect 214:25 indirectly 211:17 individual 71:2 72:9 156:24 163:16,24 165:1 174:4 175:23 176:3,5 176:19 235:12 291:7 individually 113:4 induction 289:11 industry 36:20 162:14 inexact 228:8 infection 269:9 270:21 281:20 infections 157:16 257:14 258:2 267:4 270:12 infectious 265:18 inferior 287:8 inflammation 221:12 influence 94:1 214:7 266:13 influenced 8:6 8:10 98:8 212:10,10,22 214:21 225:16	information 24:5 32:5 43:19 54:16,18 57:7 75:15 93:10 98:3 113:10,13 122:17 134:23 138:25 174:20 178:13 244:25 245:25 283:11 initial 75:9 87:4 112:6 initially 287:2 injected 215:8 innovations 90:6 inputs 280:12 inside 231:7,8 insomnia 173:23 176:15 237:25 238:7 institute 149:21 institutionali... 211:25 institutions 29:7,8 30:22 31:2 50:13,14 instruct 28:1 37:25 38:13 59:14 60:12 61:14 64:24 65:15 93:4 128:25	instructing 62:3,5,15 67:2 69:18 instruction 11:3,17 52:3 60:18 65:20 66:24 68:16,22 69:5 93:1 insurance 197:6,13 intake 214:3 intelligence 137:8 intend 31:7 32:15,18 intention 39:22 39:25 intentionally 8:25 9:3 interest 100:12 interested 295:19 interfere 143:15 internal 179:8 194:25 international 187:4 internationally 187:7 internet 104:7 interpretation 22:2	intervention 234:17 interview 24:5 intro 122:9 introduction 119:13,21 121:16,16 123:12,15 125:8,12 126:3 137:11,15 251:4,12,23 252:5 introductory 119:7 243:15 inulin 215:10 invitae 75:10 126:4 invites 20:14 invoices 56:2 120:11 involve 62:7 involved 46:25 50:17 59:23 63:25 66:21 68:8 81:14 88:24 89:2,2 100:17 145:12 274:12 276:18 involvement 19:1 65:4 116:14 involves 47:21 62:20 209:20 264:3 292:6
--	---	---	--

involving 49:3 49:8 50:5 60:22 61:19 71:21 ipad 41:1 iron 230:5 ischemia 235:11 250:15 250:16 287:5 ischemic 227:15 ish 191:25 island 2:5 isolation 170:8 issue 183:1,2 202:3 238:1,4 242:6,9 issued 180:1 183:14 286:11 issues 63:4,5 71:5 72:12 164:16 167:10 175:19 179:3 183:6 185:11 185:16 191:17 255:15,17 256:16 264:3 264:14,18 266:2,24 269:9 itching 200:8 item 114:21 115:11 190:16 248:2	items 22:3 30:1 iterations 280:15,18 j j 2:13 293:3 jackson 115:16 jama 4:2 january 99:22 122:13 127:13 174:24 179:23 180:1,10,23 181:14 jayaram 3:14 106:12 107:9 108:12,25 109:13 110:6 110:11 243:21 jayaram's 106:18 107:24 108:7,18 109:3 244:3 jenkins 179:7 job 1:25 7:5 115:6 170:5 288:1 johnson 2:14 5:23,23 johnstone 1:11 5:13 6:3,9 10:11,22 11:18 11:25 16:24 17:8 24:11,21 26:13,18 27:25	32:11,19,25 33:2,15 35:23 36:12 37:20,25 38:4,11,16 52:10 55:20 58:22 59:11 60:8,19 61:24 64:25 65:12 74:8 76:3,22 77:10 87:13 89:18 91:3,22 93:2,7 105:11 116:20 123:19 129:13 139:25 149:24 156:6 164:6 167:7 180:15 216:11 229:10 236:22 261:7 262:14 268:8 278:13 292:8 293:9 294:2,15,18 johnstone's 3:7 3:8,12,15 13:22 22:23 34:19 37:14 63:24 98:21 120:11,15 join 67:23 68:23 joint 189:13 jonathan 86:11 jones 2:7	journal 103:11 103:20,22 104:12 105:10 106:7 243:16 246:21 247:25 248:5 258:14 291:23 journals 243:3 243:3,11,12 judge 186:20 187:18 judged 242:2 judging 100:18 judgment 111:20 julianne 86:10 july 218:8 293:2 295:22 jump 168:7 jumped 132:24 june 1:12 5:11 64:15 106:14 106:19 107:4 108:24 293:10 justice 2:15 32:24 59:19 60:1 61:2 112:23 113:17 293:3 justify 35:1 k kansas 2:8 48:20 49:4,8
--	---	---	--

87:25 88:12	40:20 41:22	169:5,6,8,10,15	211:5,6 216:21
89:21 188:18	42:15 43:14	169:16,20,22	217:23 218:15
188:25 189:7	44:21 46:11,12	169:25 170:7	218:17,23
189:11,15	47:11,15,22	175:4,5,8,13,14	219:1,12,15,20
192:16,21	48:1,19 49:20	175:18 176:10	219:21,22
193:4 198:4	50:9,12 53:2,9	176:11,12,12	220:2,19 221:4
217:4,13	54:6,6,11,15,19	176:21,22	221:7,15,20,20
278:20 295:5	68:25 72:5	177:1,10,10	221:23,23
katie 74:23	87:15,16 88:5	178:15,16	222:13,15,21
75:22	88:11,24,24	179:5,15,18	223:1,2,4,8,10
kdigo 291:21	89:16 90:24	182:22,24	223:10,23
292:1	93:23 94:1,3,6	183:2,4,5,6,8	224:2,6,19,19
kdoqi 243:17	94:24 95:4,6,9	184:11 185:3	224:21 225:6
269:4	95:19,22 96:3	185:16,18,25	225:18 227:7,8
kdpi 249:7,9,23	96:5,9 97:3,7	186:13 187:5	227:17,19
287:5	98:9,10 106:22	187:13,23	228:5,10,21
keep 62:1 77:15	107:5,14,21,23	188:19 195:23	230:8,9,10,16
84:20,22 96:2	109:17,22	196:1 197:10	231:2,4,9,13,22
140:5 165:15	110:17 111:22	197:11,12,13	231:25 232:24
203:4 210:2	111:24 121:15	197:17,18	233:8,12,16,18
272:12 289:10	137:20,23	198:7 201:23	235:4,7,10,11
keeping 195:16	150:4 153:15	202:4,8,11,12	235:19,22
199:17	154:9,11,12	202:16,19,24	236:3,7,12,17
keeps 198:22	155:1,11 156:9	203:4,5,7,8,11	236:18,25
keller 2:20	156:11 157:15	203:16,19,23	237:3,4,11,12
kellerpostma...	158:9,14	204:2,3,5,10,11	237:17 238:3
2:21	162:10,12,21	204:12,22	238:12,14
kelly 179:20	163:5,10 164:1	205:2,5,14	239:17,23
180:5 181:13	164:2,3,4,5,5,7	206:10,11,24	240:7,8,14,16
182:14	165:2,7,12,15	207:9,12,17,17	241:2,5,11,16
kept 132:25	165:18,21,25	207:19 208:7,8	242:7 243:18
kicking 220:3	166:3,7,13,16	208:10,12,13	243:22,25
kidney 4:3,5	166:20 167:6,8	208:16,18,19	248:1,24 249:2
38:23 39:17	168:5,21,24	208:22 209:2,3	249:2,6,7,9,14

250:10,20 251:6 256:9 257:6 261:21 261:24 262:6 267:14,23 268:2,6 269:12 269:22,23 270:20,23,23 270:25 271:25 272:8 273:4 274:2,5,20 278:16 279:16 279:22 280:5,7 280:8,12,21 282:25 283:2 283:16,17,18 283:23 284:7 284:10,15,19 284:21 286:2 287:1,4,17 288:5,10,14 290:25 291:22 291:24 292:4,5 292:6 kidneys 40:22 54:2,22 110:13 158:14 159:7 188:20 195:8 195:13,19 196:3,8,13,23 197:5 198:3 206:9,10 219:2 222:6 223:14 224:11 226:17	227:13 240:1 267:16,21,22 271:4 kill 287:23 kind 10:24 42:18 58:15 64:22 109:18 110:19 157:24 195:5 235:4 249:19 269:14 274:17 276:6 276:10 285:2 kinds 11:8 292:4 knew 12:1 19:14 73:6 95:7 145:4 146:3 194:11 201:15 254:4 knoll 262:5,21 262:24 know 6:17 10:25 12:1,4 12:19 18:8,18 19:7,14,15 20:1 28:22 32:15 34:2,3 34:13 38:7 43:22,24 70:7 74:11 75:14 76:10 77:2 90:13,17,19,19 90:20 94:5,14 96:18 101:12	101:20 104:1,3 104:5,9 106:4 108:15 109:18 110:19 111:5 112:13 114:17 117:8,24 118:5 122:18 128:9 129:1,4,12,15 129:17,18,24 130:4,5,8 131:10 134:21 136:6,8 142:14 144:16 149:16 149:18,22,25 154:23,25 156:16 157:6 159:15 162:16 165:13 167:11 169:18,25 170:3,11,13,15 170:24,25 171:10,15 179:2,19 181:25 187:3 187:10,24 188:1,4 194:11 200:15 208:7,8 220:14 222:2 223:5 232:5,13 237:8 238:2,2 238:6 241:6,7 248:16 256:12 256:25 262:9 262:11 280:2	283:13,15 285:6,25 286:4 286:22 knowing 93:25 225:9 240:9 289:15 knowledge 27:23 114:4 187:14,16 204:18 212:5 232:18 239:13 known 78:14 219:22 220:22 220:24 226:22 283:14 285:7 knows 34:4,7 ku 50:8 189:14 191:7 l l 1:16 2:9,16,24 5:5 293:4,20 293:21 295:2 295:24 lab 86:24 labeled 142:17 lack 290:7 language 78:7 111:18 112:1 large 123:25,25 127:16 206:14 late 123:5 law 5:21 113:16
---	---	---	--

lawful 6:4	168:21 176:11	level 54:5 88:17	light 139:1
lawsuit 186:13	197:13,18	149:19 156:24	182:7 282:17
lawsuits 19:1	204:2,11 209:2	213:11 214:4	likelihood
112:21	217:5,6 233:18	222:23 289:16	54:14,20
lawyer 6:10	236:7,12,17,25	levels 135:25	279:16,23
31:12 128:21	237:3 238:12	187:11 214:8	280:9 281:12
275:11,12,13	260:8,11	216:12,13	282:23 285:17
lawyers 62:9	266:24 284:7	227:22 228:1	likely 85:17,23
129:20	284:10	258:4 272:14	86:25 158:11
lead 224:18	legal 2:10	272:25	158:17 159:1
232:24 267:6	112:6 276:24	life 7:17 12:13	233:11,17
272:8 273:1	legitimate	18:19 20:11	236:11 238:11
leads 214:14	175:12	21:2,14 22:10	238:13,17
221:12 222:22	lejeune 1:5,21	32:10,12,13	242:22 243:25
223:8 227:16	5:14 61:3,19	35:3,5 36:16	284:24 285:5
leaking 280:17	62:7,17,21,24	52:18 53:12,17	limit 261:21
282:5	63:12 65:6	54:23 55:2,9	263:11
learn 201:19	71:11,21 72:6	55:13 56:6	limited 62:23
learned 73:12	111:22 112:21	57:20 127:19	267:5
165:14 242:17	112:22 113:16	127:20,20,23	limits 188:8,13
243:2 286:16	185:22 186:6	128:2 156:2,12	line 37:8
learning	275:20 293:6	160:20 161:5,7	108:22 109:3
143:11	294:2	163:6,7 164:9	180:24 234:22
leave 79:1,16	lenexa 189:21	165:16 166:17	251:5,5,6
79:22 81:19,22	190:18 191:19	168:14,20	259:18,21,24
82:1	191:23	182:25 185:6,7	261:20
lebron 179:11	length 185:6	197:2 204:13	lines 10:8
led 61:11	letter 3:20	206:25 207:14	259:19,23
111:24	75:21 76:8,12	208:14 230:25	link 99:20
lee 2:9	76:23 78:3	232:22 252:23	100:22
left 42:11,13	84:19,25 86:10	258:1 279:20	lipid 272:13
79:18,20 82:2	86:22 293:16	281:19	lipids 273:1
82:7,16 107:5	letters 216:15	lifestyle 284:11	list 30:4 98:14
141:21 148:14			108:1 130:9,11

130:16,23,25 131:2,8,12 132:7 134:11 135:8,13 137:5 172:10 232:10 248:3 listed 49:7 88:11,22 99:6 99:19 131:22 134:10 175:1 185:5 194:22 265:24 271:15 listen 33:12 listing 50:16,18 literature 80:14 100:10 103:16 114:19 115:6 135:14 159:7 188:1 219:19 239:15 242:19 243:2 261:24 265:24 lithium 274:19 275:22 litigation 1:5 1:21 5:14,21 6:11 62:17 136:5,15 141:22 142:8 293:1,6 294:2 little 16:15 74:15 125:1 144:19 188:1 260:20 265:16	278:14 289:23 290:21 live 47:7 48:2 49:23 158:24 170:7 195:22 208:8 liver 170:2 lives 161:8 170:8 208:8 living 90:3 161:15 163:6 182:25 198:23 249:2 llc 2:7 lmi 136:14 140:14,23 141:14,18 142:10,17 145:4 147:5 148:25 149:3,9 149:15,20,22 ln 294:4 local 182:8 284:14 285:3,5 location 201:1 201:6 logo 217:4 long 4:2 118:19 125:8 131:13 131:17 150:3 153:15 154:9 155:1 159:6,8 161:7 189:6 198:13 238:10	238:13,15,19 239:11 240:16 242:8,14 248:1 288:4 289:25 291:24 longer 33:24 34:10 158:25 220:14 235:20 241:17 look 14:10,14 14:23 15:2 23:6,7,8,9,14 26:4 27:10 31:20 36:3 71:2 77:20 78:6 80:1 83:16 84:18,24 86:13,22 95:11 95:15 100:9 106:17 108:17 108:20,22 109:3 120:16 120:21 122:20 125:9,22 139:2 140:24 142:7 144:18 145:3,6 146:12,17 147:5,17 151:2 151:4 152:12 155:23 163:15 164:13,17,19 166:1,5 168:11 169:7 175:22 178:1 181:2	190:12,15 205:20 206:2 207:4,15 217:17,21 225:23 234:7 234:11 237:23 244:13 251:21 251:25 252:9 254:10 255:10 255:11,12 263:19 291:10 looked 20:13 88:9,19 91:19 93:10 96:19 132:10,21,22 141:11 142:3,7 142:9,11,14,16 142:20 159:10 282:1 286:3 291:21 looking 17:17 35:15 77:13 145:9 175:16 205:4,5 223:20 245:9 252:5 259:16,24 269:23 282:5 287:7 289:4 290:18,19 291:7 looks 14:5 17:17 19:5 141:8,14 142:15 194:6
---	--	--	---

237:22 253:25 lose 197:7 202:11,13 208:19 loses 208:18 losing 197:9 207:19 loss 40:23 183:4 227:19 258:7,16,19,23 258:25 259:4,4 259:8,14,25 260:2 265:19 267:6,7,15 273:3 losses 255:14 255:16,22 256:4 lost 197:16,17 198:2 204:21 lot 42:14,20,25 43:1 57:7 123:23 135:10 164:22 185:15 197:21 268:5 285:6 lots 170:19 low 106:25 169:15 220:4 lower 95:1 237:11 245:11 250:16 253:6,7 253:18 258:4 272:23,25	273:3 289:3,24 lunch 215:25 lymph 95:25 96:8 m m 2:3 machine 295:10 madam 14:2 made 44:19 48:3,8 51:1 57:3 157:13,23 171:18 173:14 193:17 196:16 197:25 224:5 261:8 266:4 main 2:7 291:20 major 87:14 174:1 241:21 267:5 majority 119:20 make 14:21 39:13 40:17 50:18,20,22 51:20 52:2 56:22 65:23 71:17 80:16 82:23 83:15 117:21 149:6 149:23 151:17 152:17 163:23	188:6 207:7 218:22 246:19 251:3 252:4 256:21 261:13 269:13 272:3 282:17 maker 137:25 makes 40:16 143:21 264:5 making 7:4 39:18 48:14 52:14 196:19 253:10,12 272:7 279:24 283:21 mallon 132:11 133:6 malpractice 40:1 managed 232:22 management 31:16 86:7 90:4 136:15 141:22 142:9 manager 181:5 mandell 2:3,3,4 2:4 3:3 5:20,20 6:8,10 9:20 10:15,20 11:5 11:21,24 13:21 14:7 15:6,10 15:13,14 17:2 17:11 22:17	23:3 28:5 31:6 33:18 34:1,12 34:22 35:14,18 36:1,6 37:10 38:7,15,18 41:8,10,12 51:20 52:7,17 59:2,15 60:15 60:21 61:10,18 61:22 62:11,13 62:20 63:6,10 63:20 64:3,8 65:1,18,21 66:8 67:2,5,6 68:6,21 69:6 69:23 71:19 72:3 73:23 74:8 76:1,8,14 76:19,21 77:9 77:16 85:13 86:4,17,20 91:8,23,25 92:5 93:7 98:20 99:2 102:17 105:13 105:16 108:6 108:14 113:9 113:22 120:10 120:16 125:21 129:1,4 130:15 130:24 131:4 139:24 140:2,4 140:13 143:20 143:23 147:20
---	--	--	--

147:22 150:2	59:21 68:15	marking 76:6	43:9 45:12
172:8,16 180:4	92:17,18 93:18	98:24 108:10	51:7 107:13
180:13,18,21	96:24 125:22	130:21 131:1	mclawhorn
215:17,21,24	125:24 126:15	172:12 180:8	218:16
216:4,11	margins 95:24	180:10 229:5	md 1:11 3:14
228:18 229:1,4	96:7 285:4	248:4 262:25	6:3 184:5
239:21 243:9	marine 238:25	martinez 179:9	293:9 294:2,15
247:24 248:14	marines 113:3	179:10	294:18
248:16,22,23	mark 2:3 5:20	mass 213:1,5	mdlg7403787
250:12,14	6:9 13:24 15:4	masses 270:23	1:25
255:7,9 256:24	15:11 33:17,19	masson 230:6	mean 7:2 12:13
260:7,12,15,23	37:6 40:25	match 287:7	34:22 35:15
261:6 262:16	41:7 76:15	material 130:9	37:6 54:8
262:23 263:3	77:5 86:15	130:16	62:23 70:20
278:1,5 281:9	98:21 105:12	materials 30:4	72:3 73:23
282:8 283:3	108:8 143:13	107:25 130:22	89:1 94:13
285:9,15	143:19 147:19	130:24 131:2,8	98:6 99:10
288:15 290:5	180:4 228:23	131:12 132:7	107:19 112:13
290:16 292:10	248:3,11,15	134:11 135:8	112:16 124:6,7
293:24	262:23 292:9	135:13 143:8	124:25 134:21
manifest 223:7	293:24	matter 5:14	137:17 138:17
223:10	marked 14:1	64:22 148:16	139:18 142:5,5
manner 65:25	22:20,24 31:9	150:5 162:1	152:8 153:23
march 25:2	76:5,17 99:1	165:21 208:17	154:12 162:11
26:15 28:24	108:13 120:12	247:11 274:16	162:12 165:8
29:11,15,20,22	120:13,14	293:18	181:11 188:13
30:2,5,10,13,21	130:18,20	matters 61:25	192:9 196:22
31:1,7 32:21	137:7 140:12	247:15	199:16 213:14
33:9,21 38:3	140:14 172:14	matthew	219:24 221:18
38:10 51:8,11	180:7 190:13	132:12	226:12 231:16
51:21,25 52:12	229:7,10 248:7	mbmjustice.c...	231:21 245:4,5
56:5,10,16	251:13 263:2	2:5	245:6,12,14
57:25 58:3,16	market 289:20	mccarthy 39:22	246:3,9 247:2
58:20 59:5,17		39:23 42:9	247:17 284:1

288:13	median 153:9	147:2 148:3,20	179:8 184:5
meaning	244:17,21	149:2,4 159:11	194:25 243:17
105:19 109:9	245:3,8,16	163:2 164:18	246:21 247:25
212:24 235:19	246:1,4,8,23	165:9 167:11	248:5 253:24
269:5 277:17	247:2,3,11	167:15 169:2	258:14 289:9
means 96:9	288:13	170:13 171:9	medium 182:7
124:11 152:10	medical 3:11	174:1 181:12	meet 16:17
178:16 220:12	8:12,22 12:5	181:18 187:25	218:9
231:23 233:17	12:16,23 20:17	189:11 191:13	meeting 16:14
234:17 242:21	22:3 24:20	191:17 192:17	26:9 27:21,22
284:3 285:3	26:17 27:17	192:20,21	28:18 31:1
288:11	28:12,14,21,22	193:5 198:5,17	37:23 50:16
meant 56:24	29:2,8 36:15	201:3 204:20	52:12 57:1
126:6,17	39:25 40:3,4	205:17 206:2,8	59:21,24 60:9
139:18	42:23 43:2	206:15 217:4	71:16
measure	45:18 48:20	217:14 224:9	meetings 10:8
210:23,24	49:4,9 51:9	238:9 239:14	10:24 50:18
211:2 216:14	52:10 82:3	242:19 243:2	65:22 129:19
258:16,23	83:11,24 84:2	244:3 276:24	279:4
259:4 291:5	86:12 87:25	285:13 286:22	melissa 179:11
measurement	88:12,14 89:21	medically	member 103:4
211:19 212:9	91:13,20 97:21	227:8 232:22	members 59:18
212:20 215:6	100:10 103:15	medication	59:25 115:3
216:17 291:12	105:10 106:13	169:9 232:10	149:20
measurements	108:2 123:8	268:11	memory 22:15
211:11	124:8 125:9	medications	92:10 114:15
measures	126:18 134:24	232:11 257:24	132:9 143:3
209:15	135:1 137:3,4	257:24 269:13	239:2
measuring	141:4,6 142:2	270:1,22 271:8	mental 177:5
211:25 290:25	142:4,6,7,12,14	271:15,24	178:20,24
meat 213:18,22	143:11 144:1	272:20,25	205:4 208:23
mechanism	144:12,21	287:22 289:17	208:24 282:18
158:13 221:11	145:6,14,19,21	medicine 7:17	mention 15:17
	146:1,6,9	103:11,20,22	16:6 38:25

40:11 123:6,10 123:15 126:24 160:22 184:8 185:19,23 187:1 202:2 236:24 244:20 mentioned 15:23 18:9 30:21 43:8 55:23 66:9 96:1,2 133:19 154:9 184:9,14 184:17,20,23 185:2,10,15 186:11 199:5 200:15 221:9 226:21 244:7 268:8 274:8 286:7 mentioning 13:10 186:16 mentions 40:17 met 18:10,15 19:14 20:10 24:25 74:17,23 75:6,8 113:5 metastasis 96:17 97:12,17 metastasize 107:1 michael 23:24 55:1 microscope 222:13 223:21	226:13 microscopic 223:13 mid 88:17 260:6 262:17 262:19 middle 104:19 245:13 mild 204:11 287:20 mind 11:13 13:15,22 44:14 44:23 70:12 155:13 157:3 160:21 161:15 161:23,24 278:3 mine 134:8 194:12 minimal 270:13 minimize 268:10 289:25 minute 57:15 58:16 74:2 124:3 278:4 minutes 17:20 58:11 64:13 68:14 80:23 121:6,10,21 122:10 123:1 124:21 162:6 169:19 184:16 215:20 236:10 237:2 250:16	260:10 misclassificat... 214:14 misclassifying 264:20 missing 286:9 286:10 missouri 2:8 295:3 misstate 8:25 mistakes 119:22 misunderstan... 102:15 255:4 mixing 103:13 247:21 mmandell 2:5 mobility 267:6 mock 128:12 128:17 129:5,9 models 154:19 155:4 modify 185:9 mole 207:25 moment 260:21 275:17 money 119:2 206:17 207:5,7 monitoring 268:13,21 269:14,21 272:12,13 month 51:8 121:13,20	122:1 148:10 148:15 149:11 191:4,22 192:1 192:8,12 270:4 283:14 months 25:5 55:11 123:13 123:14 157:13 191:23,24 192:3,4,7,10,11 192:13,19 198:14 219:5 219:12 268:24 269:19 278:23 278:24,24 279:1 285:21 286:3 mood 173:25 moonlighting 193:8,10 moore 2:22 morning 1:13 mousser 3:7,9 3:16,18,20,21 3:22,23 14:5 14:12,13,15 15:9 21:18 22:19,21 23:1 23:11,23 28:23 29:13 32:13 33:3 36:3,17 37:19 38:20 44:5,6,7 45:14 52:21,25 53:1
--	--	--	--

53:5,8,13,16 54:1,19 55:3,6 56:7 57:20 60:10,14 61:5 61:17,20 62:2 62:19,22 68:12 71:12 72:13 90:11,18 91:14 92:4,19 93:11 94:11,16,19 95:12,20 111:19 118:23 119:4,5,14 123:9,17 125:10 127:23 130:23 132:17 136:13,23 139:11 140:15 142:3,24 162:7 164:10,14,17 164:17 166:24 170:12 173:12 175:17 176:18 181:3,21 182:6 183:3,16 184:10,14,21 185:20 186:6 197:10 202:8 203:18,23 204:1,23 206:24 207:12 217:9 222:2,5 226:15,22 230:9 232:1	233:14 234:3,8 234:9 236:3,10 236:11,15,23 238:7,11 281:12 284:24 286:17 mousser's 13:23 23:5,6 28:14 30:25 39:5 67:18 71:5,10,22 91:21 92:21 93:19 94:22 97:23 111:17 112:2 118:8,18 119:11 128:1 130:17 134:20 140:23 142:11 170:21 171:12 175:16 177:9 179:5,15 184:23 201:23 204:20 205:16 206:1 209:2 224:9 228:21 230:25 231:9 236:7 238:21 281:1,10 282:9 282:13 283:8 move 37:8 288:15 290:5 moved 96:15 158:15	multidiscipli... 49:1,7 50:5 multiple 77:23 80:15 multiplied 192:7 murphy 115:14 115:23,24 muscle 200:7 213:1,5 muscles 212:16 mutation 78:14 79:5,14,24 82:20 mute 19:5 147:21 mutual 167:24 myfortic 289:21 n n 2:1 3:1 nagesh 3:13 name 5:17 6:9 12:16,18 13:19 17:15 19:15 20:1,5,13,14 33:1 52:18,21 64:20 70:8 74:25 115:2 128:1,3,6 134:15 221:17 named 12:24 20:22 55:1	104:6 141:13 183:3 295:6 names 12:21 189:19 narrative 22:1 33:4 266:22 narrowing 227:12 nathan 2:13 5:18 10:15 15:6,13 17:5 31:6 35:14 61:20 115:17 143:20 248:17 278:1 293:3 nathan.j.bu 2:17 293:5 nation 193:19 193:24 national 135:17 162:11 164:25 182:8 187:4 200:12 nationally 187:7 nationwide 154:1 native 219:1 natural 87:4 273:11 naturally 63:16 nature 178:8 262:3 263:14
--	--	--	--

navy 65:10,14 122:5 nc 83:1,8,14,25 near 279:17 nearly 263:22 necessarily 48:11 50:3 necessary 31:16 53:20 54:1 268:22 269:1,20 270:4 270:16 271:10 271:21 272:14 273:6,8 need 22:14 42:4 44:5,9,15 54:14,21 72:15 72:17 73:20,24 91:22 105:11 105:13 111:23 140:3 151:11 154:24 156:7 158:20 161:14 168:11 169:25 170:2 194:15 194:17 203:22 209:22 215:3 215:15 223:23 231:23 243:25 246:7 251:24 255:6 260:17 260:19 262:13 270:14,14 279:9,13	281:12 282:13 283:8 284:24 291:18 needed 53:7 136:7 190:6 191:13 198:1 needing 45:14 205:9 280:10 needs 53:16 271:12 nefarious 41:10 nefariously 82:5 negative 95:24 95:25 96:7,7 159:23 160:20 160:22 204:11 204:13 206:23 206:25 207:11 227:9 285:4 288:6 negatives 199:19 negligence 40:3 40:4 negligible 204:14 207:1,2 207:13,14 neither 112:18 124:1 203:2 neoplasm 176:9 neoplastic 229:25	nephrectomies 42:11 231:13 nephrectomy 42:10,12,13 111:23 171:12 224:14 226:20 228:20 229:15 238:19 nephritis 222:1 nephro 87:10 87:12,19,22 nephrologist 24:22 26:18,24 29:4 41:15 42:3 45:25 71:4 73:16 81:13 89:13,14 89:17 167:13 168:2 189:24 190:19,23 264:13 265:2 268:24 nephrologists 47:19,20 48:16 49:10 88:22 89:21,25 280:22 nephrology 87:9 191:8 192:20 193:14 193:24 nephron 235:13,13	nephrons 202:13 222:23 nephropathy 220:24,25 221:19,19 nephrosclero... 222:6,8,18 223:9 224:3,8 224:13,16 225:1,25 226:1 226:9,16 227:1 227:21,25 228:3,6 230:4 230:11 232:25 233:12,16,18 235:9 236:11 236:17,24 237:3,6 238:11 240:2,8 nephrotic 99:14 nephroureter... 171:13 neurologist 265:2,3 never 18:9 19:14 20:10 46:7,17 47:25 48:3 88:9 96:21 111:10 111:15 142:16 153:4 180:2 188:8,13 189:23 190:1
---	--	--	---

190:11,23 191:6,8 193:13 200:23 241:20 256:3 new 50:11 54:10 57:7 103:10,20,21 134:22 138:25 243:16 246:21 247:25 248:4 258:13 263:22 271:3 281:17 289:7,8,11 291:23 news 87:3 nice 287:25 nickname 20:5 20:9 nine 88:4,10 198:14 247:9 nocturia 176:15 nodes 95:25 96:8 nominate 101:14 nominated 99:13 nomination 105:24 non 48:16 190:5,16 229:25	noninvasive 95:23 96:6 nonresponsive 288:16 290:6 normal 85:4,8 85:15 285:13 normally 279:14 north 1:1,20 12:7 17:22 18:1 29:3 84:17 199:11 nose 207:25 208:3 notable 100:18 notarized 293:15 notary 5:6 293:13 294:22 notations 144:4 147:9 note 106:24 107:9 144:17 146:20 147:2 147:23 199:8 218:16 notes 40:14 106:13,18 126:11 144:18 145:9 238:22 239:3 287:12 287:16 november 74:18 75:4,21	76:9,24 78:4 78:22 84:19 85:22 121:21 179:11 218:14 218:20 287:16 null 101:1 number 14:18 23:11 26:4 29:19,23 36:13 74:11 75:3 77:12 86:16 87:15 100:17 106:10,15 130:25 135:16 148:1 158:21 172:9 173:23 174:4 176:4,19 181:3,17,21 182:4 185:2,11 199:21,22 212:12 228:24 229:2 245:10 245:17,18,19 245:20,20 246:25 247:7 248:2 251:14 252:24 286:18 291:5 numbers 23:20 136:6 220:4,5 245:7,9,17,19 245:21,22 246:24 247:6,8 247:17	numerous 40:11 nurse 179:10 179:12 199:4 nurses 88:17 188:21 nutritional 213:10 nw 2:16 293:4 o oath 80:23 106:1 110:20 126:14 141:10 148:1 205:11 obesity 184:20 object 9:18 10:10 16:22 37:11,24 61:7 68:1 71:13,24 113:6,19 123:18 125:19 156:20 204:25 239:19 242:24 243:5 247:19 256:20,23 290:6 objected 69:14 objection 11:2 85:11,25 102:12 285:15 290:16 objective 7:10 7:13 8:12,22
---	--	---	---

observed 267:11	offering 39:3,7	81:18,19 84:15	230:21 232:6
obtain 245:24	offhand 117:24	87:24 91:12	232:13,23
obtained 130:2	office 1:15	98:11 99:5	233:24 234:9
229:14	14:20 106:14	100:3 101:5,15	235:3 236:14
obvious 33:16	167:24 188:19	101:22,22	238:5,20
37:15	295:21	108:17,20	239:13 241:15
obviously	officer 116:4,11	117:8 123:3	244:6 246:17
98:14	official 295:20	131:17 132:19	248:20,21
occasional	officially 287:9	135:5 138:12	251:11,16,21
285:20	oh 14:10 18:22	139:6,14,17	254:8 255:9
occupation	81:24 148:11	140:1,4 141:20	257:1,15
176:8	180:18 239:12	142:18 143:12	260:15 261:19
occupational	284:1	143:15,16,19	262:9,16,19
177:20 184:5	okay 6:18,25	143:20 144:9	267:18 271:8
occur 50:1 84:7	7:18 8:19 9:24	146:2,12	275:5,14 276:6
203:1 231:10	10:6 12:15	148:11,13	276:10,13,23
occurred 38:10	13:2,14,20	149:15 151:3	277:4,10,20,25
58:20 59:4	14:10,13,25	153:22 160:7	280:7 285:21
occurrence	15:10,22 17:2	160:19 162:4	old 20:14
270:8	17:25 18:3,22	167:3,17 170:1	165:14 262:9
occurs 103:6	19:4 20:7,16	170:2,2 171:7	262:10
284:4	20:19 21:20,23	172:16 173:2,8	older 4:6 256:8
october 66:9,19	22:16 24:2,6	174:11,15	256:15,17,19
121:14,14,17	25:15,25 26:23	175:22 177:16	256:25 257:16
174:6 176:6	27:10,20 28:8	183:19 190:1	258:3 261:24
179:12 228:19	29:18 31:5	201:3,22	262:7 263:23
229:12,14,16	37:5 38:15	203:12,21	263:24 264:1
230:10	40:7,24 44:19	206:19 210:8	265:6,7,13,17
odds 287:3	48:18 49:12	212:4 213:18	265:25 266:3,6
offer 150:17	50:4 51:6	217:1,17 218:2	266:15
204:4	52:24 63:21	219:4 224:2,23	once 39:14
offered 82:25	67:5 70:11	225:4,22	127:13 143:6
84:13	71:8 73:11,19	227:24 228:17	145:8 171:1
	75:2,25 78:3	229:8,17,20	239:5 243:7

280:2 286:15 289:12 oncologist 12:5 12:17,23 20:17 24:21 26:17 41:25 47:15 81:14 87:19,22 89:10 97:21 106:13 108:2 244:4 oncologists 88:14,14,15 oncology 87:10 87:12 106:24 107:17 ones 132:5 134:3 142:5 271:16 ongoing 173:24 176:16 onion 222:20 onset 270:6 271:3,6 onward 268:12 operating 46:5 289:13 operationally 223:18 opinion 16:3 28:20 73:5 92:1,2,5 107:15,19 145:13 146:21 147:24 151:13	151:13 152:23 153:14,18 154:7,25 155:7 155:15,16 156:15 160:10 160:24 161:6,8 161:16,25 162:9,17 164:6 164:10 168:12 169:18 178:11 182:20,23 183:14,15,16 185:13 203:21 203:25 204:8 205:25 206:13 206:23 208:18 208:25 210:14 232:7 240:23 243:1 282:13 opinions 8:20 8:20 9:4,8,16 20:8 35:1 36:24 38:4,12 39:3,8 40:19 71:4 72:20 73:15 135:9 138:13 139:22 143:25 144:5 145:17 150:17 154:15 176:25 177:2 186:25 217:8,10,12 283:8	opportunistic 271:22 opportunity 26:16 31:11,13 35:22 36:9,11 36:22 139:9 204:4 269:7 285:19,23,25 opposed 16:11 73:5 115:6 148:19 249:2 opposite 104:20 optimistic 156:25 161:2 161:18,20 283:22 oral 31:24 109:19 110:22 order 31:17 77:6 148:6 organ 46:14 47:6 48:2 49:23 195:8 196:2 organization 129:13 136:14 149:16 150:1 organizations 187:4,7 organized 129:5 organs 196:23 197:1	original 138:5 142:4 200:22 293:10 outcome 288:4 outcomes 94:2 153:25 266:14 289:22 292:6 outpatient 278:22 279:2 outside 9:8 23:22 143:14 264:12 284:8 overactive 176:14 overall 166:20 200:1 228:5 259:7 269:9,10 288:12 289:1 overbilling 56:22 overseas 239:6 overstate 9:3 overstated 255:1 overt 271:7 overview 3:18 3:19 121:15,17 121:24 122:9 122:13 137:23 267:17 overwhelming 143:18 own 34:25 38:4 138:7 167:14
--	---	--	---

198:8 217:16 287:23	132:21 133:8 133:23 134:10 135:12 136:3 136:20 137:11 138:3 146:12 147:7,8,10,11 147:12,14,25 148:3 150:25 151:2,15,22 152:3 155:13 155:22 156:4 160:11,24 161:10 162:24 172:18,21,23 173:19,19 174:15,17 175:22 177:25 178:1,3 180:25 180:25 182:16 188:10 190:4 190:15 217:5,5 217:6,18,22 218:13 229:21 244:10,12,14 244:22 251:2 251:18 255:11 261:11,17 263:7 266:11 266:11,21,22 268:9 293:10 293:13,15	119:6,13,15 125:8 131:12 131:19,22 132:2 135:20 136:3,8,12 137:15 140:24 141:3 147:8 195:12,12 paging 123:24 paid 106:3 117:11,13,14 117:22 119:3 205:24 painful 200:8 panel 79:24 85:6 paper 77:2 291:24 papers 100:11 114:19 papillary 75:13 78:19 80:9,12 80:15,17 81:3 81:12,25 95:23 96:6 106:25 paragraph 14:17,24 15:3 15:15,17 16:2 19:18,19,22 24:24 27:11 31:21 74:11,16 75:2 77:21,21 78:6,7,22 83:4 84:24 95:15,17	96:4 106:10,15 146:17,24 150:25 151:4,5 151:16,22 153:2 155:13 155:23 160:11 160:25 161:10 162:25 175:25 177:17 178:3 188:11 217:19 217:21,22 218:3,13 244:13,16 251:2 261:12 261:17 267:1 268:10 paragraphs 36:7,13 37:22 parallel 189:20 190:18 191:18 191:23 paren 173:24 174:2 park 2:4 part 6:16 9:14 9:25 10:16,16 16:10 21:1,19 21:20,21,23 22:5 27:9 32:5 36:2 43:9 44:12 45:3 46:14 47:1 49:7 78:21 82:2 84:21
p			
p 2:1,1 p.m. 122:22,25 123:12,20 124:21 292:17 pack 245:13 packet 77:4,11 86:9,19 172:18 172:23 packets 248:12 packs 239:11 page 3:2 9:16 10:4 14:23 15:2,15 23:7 23:11,15,18,20 23:22 24:2,4,9 24:10,15 26:4 26:8 36:4,9 37:20 74:9 77:2,4 83:3 86:19 92:19 93:15 95:11,15 96:4 97:6 98:17,17 106:10,16 108:17,22 109:2 110:16 110:20 118:23 119:4,11,12,16 120:17 131:22 131:23,24	pages 29:2,10 29:14,19 77:6 118:9,19,21,22		

88:22 94:12	participated	224:13 226:19	214:15 243:19
103:23 105:5,7	17:12 21:3,15	228:19 229:6,9	258:4 263:23
105:9 112:7,23	32:14 103:1	229:18,21	264:2 265:6,7
113:3 119:7	128:16	230:7,15 231:4	265:21 266:3,6
122:15 123:25	participating	238:17	267:4 272:17
133:5,13,18	34:15	patient 48:5,9	278:15,21,25
134:11 135:3,5	participation	48:10 49:15,18	279:8 285:18
135:16,20	33:5 84:5,7	49:25 50:11	285:24 291:22
137:8 138:9	particular	51:2,3 139:1	pause 15:5
141:12 152:6	10:21,21 21:1	166:16 167:8	pay 37:14
152:10,23	33:8 37:2	167:18,20,22	105:19 106:1
153:21,22,23	100:11 191:4	167:25 168:5	243:4,7,13
153:24 155:6	particularly	169:21,24	265:1,3
156:17 157:19	231:6 261:14	170:4 188:22	pce 187:22
159:2 176:23	parties 295:17	199:25,25	pcp 237:19,21
177:5,8,13	partly 187:19	200:5 219:13	peer 101:9,16
188:3 189:11	parts 14:21	222:16 223:5	101:18,25
189:14 190:7	87:14 132:22	256:14 257:5	102:7,8,10,15
191:13 196:22	133:25 136:1	265:8 266:12	102:18,23,25
197:23 206:14	163:20 197:22	266:15 267:3	103:2,6,11,13
206:18 219:23	206:7	269:6,14 272:6	103:20 104:1
223:8 235:2	party 70:17,19	272:7 274:19	105:9 115:9
269:4 273:15	145:25 146:3	274:21 276:20	242:18 243:3
partial 42:10	past 70:18	279:13 280:10	pending 1:19
42:11	157:13,23	285:20 289:12	125:20
partially 45:2	181:4 191:22	291:7,25	pennsylvania
117:2	234:4 274:9	patient's	70:5 130:7
participant	pathogenic	167:19 223:20	people 7:23
20:20	78:14	patients 41:21	10:25 54:11
participants	pathology 3:23	49:13,14 89:8	65:23 66:11
56:14	95:18,22 96:5	90:2 165:6,8	87:5 100:17
participate	97:7 146:21	167:14 193:3,6	104:1 138:6
83:14 84:3	147:3,10,11,14	199:14 200:9	149:19 158:8
	147:18,24	200:10 214:14	162:3 163:5,9

163:10,10,11 165:4,17 194:8 194:10 195:22 196:4 198:22 198:25 200:1 208:7,9 243:3 246:20 257:16 260:4 269:12 272:15 percent 118:9 141:7 174:3 202:13,19 203:9 216:4 220:6 251:7 252:12,19,25 252:25 253:8 253:12,14,15 253:18,20 254:5,14,14 255:2,16,18,19 255:23,24 256:3 258:8,11 258:17 259:3,3 259:5,7,11,14 259:17 260:2,6 265:10,12 277:11,22 288:19 290:10 290:14,24 percentage 255:1 258:25 percutaneous 234:16	perfect 75:12 78:9,18,23 79:4,12 80:5,8 80:11 82:25 225:12,14 perform 181:4 182:6 performed 39:23 46:18 230:6 period 157:4,8 202:18 209:17 periodic 270:15 periods 157:5 peripheral 184:24 234:14 235:5,17,20 236:5 peritoneal 200:20 201:18 permanent 178:8 permission 167:22 286:15 persistent 232:21 person 19:13 20:19 25:11 46:5 47:7 48:7 49:17,23 65:2 105:19 116:13 128:13 158:19 163:25 164:3 164:14 165:1	165:20 166:2 168:11 169:2 183:3,9 204:23 208:18 274:25 person's 12:18 170:1 249:2 personal 77:22 107:15,18 269:14 personally 12:5 12:20 pertinent 95:2 pg 294:4 ph.d. 23:24 pharmaceutical 243:12 phenomenon 202:22 philadelphia 129:16 188:17 274:14 275:18 275:24 philly 277:15 phone 41:3 phosphorous 280:19 phrasing 168:16 physical 163:14 181:24 207:16 physically 170:3 physician 7:13 50:15 73:7	276:17 physiologic 262:3 263:14 picking 245:10 piece 117:16 pittsburgh 188:18 274:13 274:18 275:16 275:23 place 191:12 placed 188:8,13 places 39:12 plaintiff 5:2 6:11 124:22 125:17 127:6 275:7 276:20 plaintiff's 34:23 275:11 plaintiffs 2:2 5:21,21 34:23 55:1 113:18 131:23 132:21 133:9 183:21 186:12 plan 10:2 22:10 32:12,13 35:4 35:5 36:16 52:19 53:12,17 54:24 55:9,14 127:19 128:2,3 128:6 156:2,12 169:19 200:23 280:4
---	--	---	--

planner 12:8 12:10,13 21:2 21:15 32:11 55:2 plans 56:6 57:20 127:20 127:21,23 play 164:8 165:10 166:18 please 5:16 6:2 22:17 26:5 76:4,9,22 95:20 108:7,8 120:12 130:15 130:19 172:17 172:18 176:1 177:25 179:20 180:6 182:5 194:19 228:23 234:12 260:8 293:9,12,15 plg 5:25 131:23 plural 22:18 127:21 pms2 86:25 point 10:17,21 28:21 71:20 102:3 109:8 110:2 116:1 125:13 151:14 160:21 161:19 161:21 168:10 186:8 193:17 194:2 200:2	201:10 214:9 230:24 237:16 251:25 253:11 253:17 261:1 290:20 points 253:9 pole 250:16 287:8 policies 222:12 population 263:22 position 8:11 33:20,23 35:9 37:6,7 38:6 positive 199:18 231:17 250:18 possibilities 112:18 possibility 186:15 264:1 possible 8:3,21 21:6 79:5 82:18 118:17 140:20 158:24 214:19 268:3 269:17 270:18 270:22 possibly 34:16 101:20 207:10 post 90:4 159:16 176:10 219:6 252:11 258:8	posted 104:7 postman 2:20 potential 199:13,16 203:22 227:18 235:22 257:4 282:13 283:8 potentially 115:10 199:7 214:15 223:22 powerpoints 65:22 practice 7:25 18:25 45:25 46:15,18,21 47:5 48:21 49:14 72:11 210:4 266:10 269:5 278:14 278:17,19 279:15 285:13 practicing 45:25 practitioner 179:10,12 191:21 199:4 pre 90:1 precise 226:3 precisely 223:4 227:2 precluded 35:6 predict 153:8 154:1 219:20 244:16 280:9	288:12 predicting 241:8 286:23 prediction 151:16 152:16 154:10,18 155:4 280:5 predictions 150:9,14,18 151:5 157:11 158:2 286:21 287:9 predictive 248:25 250:18 predictors 288:3,6 predisposition 84:23 85:18,24 prednisone 271:9 289:24 290:1 preexisted 184:25 preliminary 7:1 21:22 prepare 137:8 prepared 55:9 56:17,17 131:7 136:14 141:22 142:8 preparing 65:8 122:2 present 2:19 129:9 190:4,17
---	---	--	---

236:6 238:18 271:25 272:3 283:2 presentation 65:10,23 83:18 122:3 137:16 presentations 66:6 137:19 presented 66:18 69:15 70:21 preserve 107:22 pressure 222:17 223:6 269:8,16 pretty 33:16 37:1,15 237:5 237:15 284:18 287:4 291:16 prevent 109:21 163:5,17 182:24 257:25 prevented 175:19 previously 173:25 pride 194:2 primarily 238:3 primary 77:23 136:22 286:1,5 prior 28:24 36:19 70:10,13	70:14 101:10 101:18 114:3 115:10 126:15 159:17 private 29:4 46:15,17 privileged 10:13 191:2 probability 288:19 probably 13:13 20:3,6 59:18 59:25 81:11 91:11 114:5 115:9 127:22 129:7 146:11 148:23 191:24 232:4,7 257:2 257:13 276:4 277:19 problem 166:11 175:7 212:19 problems 169:2 274:6 procedures 47:8 process 50:9,16 56:21 100:18 102:15,23 103:23,24 105:9 116:17 124:1 133:21 235:9	processes 235:25 processing 105:18 produce 13:22 22:18 202:18 212:16 produced 1:12 54:25 136:4 product 32:1 212:17 productive 163:6 182:25 professional 99:15 100:2 106:7 107:16 114:18 professionals 40:15 profile 249:10 profit 189:16 192:22,24 193:8 prognosis 204:1 242:14 242:15 prognostic 158:22 program 47:2 progress 123:21 236:18 279:17 progression 98:10 279:22	285:18 progressive 175:5 206:11 221:13,14,21 222:22 223:16 224:20 225:5 227:12,17 270:11 projected 94:2 254:6 projection 98:9 253:21 projects 60:24 60:25 prolonged 250:15 287:5 pronounce 117:7 pronounced 117:9 properly 169:25 propounded 295:9 prosecution 277:15 protect 40:21 protected 10:14 11:20 17:1 28:3 31:23 34:7,10 35:11 38:6 51:17 52:4 58:24 59:13
--	---	--	--

63:5 65:14 66:2 67:1 68:3 68:18 69:20 91:5 93:4 protein 214:3 270:6,11 proud 195:6 prove 113:3,17 proven 83:20 provide 9:8 72:10,20 76:3 154:8 provided 56:4 86:8 135:7 providence 2:5 provider 286:5 providers 88:17 286:2 psychiatric 164:19 166:10 166:25 167:10 167:19 169:2 205:4,18 238:1 264:14,18 282:9 psychiatrically 166:5 170:4 psychiatrist 166:12 167:2 167:12 168:2 169:13 177:2 179:2,13 205:21 275:4	psychiatrist's 167:23 psychiatrists 168:6 psychiatry 169:10 177:4 179:3 psychological 163:13 psychologists 48:16 public 5:6 210:4 293:14 294:22 publication 101:19 103:7 103:14 publicly 31:10 32:16 33:9 34:19 36:23 37:3 publish 101:11 published 102:1,8,20 103:12,21 104:8,13,17 105:5,7,8,20 106:2 publisher 102:2 106:6 publishers 102:24 publishing 101:10	pull 76:12 pure 81:16 156:16 purely 158:4 183:22 purplish 287:7 purpose 67:25 68:8,13 69:2,9 69:16 purview 208:16 put 20:14 31:15 35:5 40:13 42:8,13,17 43:2,6 54:3 57:22 74:3 78:8,17 79:2 79:10,11,12 80:4 82:13 83:9,13 86:13 97:5 99:8,9 100:22 101:7 107:8,12 112:7 133:12,13 146:7 150:6,12 150:20 151:21 153:20,22 154:6,8 156:19 156:22 159:3 160:11,24 161:9 190:21 191:10,24 193:22 194:1 194:21 204:14 205:19 206:21	207:2 217:20 228:22 256:18 261:25 262:21 264:16 268:16 278:6 puts 198:8 214:15 281:21 putting 13:18 194:18 225:8 pyelonephritis 230:5
q			
qualification 191:11 qualified 177:3 179:3 186:19 quality 161:5,6 164:8 185:6 204:13 206:25 207:14 249:14 279:6,20 question 6:16 6:18 10:12,22 10:22 13:14 17:4,5 18:17 41:13,17 44:14 45:24 59:3 61:15 62:6 63:7 68:7,22 69:7,12,14 70:12 72:8 82:7 91:23 93:8 97:20			

99:10 105:14 109:7,25 125:20,22 127:5 129:3 139:6,25 150:16 169:6 169:14 185:8 188:12,20,23 192:23 194:20 197:22,23 201:25 202:1,6 205:16 206:16 206:18,20 207:20,23 219:18 220:16 221:8 226:17 239:22 246:19 250:13 255:7 258:21 259:12 273:23 288:17 290:7 questioned 128:20 questioning 7:20 questions 6:13 6:16,22 7:3 31:8 35:7 37:11,21 38:1 60:6,17 61:12 62:23 64:19 65:11 66:7 68:24 100:4 101:6 138:21	139:9 156:18 159:6 162:5 248:9 250:24 269:7 278:2 281:10 285:10 288:19 290:10 292:11 295:9 quicker 211:17 quickly 56:20 127:16 145:14 quit 170:12 240:11 quite 72:6 150:10,19,24 151:7,19 152:20 153:7 153:19 155:6 156:22 161:17 194:23 198:15 198:20 199:25 227:23 244:15 261:22 quote 109:8 204:5 218:9 quotes 262:1 quoting 262:1 r r 2:1 12:12 295:1 radiation 88:14 radiologists 88:16	radiology 274:1 rainbow 189:22 190:2,8 190:18,21 191:9,18 raise 81:2 randall 2:9 range 157:4 195:1 237:10 249:23 260:6 rare 200:1 rate 196:14 209:11,14 210:11 252:11 258:7,24,25 259:1,7,14,24 260:2 273:1 289:2,5 290:11 290:23 291:15 rated 173:25 rates 259:15 266:16 273:3 289:10 rather 42:4 ratio 210:15 ratios 209:9 reabsorbing 209:21 reach 237:21 286:5 reached 70:18 168:6 171:23 218:7	reaches 188:21 reaching 116:18 reaction 11:22 34:19 267:12 267:20,24 reactions 163:13,14 270:22 read 16:3,12 23:15 26:19 29:19,22,23 31:12,13 34:3 36:1,2,2 75:4 75:15 78:21 82:14 95:20 104:11 107:24 108:2,19 110:8 112:20,23 113:1 114:20 133:5 135:6,14 135:16,21,23 143:1 144:10 144:12,14,15 148:19,23 149:3,8,10 166:24 170:17 171:16 174:7 175:25 177:8 177:13,18 179:1 181:7,11 181:13,18 182:4,12,17,20 187:17 188:1
--	--	---	--

194:19 198:10 201:3,13 205:16,18 238:8,22 255:24 263:16 264:8,17 265:14 292:12 293:12 294:16 reading 13:12 81:23 111:13 132:24 134:2 137:4 145:23 182:2 206:7 reads 31:22 56:5 79:4 85:14 181:21 266:13 reaffirmed 183:16 real 163:4 208:2 reality 199:20 really 13:9 16:14 36:1 44:13 56:24 81:7 110:15 133:21 137:22 146:2 237:5 238:16 247:10 247:15 252:24 271:23 283:17 284:21 287:14 288:24	reason 56:8 84:11 111:2,6 165:25 166:17 166:18 167:5 176:20 236:22 284:23 294:4 reasonable 51:12 52:1,14 83:19 reasonably 215:11 reasons 112:8 156:24 158:9 175:11 176:2 176:20 177:4 177:12 270:17 reassuring 85:5 85:16 154:3 282:7 recall 12:19 17:22 22:4,8 25:10,18 30:7 30:9,12 39:18 45:1 57:4,10 58:7,18,19 59:3,10 64:12 97:14 114:24 120:7 134:4 141:15 170:18 170:20 209:9 225:3 226:19 232:16 276:22 277:16 282:10 283:4 288:20	290:11 recalling 275:16 receipt 293:16 receive 29:25 30:2 208:9 received 30:3,6 30:10,13,20,23 51:10,24 52:11 66:16 86:23 92:9 93:10 98:15 193:23 receiving 169:3 233:21 recent 92:23 93:14,19 232:9 252:10,15,16 253:3 254:12 254:19 259:16 recently 86:23 189:4 recertification 193:15,25 recess 74:5 140:9 216:8 261:3 278:8 recipients 265:9,11,17 266:15,17 recitation 139:22 recollect 18:4 20:12 22:14 55:5	recollection 11:10 16:13 45:5 55:4,18 57:16 69:1 84:12 recommend 86:6 101:13 109:23 110:25 recommenda... 269:3 recommenda... 75:10 214:23 recommended 99:18 100:5 107:12 recommending 111:3,7,8 recommends 86:5 reconvene 37:12,15 record 5:11,17 10:19 42:24 43:2 52:8 55:19 74:3,7 75:5 76:2,7,18 80:2 82:4,15 83:24 84:3,4 84:13,15,18 95:21 124:18 127:8 128:12 133:16 135:2 136:7,8 137:3 137:4 140:8,11
---	--	---	---

143:11 144:22 145:14 146:1 148:3 149:4,13 163:2 165:9 167:16 168:7 176:1 177:8 181:12,18 206:15 216:2,5 216:6,10 238:9 261:2,5 264:22 278:7,10 282:1 295:13 recorded 5:12 records 3:11,15 22:3 27:6,13 27:17 28:6,13 28:14,17,21,22 29:2,4,8,11,15 29:16,25 30:10 30:12,14,17,19 30:23 43:18 55:8 63:14 71:2,17 75:18 75:19 83:12 84:10,18 91:13 91:13,20 92:2 96:20,21,25 112:10 114:13 116:16 120:15 120:18 123:7,8 123:24 124:8 125:9 126:18 134:24 141:5,6 142:2,4,6,7,10	142:11,12,14 143:2 144:1,12 145:7,19,21 146:4,6,9 147:2 148:20 149:2 159:11 159:19 166:25 167:12,19,21 170:13 171:10 172:6 175:16 201:4,13 204:20 205:5 205:17,18 206:3,8 207:16 218:14 222:5 224:9 225:2 267:11 282:10 286:8,9,10 recurrence 90:12,18,21 91:14,21 93:11 93:22 94:1,5 94:23 95:1 96:12,13,17 97:13,17,23 283:4 284:23 285:2 recurrences 109:21 recurrent 106:22 176:12 red 213:18,22 reduce 271:13	reduced 295:11 reduction 287:21 refer 13:3,3 14:21 27:1 49:13,24 100:16 251:23 reference 14:25 18:5 21:24 27:20 38:21 39:13 66:19 109:8 125:4 127:1 147:23 193:20 252:3 263:8 referenced 13:15 34:11 199:9 282:9 283:3 293:10 references 40:14 114:6,7 114:10,14,15 114:18,19 115:4,5,6,9 referencing 13:13 44:12 referral 50:9 referred 49:13 99:18 115:1 155:5 174:23 209:3 225:4 239:4 referring 27:9 27:16 49:20,22	50:15 64:1,6 77:7 78:12 82:15 85:5 96:11 109:4 110:3 130:13 222:7,19 227:10 243:10 243:10,24 261:10 274:11 283:25 refers 24:9 64:7 106:18 121:23 127:22 reflect 63:15 reflecting 121:14 reflects 26:9 regard 72:6 94:3 137:21 139:4 235:8 regarding 286:21 regardless 166:20 regimen 266:5 271:17 region 292:7 registered 133:11 regular 109:17 110:18 182:9 268:23 regulate 196:8 196:10
--	---	--	--

rehab 171:24 171:25 179:22 180:23 181:15 281:10 rehabilitation 23:22 rejected 81:21 rejection 157:16 220:7 220:11,11 242:1,5,9,10,13 242:21,22 246:22 255:18 255:23 256:2,5 256:8,16 257:19,25 265:19,20 268:11 269:24 270:10,21 271:14 272:9 287:1,19,24 288:20 rejections 247:7 relate 146:6 related 60:9,10 60:13 62:18 63:16 167:5 168:20 186:11 relates 142:2 relation 151:9 239:1 relative 295:16 295:17	relatively 279:17 relevant 62:21 94:10,17 95:2 97:3 98:1 175:10 181:4 281:11,15 282:12 283:7 286:23 reliance 225:8 rely 133:11 142:21 144:3 144:13 relying 8:12 35:3 210:13 242:19 remain 237:19 remaining 168:21,24 169:6 197:12 202:16 207:17 209:2 225:6 283:16 remains 261:22 remember 12:20 13:10,12 17:11,16 19:19 21:7,23 26:22 29:21 31:3 57:6 60:1,15 64:17,20,21 66:13,14 67:10 112:4 114:9 125:14,18	127:11 133:17 135:22,23 143:6 148:18 232:9 239:12 274:2 277:21 remembering 13:18 132:11 133:21 287:6 remote 2:3,3,9 2:14,20 25:13 removal 176:11 176:11 178:16 231:1 267:21 284:3 remove 107:14 removed 39:15 39:17 43:9 95:19 107:6 164:1 175:18 176:22 177:11 177:12 201:23 202:4,5,12 228:21 230:8,9 233:17 236:4 236:19 237:12 renal 75:12 77:23 78:19 80:8,11 81:2 81:25 84:23 85:18,24 95:24 96:6,9,14,15 97:6 146:22 229:25 263:21 264:2 270:15	273:21 render 145:12 206:13 renewed 183:15,20 repeat 8:14 111:18 112:3 153:4 repeating 210:2 rephrase 6:18 replacement 196:1 replied 18:21 19:9 report 3:7,8,9 3:10,22 13:3,4 13:7,12,16,18 13:23 14:3,15 14:16 15:3,15 15:24 16:2,2,6 16:12,16 19:17 19:18,22 20:7 21:16,24,25 22:5,6,9 23:1,2 23:5,6,10,17 24:8 27:2,7 33:5,22 34:4 34:11,18 35:13 35:16,18 37:18 38:9,9,19,20 39:13 40:10 42:8,14 43:3 44:7 52:9,20
---	---	---	---

52:24 53:6,18 53:23 54:3,24 73:4,8 74:9 78:8,18 79:2 80:4 81:24 82:23 83:3,7,9 83:13 92:13,15 92:19,20 93:13 93:21,23 94:10 95:12 96:4 97:6,25 98:2,6 106:9 107:9,13 111:19 112:1,2 112:7 118:9,18 118:23 119:5,7 119:11,16 120:6,9 121:1 121:5,9 124:6 124:7,11 126:4 126:17 132:10 133:5,12 137:9 139:11 140:23 145:16 146:13 147:10,11,14 147:18 148:12 150:6,12,21 151:1,21,25 152:2,13,16 153:20 154:7 155:14 156:5 156:19,23 157:9 159:3 160:11,25 161:10 162:17	162:25 171:25 172:1 180:1,2 180:5,6,9,11,23 180:25 182:3 182:15,17 183:20 184:7 185:3 186:7,23 187:2 188:5,11 199:9 200:16 202:3 204:14 206:22 217:18 217:18 226:19 228:19 229:6,9 229:18,21 230:8 234:8,11 236:23 240:18 242:4 244:10 244:12,14,22 244:23 246:2 246:20 247:4 251:3 253:19 254:5,15,25 258:6 259:10 261:7,7,11 263:8,9 268:9 273:17,19 274:1 281:1 285:11,12 reported 2:23 218:16 reporter 1:17 1:18 2:25 5:5 6:2 14:2 76:4 207:21 295:3,4	reports 3:23 13:5,11,16,22 14:22 15:9 21:17 22:18 31:9 32:8 38:25 41:15 44:2 60:9 61:17 62:19,22 72:19,22 94:15 111:17 112:3 118:7 119:20 119:23 122:18 123:10 126:18 127:3 131:21 132:2,6,20,23 133:3,8,18,23 133:25 134:1,6 136:19,20 137:6 138:8,12 138:21,23 139:4,16,20,21 142:24 144:5 146:7 184:9 186:20 187:17 217:2,9 263:11 286:12 repository 145:3 represent 52:8 representation 52:15 representative 6:10	represented 141:4 request 115:16 183:22 requested 89:7 require 101:9 128:23 151:6 268:13 284:2 284:12,13 required 151:18 152:18 requires 113:17 124:2 158:6 reread 152:12 research 90:5 135:17 149:21 243:11 researched 102:6 resect 285:4 resected 95:22 96:5 reserve 267:5 reserved 5:8 residency 45:20 47:1 residents 279:6 residuals 181:22 182:10 respect 206:6 respectfully 35:15
---	---	--	---

respond 60:12 91:24,24 105:14 128:25 129:1,2 250:13 255:8	retain 284:9 retained 31:19 32:2,18 33:11 33:25 275:5 return 151:7,11 151:18 152:19 293:15	reviewed 27:5 27:12,16 28:7 28:12,18,20,23 29:9 30:25 43:5 92:21 101:10,16,18 102:7,10 104:1 104:8,25 125:6 125:16 126:8,9 127:1,8 132:3 133:25 134:3 134:12,21 136:21 140:21 242:18	17:15,19 18:6 18:24 19:12,25 20:4,25 21:7 22:8 23:13,14 23:21 24:10,13 24:17 25:5 26:1 29:24 30:9,18 34:5 34:21 37:6 39:2 41:18,20 42:5,10,12 44:6,22 45:9 45:11 46:3,10 46:24 47:4,14 47:24 48:7 49:19 53:4,21 54:4,12,17 57:18 58:4,9 59:9 60:21 64:8,15 72:13 72:14 74:14,22 76:17 77:13 78:12,24,25 80:19,23 81:1 81:15 82:11 85:3,7,24 86:4 88:10 89:4,12 89:24 92:11 93:17 94:9,12 95:14 96:1,20 97:11 98:4,16 98:19,19 99:17 99:24 100:6,20 100:23 103:10
response 33:13 65:16 128:23 151:24 152:13 295:8	reveal 78:14 revealed 33:9 34:20 43:19 reveals 36:18 revenue 116:4 116:11	reviewer 103:3 104:12 reviewers 102:25 reviewing 124:8,18 126:4 126:17 127:14 133:10 141:15 145:21 205:3 revised 116:22 revisit 37:9 rhode 2:5 rid 196:18 209:21 ridge 2:10 right 6:20 8:5 9:7,12 11:5,11 11:12 12:21,22 13:8,20 15:10 15:23 16:1,17	
responsibility 192:5			
rest 79:1,3,13 133:8 232:21 279:3	review 28:5,13 29:14 55:12 71:16 75:17 91:12 101:25 102:8,15,18,23 103:6,12,14,20 105:9 116:16 123:1,6,16,21 124:15,15,16 124:21,25 125:12,15 126:25 127:6 127:18 130:10 131:11 132:1,6 132:8 133:9,23 134:5,9,13,19 136:15 143:25 204:19 222:4 224:8 225:1 269:8 276:1		
result 34:2 53:1 69:25 85:4,6 85:15 163:3 176:9,20 179:24 198:2 272:10			
resulted 111:22 267:15			
results 75:10 85:9 194:4 209:3,5 218:9 231:8			
resume 98:11 98:17,21 99:19 101:8 190:2,4 190:12,22 191:10 193:11 193:13,23 194:21			

104:17 105:25	177:10 178:15	245:22 246:5	211:22 240:10
106:11,21	179:19 180:20	246:12,13	240:12 241:21
107:2,6,8,18	181:3,9 182:4	249:6,7,15,21	256:13 268:11
108:5,21 109:2	183:1,13,19	250:6 252:2,7	risky 157:23
110:25 111:1	185:4,12 186:7	253:2 255:12	rlee 2:11
111:11 112:15	189:6 190:19	261:6 263:9	road 267:25
112:19 114:12	192:2,7,13,24	264:8,11	roc 39:22
115:22 116:9	193:2,4,22	266:22 267:1	role 7:9 207:8
117:10,11	194:15,24	268:18 286:6	278:21
118:12,24,25	196:6,11 197:7	289:16 292:15	rose 106:23
119:16,23	197:16 201:23	ring 12:25	107:10 109:9
120:10,20	202:12,24	134:15 136:17	rotation 190:7
121:2,3,12,13	204:6,15,17	ringing 134:17	roughly 242:2
121:18,19,24	205:15 207:10	rings 115:21	route 275:1
122:1,10,20	207:19 209:20	rising 223:11	routine 273:15
123:1 126:1	210:16,22	224:20 225:5	row 2:4
128:11 131:25	211:10,16	risk 87:6	rugby 165:10
132:5,19 134:4	212:6,19	159:23 184:11	rule 33:16
136:18 137:14	213:18 214:12	185:2,6,16,24	ruling 75:12
139:18 144:25	215:25 216:20	203:9 205:8	78:19 80:8,11
146:16,19	217:7,25	206:11 211:15	run 149:20
151:9 152:5,23	218:10,12,20	214:15 220:18	rural 101:1
153:5,11	219:7 225:24	221:3 226:22	ruzicka 2:6
154:22 155:8	226:5,15	230:22 231:6	5:25,25 22:25
155:15 156:18	228:21 229:12	231:11 233:14	76:6,11,17,20
157:7 158:23	229:13,17	239:17,23,25	98:24 108:10
159:3,5,25	230:9,10,13,16	240:6 248:25	120:14 130:21
162:8,19,25	232:1,4,15	265:19 270:9	131:1 147:19
166:1 167:3	233:13,16	271:13 272:18	172:12 180:8
168:7 171:22	235:14 236:3,9	280:5,13,21	228:24 229:5
172:7,15,17	236:18 237:17	282:25 287:1	248:4 262:25
173:5,10,18,21	238:6,14	riskiest 259:9	
174:20 175:18	239:25 241:4	risks 54:6	
176:10,17	243:20 245:14	199:22,23	

s	36:21,23 46:20	172:25 173:22	screen 31:15
s 2:1,3 149:4	62:1 63:23	174:16 175:23	76:23 77:18
293:20	64:4 70:22	188:19,22	84:19 86:14,21
sakala 179:20	80:10 84:6,20	198:5 229:22	173:3,6,19
181:13 183:14	84:22 95:4	229:25 234:22	217:19,20
sakala's 180:5	96:2 104:10	242:20 255:13	228:22 229:9
180:22 182:14	115:5 152:11	258:22,22	229:22 262:22
182:15	152:16 153:14	263:10,25	263:5 268:17
sake 206:16	154:22 155:12	265:6,9,16	272:2,5
sales 36:20	158:3,6 159:21	266:25 267:2	screening 85:1
116:7 181:5	159:22 160:3	285:20	85:15 86:7
salesperson	161:21 162:1	scarring	271:19 273:6
181:5	165:24 167:10	221:13,14,21	se 95:8 163:5
salt 196:19	167:25 178:18	scenarios 284:2	182:24 183:2
209:22	190:22 196:1	schedule 71:18	189:15
salts 195:18	206:1 207:1	schedules	seal 295:20
196:9	215:21 226:10	115:4	second 27:11
sat 170:25	244:8 259:18	school 45:18	56:1 73:22
171:5	says 23:12,22	science 7:17,22	86:18 101:23
satisfy 196:3	24:4 26:14	scientific 8:12	143:13 146:21
save 77:17	27:12 32:2	8:22 100:10	147:21,24
107:22 207:4	35:20 36:9	103:16 105:10	155:22 158:6
saving 206:16	60:5 79:13	239:14	158:12,20
savitz 134:16	84:3,13 86:5	scientist 7:10	172:1 178:3
saw 20:14	86:23 87:3	scientists 100:9	180:17 183:19
21:20 22:7,13	92:13,15 93:13	103:15 106:8	233:9 239:7
42:23 43:1	96:23 109:7,14	scope 264:13	243:25 257:13
55:8 83:23	110:2,15,24	score 194:11,25	274:21 291:22
96:21 148:6	115:1,3,22	195:1,2	secondary
175:2 182:1	120:25 121:20	scored 193:14	203:10
218:13	122:21,25	194:9,12	secretions
saying 13:10	124:13,14	scores 193:18	213:25
16:12 17:23	126:25 141:21	193:24 194:6	section 21:25
	156:5 172:21	194:13,23	24:14,24 31:21

94:10,16 98:12 98:16 99:8 112:5 119:12 135:13 151:23 152:2 243:15 251:4,12 270:3 sections 157:10 258:19 secure 116:17 176:7 security 115:15 116:12 120:22 sedentary 182:7 sediment 223:13 see 14:17,18 22:12 23:25 24:14 25:20 26:7 38:19,21 41:13 42:4 53:22 54:23,24 63:21 74:14,20 75:22 76:24 77:14,17,23 78:9 79:8 83:3 85:1,19 87:2 89:7 93:12,15 96:25 102:6 106:14,16,18 108:9,25 109:6 120:21 139:16 141:20 146:23 147:6,9,12,15	159:19 165:6 167:21 173:5,9 173:15,19,22 174:7,16,24 175:24 180:24 188:8,14,22 190:16 217:22 218:14 219:2 223:11 225:5 229:8,20 244:2 244:5 251:8,19 262:22 263:4 263:16 272:10 278:21 279:8 281:25 282:5 285:21 seeing 55:4,6 133:15 143:7 193:3,5 seeking 111:20 seems 33:15 35:7 37:1 seen 21:16 48:24 53:11 88:7 92:3 108:19 136:10 139:2,3 140:17 148:11 180:2 193:13 226:13 segment 284:6 selecting 264:6 266:4 selection 100:18	selectively 205:17 206:3 207:15 send 292:14 sending 66:12 114:14 115:4 sent 114:8 194:5 sentence 26:14 27:11,14 74:16 75:4,16 78:21 79:2,3,7,13,18 81:5,9 82:13 82:14,24 85:14 85:14 95:18 96:3 106:15,17 146:24 151:4 177:17 separate 167:4 221:18 sepsis 257:14 september 114:12,22 115:12,13 120:3,3,19,25 121:4,8 123:5 125:5 126:24 sequence 22:22 245:10 series 136:5 233:1 serum 214:13 237:5 242:3 280:16 281:5	282:2 291:4,8 serve 135:8 207:8 209:4 server 116:15 serves 73:14 145:17 service 48:19 48:19 70:5 113:25 176:9 177:19 178:7 178:20,22,23 181:23 182:11 services 293:1 set 41:8 72:21 131:6 295:9 settlement 63:4 63:15,16,21 64:7 65:5,14 66:21 settlements 63:25 65:9,24 122:3,5 seven 215:22 247:9 several 31:20 147:9 195:12 248:24 282:3,4 291:11,13 severe 157:16 158:16 181:23 200:7,9 213:7 228:6 237:7 severity 262:4 263:15
--	--	---	--

sex 212:24	sharing 167:18	signature 5:7	259:13 283:17
shahnasarian	she'd 44:22	180:24 293:10	291:12
21:3,14 23:24	she'll 154:24	293:13,15	sir 7:15 11:9,14
25:1,15,19,21	262:17	294:16 295:23	12:11,25 14:18
26:15 27:4	sheet 293:11,15	signed 32:11	17:23 18:7,8
28:16,25 31:8	sheets 293:13	41:2 92:6,13	20:17,25 21:21
32:7,10,16,19	shock 274:23	167:22	24:18 26:19
32:23 35:3,21	short 57:12	significant	43:25 45:4
36:10,18 38:8	shorthand 1:18	240:13 242:6,9	46:21 47:11
51:22 52:20	5:4 295:4,10	signing 127:18	48:12 49:4
56:10,15 57:2	show 13:7,17	127:20 166:8	52:18 54:12
57:11 58:1	21:12 75:20	signs 270:7	59:16 60:7
59:22 67:8,21	130:12 146:4,5	similar 11:17	69:7,17 74:12
68:9 72:16	147:2 156:3	112:1 141:15	75:5,23 76:25
73:1,12 92:19	173:3 258:21	141:18 142:15	77:4 86:13
92:21 93:19	258:22 259:3	144:16 208:6	88:2,8 90:7
96:23 127:24	showed 177:18	224:18 263:8	91:17 97:14
129:25	181:10 255:2	similarly	98:23 100:8
shahnasarian's	282:8	157:24	103:13 105:8
3:9,10 21:24	showing 180:21	simply 34:10	107:25 108:19
22:18 23:10	228:4	96:14 105:24	110:9 112:16
27:7 33:4,22	shown 22:14	164:23 226:13	112:24 114:8
34:4,11,18	shows 178:5	282:18	115:20 117:23
35:12 37:18	231:21 252:11	sincerely	132:2 135:22
52:9 53:12,18	shrink 223:15	293:19	138:24 146:18
93:13 134:5	shrinkage	single 43:7	151:3 162:17
156:1	235:10	48:14 165:1	172:24 173:7
share 31:15	side 199:21,24	167:6 168:21	174:7 176:1,24
173:2 217:19	200:4,6 205:19	168:24 169:14	181:18 183:17
262:22	sign 127:19,21	169:16 202:24	187:15 190:15
shared 32:1,6	165:4,23	203:11 204:12	198:13 199:15
32:17 33:10	220:12 292:13	206:24 207:12	204:24 206:6
34:13,16 66:15	293:13	208:13 213:17	221:25 222:5
77:18		213:20,21	222:10 230:19

239:14,22 243:10 244:13 251:9,19 255:4 256:21 261:15 261:17 263:17 264:15,19 267:9 274:11 sit 90:11 113:10,14 138:19,23 139:7,8 232:15 277:20 site 191:9 situation 165:16 six 98:22 122:21 157:13 174:19,25 190:14 219:5 219:11 268:24 285:21 286:3 sixth 245:18,19 size 39:15 140:25 223:15 skew 246:24 skin 273:14 skinning 222:20 skip 206:17 sky 165:11 slide 66:12,14 66:17,18,20 slides 137:18	slightly 245:11 245:11 253:23 254:1 slow 80:15 221:13,14 slower 273:1 small 29:22 39:14 40:11 42:16,19 79:7 79:15,16,23 80:15 81:6,20 82:8,10 133:13 133:18 194:8 216:16 222:21 235:10 246:11 274:22 275:9 289:9 smaller 223:15 smoked 239:11 241:20 smoking 184:15 224:17 230:23 238:21 238:23 239:10 239:16,17,22 239:25 240:5,6 snapshot 214:9 235:18 sneeze 195:3 solely 9:4 34:12 solo 191:21 solutions 214:19	somebody 20:10 160:22 256:7 someone's 40:22 199:23 206:9 281:18 somewhat 141:9,14 soon 268:3 sooner 11:23 sorry 9:19,22 12:9 15:4,6,8 15:20 18:23,23 28:6 38:15 40:25 41:7 54:17 61:21 62:12 76:11 85:12 105:12 105:15 129:3 133:3 134:17 135:5 140:1 143:13,19 157:1 172:5 180:16 207:21 226:24 230:18 230:19 248:10 248:11 256:22 260:12 272:7 sort 109:9 205:22 287:23 sought 116:21 sound 58:4 92:10 143:15	sounds 74:25 92:11 288:1 source 43:18 91:9 175:17 south 2:11 southern 1:2 spans 115:12 spare 41:21 speak 84:16 104:16 149:23 208:21 262:13 273:17,19 special 274:25 specialist 115:15 268:25 specialists 27:12 88:5,11 88:25 99:14 specialties 206:4 specialty 188:15 specific 13:19 30:7 51:21 54:21 55:17 72:1,12 73:10 76:12 113:13 123:16 125:2 267:17 specifically 55:5 76:8 118:22 119:15 187:13 261:10
---	---	--	---

specimen 230:16	spoke 16:7 64:18	128:2,7 130:1 133:24 156:6	127:13 133:10 201:2 289:22
specter 81:2	spoken 111:15	stadler's 52:21	starting 112:8
spectrum 284:20	sponsor 129:15 129:18	staff 48:17	201:5 205:6
speculate 150:5 154:15 160:10 161:9	spread 109:22	stage 218:25 219:15 263:21 264:2	starts 74:17 77:22 85:3 98:16 147:8 217:23
speculating 158:5	spring 129:19	stages 250:3	state 5:16 7:19 16:1 164:14 271:14 291:14 294:22 295:3,5 295:21
speculation 81:16 153:19 153:24 154:18 155:6 156:17 156:23 157:2,3 159:2 161:3,24	stabilize 196:10	staging 94:2	stated 112:8 225:21
speculative 84:21 150:11 150:20,23,25 151:8,19 152:21 153:2,3 153:8,19 155:7 157:7 158:5,21 160:21 161:1 161:17 244:15	stabilizing 196:19	stains 230:6	statement 17:3 56:16 58:7 60:3,5 71:6 87:18 115:20 133:7 228:15 241:7 242:20 251:3 252:18 265:22 266:18 267:8
spend 36:25 191:16 192:21 193:7 195:12 206:6	stable 195:17 291:11,13	stamp 86:16	statements 56:19 57:25 90:7 120:2,5 124:22 125:17 127:7
spent 118:1,12 119:1,19 120:6 120:9,18 122:8 193:1 279:3	stacy 1:16 2:24 5:4 293:20,21 295:2,24	stamped 77:8 136:6 147:8,12 173:20 174:17 178:2 180:25	states 1:1,15,19 5:19,24 92:20 103:6 113:16 271:17
	stadler 12:25 13:4,11 15:18 15:23 16:4,7 16:11,18,21 17:9,13 18:10 19:13,20,22 20:2,5,17,21 21:4 22:2 24:20,25 25:22 26:13,17 27:4 27:19 28:15,25 32:14 33:1,3 35:23 36:11 51:23 52:9 53:15 56:10,15 57:2,11 58:2 59:23 67:8,22 68:10 72:16 73:1,13 93:18	stand 139:5 259:10 264:22	
		standard 113:17 211:4 261:20	
		standards 113:2,5 285:10 285:11,12	
		stapled 248:12	
		star 104:20 105:1	
		stars 104:18,19	
		start 116:16 124:18 149:12 207:22 220:7 263:20 270:9 289:1	
		started 120:4 123:14 127:12	

statins 272:22	184:8 220:14	subscribed	suit 112:9
stationed 239:6	222:3 234:1	294:20	275:3
statistics	235:15 244:25	subset 231:12	suite 2:7
162:11 164:25	288:16 290:5	subspecialty	suits 112:10
status 124:17	stroke 273:3	87:9	summaries
139:1 154:3	strong 257:20	substance	140:15 141:3,4
176:10 211:5	257:23 266:13	10:18 11:19	142:8,10 143:1
264:5 269:9	struck 287:2	16:24 28:1	143:4 144:2,3
statute 112:20	students 279:5	33:23 34:8	144:11 145:4,5
stay 197:18	studies 256:13	35:10,11 36:7	145:23 146:5,8
steady 291:14	256:18,25	52:5 58:23,25	148:7,20 149:1
steaks 213:15	257:1	59:12 62:16	149:3
stenographic	study 83:2,8,15	65:13,17 66:1	summarize
55:19	83:25 84:4,6	66:3,25 68:2,4	203:22
stents 234:18	164:15 242:17	68:17,19 69:19	summarizing
step 234:2	242:25 246:21	69:21 91:6	152:15
stephanie	stuff 249:19	93:2,5	summary
115:16	subject 35:19	substantial	136:22,24
stipulated 5:1	64:22 150:5	57:7	140:23 141:14
stop 162:20,21	161:25 274:16	substantially	141:18 142:17
162:23 239:15	subjects 33:6	176:8 262:2	143:10 144:18
240:5 258:10	137:21 154:9	263:13	145:19 147:25
stopped 162:24	156:14	substantive	148:3 234:8
strange 188:23	submission	57:16	superb 219:6,7
street 1:16 2:7	105:20	subtract	219:12
2:10,16 293:4	submit 246:2	139:11	supervision
stress 163:3,3	submitting	success 156:8	295:12
stretch 9:3	134:8	successful	supplement
strike 11:6	subparagraph	113:4	183:14
21:12 44:4	31:21 32:2	suggest 37:8	supplemental
55:25 60:23	269:18 273:7	suggested	3:22 180:6,11
90:16 92:17	subparagraphs	273:15	supplementary
99:6 141:25	268:16,19	suggesting 82:6	4:4
142:22 170:16			

supplemented 172:1 supply 227:14 233:9 support 48:17 81:10 supports 254:24 supposed 215:20 suppressing 273:10,11 sure 8:15 9:15 10:3 17:25 34:8 36:5 47:17 56:22 66:15 71:7 73:23 74:13 89:5,7 94:18 112:14 125:19 126:7 127:4 129:2 130:14 141:8 144:14 149:23 160:1 174:13 192:15 195:10 196:19 198:11 210:7 213:4 215:17 216:24 217:1 222:16 245:6 247:2 251:1 278:5 285:7 288:7	surgeon 42:9 46:6 47:13 48:9,14 50:10 surgeons 48:15 49:15,24 surgeries 39:18 39:23,24 40:1 43:17,20 45:13 46:18 49:21 198:1 surgery 40:16 40:17 41:22,23 42:4,5 43:8,13 44:5,10,16 45:15,17 46:5 46:8,11,13,25 47:6,9,10,20,21 48:1,4,8 49:3,8 49:16,18,19,21 49:22 50:1,1,6 50:21 51:2,7 107:14 109:15 153:5 162:21 198:7 199:6 229:18 234:23 256:15 257:6 284:12 surgical 48:16 88:15 147:11 229:18 surgically 158:15 surprise 49:11 103:9 201:19	281:18 surprised 230:22 231:5 surprising 266:14 surveillance 107:2,11 270:25 273:12 273:14 surveys 200:12 survival 4:3 244:9 248:1 252:6,12,24 253:3,13,18,22 254:7,12 265:8 266:12,16 267:3,4 286:21 286:24 290:11 291:24 survive 160:8 164:4 susceptible 258:1 suspicion 87:4 sustained 181:6 182:9 swear 6:2 sweden 211:23 212:4 switch 215:16 260:17,22 sworn 1:12 6:4 294:20 295:6	symptoms 200:2 270:13 syndrome 80:17 81:12 99:14 system 95:2 144:21 257:16 257:19,22 273:10 287:23
t			
t 295:1,1 table 23:8,9,16 23:19 24:8 32:14 35:5 128:2 131:18 289:13 tables 22:10 33:1,2 52:19 53:12,17 54:24 156:2,12 tabulated 118:2,6,14,16 tacrolimus 289:18 take 15:2 23:3 23:4,6,7,8,9 26:3 38:6 73:21,24 74:1 74:3 84:24 86:13 98:20 108:20 114:24 120:16 125:22 146:12 163:18			

164:3 190:12 190:15 224:2 234:1,11 237:23 260:21 263:19 278:3 278:24 taken 1:14 5:4 40:13 42:20 133:18 293:9 294:3 295:10 takes 203:13,13 211:13 289:21 talk 17:4 36:22 65:8 72:15,18 101:23 116:10 159:20 177:4 184:15 195:16 206:9 211:22 218:3 220:10 268:10 278:4 talked 12:24 32:7 36:14,23 64:11,11 67:10 111:10 113:23 129:25 156:14 159:7 215:5 225:18,22 227:3 230:23 246:3 talking 55:10 56:25 64:16 68:14 85:4,8 96:12 132:15 152:6 159:24	163:8,9 168:10 173:3 195:12 199:19 209:6 226:2 227:6 241:1 242:11 245:25 253:11 talks 36:17 72:5 86:21 113:2 122:2 137:19 263:21 266:23 tape 260:22 tce 187:5,12 teaching 279:5 279:5,6 team 49:1,7 50:5 66:5 86:8 88:22 90:5 115:3 269:8 teams 25:14,23 27:21 59:21 65:2 123:22 124:17 technical 255:15,16 technician 5:10 6:1 41:3,6 73:20 74:1,6 140:2,7,10 143:16 215:15 215:19,23 216:1,6,9 260:9,14,19,25 261:4 278:6,9	292:12,15 ted 2:6 5:25 13:21 22:17 76:15 98:20 108:6,9 120:10 130:15,25 172:8 180:4 228:18 247:24 262:23 telephone 25:11,16,19 tell 6:5,21 31:14 69:13 95:13 138:17 140:19 165:9 166:16 227:1 238:16 239:10 261:14 278:13 287:12,13 telling 106:5 128:8 201:15 tells 85:22 ten 290:11 tend 233:5 tends 253:22 term 4:2 149:9 222:8,9 242:14 248:1 288:4 289:25 291:24 terms 9:12 38:11 63:10 113:5 128:3 160:7 161:4,13 171:18 208:20	211:4 226:5 240:16,17 243:1 254:11 256:15 269:15 test 75:11 78:9 78:18,23 79:4 79:11,24 80:5 80:10 82:24 126:4 209:3,5 214:9 272:10 291:16 tested 78:15 170:22 testified 6:6 80:22 143:24 148:5 170:15 236:10 243:21 277:4,8 testifies 32:23 testify 35:4 39:25 52:4 110:19 138:14 141:10 144:6 275:6 276:1 295:7 testifying 31:19 32:3 33:11 40:6,9,18 80:20 167:14 testimony 8:2,6 8:10 37:24 98:1 105:25 124:9 126:14 126:21 141:24
---	--	--	--

142:1 145:15	213:6 219:22	81:24 82:17	236:9 237:1,10
147:23 148:1	231:17 244:21	86:18 92:7	238:3,8,23,25
181:19 191:5	256:8 257:15	94:22,25 97:1	239:5 240:19
205:11 206:5	280:1	97:3,19,25	241:16 244:3
227:20 244:6	things 30:6	101:11 102:3	246:15,22
295:7,13	42:25 43:1	102:14 103:17	247:21 251:24
testing 78:13	54:7,8,10	108:4 112:5,9	259:6 262:12
79:6,15 83:1	89:25 104:14	114:6 116:1	262:15 264:20
86:5	109:15 140:21	123:20 124:16	265:23 267:25
tests 83:21	141:15 154:20	129:11 132:3	268:1,3,4
269:19,21	161:23 186:11	132:22 133:2,5	273:25 274:12
text 10:7 11:15	186:16,23	134:2,7,12	275:4,8,15,17
texts 10:24	197:6 209:21	135:4,11,16	276:11,17
thank 12:15	209:22 214:22	138:6,16	277:2,14,18,19
15:11,13 19:10	219:17 237:22	141:16 143:3,6	277:24 279:21
33:17,19 41:9	247:22 249:17	143:24 144:25	280:2 281:14
91:25 103:19	286:4 287:11	145:8,22 148:2	284:24 285:9
206:20 248:15	287:15	150:13,22	286:13,17,19
248:22 260:15	think 15:5 16:8	151:23 157:3	287:6,8 290:14
261:19 292:8	17:10 22:7,11	160:9 161:11	290:18 291:6,8
292:11 293:17	22:13 23:18	163:20 164:25	291:20
theme 262:1	27:15 29:23	168:16 170:18	thinking
263:12	31:2 33:18	170:23 174:12	279:12 283:1
therapeutic	35:9,20 37:5	181:11 184:20	286:20
243:11	40:20 43:4,4	186:3,16	third 70:17,19
therapy 107:2	44:15,17 46:2	188:11 194:17	77:21 78:22
107:11 109:5	49:15 53:3,14	195:1 196:14	145:24 146:3
109:10,12,14	53:20,22 55:11	197:21 199:10	172:18,23
109:14,24	57:17 60:13	200:22 201:8	173:18 261:20
110:25 285:6	63:1,14 64:6	207:6,23 208:3	263:23 275:15
thing 6:25 27:5	66:23 67:12	208:23 213:5	275:23
76:15,16	70:9,11 72:23	220:12 224:5	thomas 126:5
136:21 178:22	73:9 75:1 77:6	227:3 228:16	thought 43:6
185:19 195:5	80:16,18 81:11	229:3 232:4,7	109:17 110:18

133:14 168:3 171:10 201:17 264:16 thousands 29:2 29:10,14 threaten 165:12 threatening 258:1 three 11:11,13 22:21 64:16 66:17 104:15 104:18,21 105:1 124:20 128:12 149:18 149:19 171:1 182:4 189:1,4 191:23 192:3,6 192:7,10,11,12 192:18 194:12 218:3 224:15 226:22 268:19 269:19 274:13 278:23 279:1 till 91:19 234:4 time 5:12 12:1 36:25 37:14 40:16 42:21 56:24 58:9 71:17 73:7 77:17 86:2 91:16,17,18 92:2 98:3,4,6 98:10,16 117:1	118:1 119:1,19 120:7,18 121:9 122:19 124:4 126:16 128:9 134:8 136:10 138:20 139:3 153:9 157:4,8 158:7 181:6 182:2,9 183:20 183:22 190:10 191:15,19 192:22 196:4 200:19 201:15 202:19 203:3 206:16 209:17 211:13 214:8 214:10 215:17 215:22 222:4 223:12 224:21 227:17 235:18 237:15 240:13 244:17,21 250:15,17 254:1 257:10 260:8 268:4 271:17 277:6 279:3 285:16 285:20 286:11 287:5 289:4,20 times 11:6 40:11 42:11 50:17 170:24 170:25 171:2,5 192:8 194:22	234:17,20 tinnitus 176:16 tissue 39:17 40:13 42:15,20 43:9 230:1 231:13 title 24:14 94:16 titled 100:25 today 6:13 7:9 8:2,6,10,17,20 91:19 106:5 113:10,15 144:6 148:2 149:9 234:4 236:4 today's 5:11 together 214:24 245:8 282:6 told 12:22 235:3 tolerance 271:15 tolerate 198:25 took 32:17 40:12 42:14,16 43:5,13 45:12 115:18 148:8 234:8 286:14 tool 225:12 top 23:12 24:13 58:6 149:19 172:19 193:18	193:23 194:13 195:1,4 217:5 217:5 240:10 topics 38:5 total 42:12,13 116:22 124:4 215:22 237:4 276:4 totally 178:6 totals 131:12 toward 77:11 towards 24:13 86:22 toxic 110:13 169:10 186:5 toxicity 268:12 toxicologic 186:19 toxicologist 183:25 186:9 toxicology 134:1,2 186:18 toxin 220:24 toxins 185:21 185:23,24 196:13,19 209:21 220:17 221:3,6 276:8 tract 94:24 96:15 97:24 185:17 186:1 trained 50:15 training 18:25 19:16 43:23
--	--	--	---

45:21 46:1,19 46:20,22,24 47:5 72:10 81:16 89:15 188:3 269:2 transcribed 5:6 transcript 3:13 108:11 293:12 294:15 transferred 201:10,11 translated 218:24 219:14 transplant 29:5 30:17 44:5,9 44:16,21 45:8 45:15 46:4,8 47:13 48:13,18 48:19 49:3,8 49:21 50:5,10 50:11 89:13,17 89:20,24 90:1 90:4,5 111:24 150:4,10,19 151:6,10,17 152:17 153:5,8 153:15,25 154:2,4,11,12 154:19 155:1 155:11,22 156:11 157:12 157:15,19,20 158:4,6,8,12,20 158:24 159:15	159:16,17 197:20 203:23 205:10 208:9 208:12 218:15 219:6,13,18,20 219:21 220:2,3 220:6,13 240:16 241:2,5 241:11,16 242:2 243:19 243:22,24 244:1,16 250:17 251:7 252:11 254:2 254:20 256:9 256:14 257:6 258:9 261:10 265:7,8,10,17 265:19 266:4,7 266:16 267:3 267:16,23 268:7,24 269:5 269:10,23 270:1,9 271:11 272:1,9,10,17 272:19 273:4,9 273:12,16 287:13,22 288:5,23 289:9 289:16,22 290:3 291:22 291:25 transplantation 4:3,6 217:24	218:4,23 219:10 248:2 253:24 255:14 261:21,24 262:6 263:12 264:1 265:25 266:14 transplanted 156:9 260:1,5 270:24 transplants 89:16 90:2 219:23 242:7 247:12 288:14 290:23 transport 274:24 275:9 275:22 transported 274:22 treat 169:20,24 284:21 treated 232:12 258:4 285:3 treating 67:15 67:18 108:1 169:12,21 275:4 278:15 treatises 243:2 treatment 27:6 27:13 30:1 36:15 51:9,23 52:11,13 53:1 53:5,7,20,25	54:21 169:3 198:6 199:2,22 200:3,11 208:4 270:14 280:3 284:18 treatments 87:17 268:21 trial 2:15 39:8 72:21 138:15 144:6 277:5,8 trials 266:4,7 tricky 283:10 trouble 271:7 true 10:3 13:5 17:10 18:12 19:2,3,9,23 20:3,25 21:5 25:8,9 26:2 27:8,14 29:11 29:12 38:24 39:1,2,5,6,10 39:11 41:23,24 43:11 45:21,22 46:22 47:2 48:3,5,6,10,21 48:22 49:19 50:2,7 53:9,10 53:19 63:7,13 63:25 64:13,14 70:2 73:17,18 78:15,16 79:9 80:6 81:16 87:20,23 89:6 89:22,23 92:25
--	--	---	--

92:25 93:17	188:18,18	trust 41:11	tukes 3:8,10,11
94:11 96:17,21	195:14,15,20	truth 6:5,5,6	3:17,19 13:24
96:23 98:12,13	195:21 196:15	295:7	14:6,16 15:3
98:18 101:3	196:24,25	truzicka 2:8	15:15,24 16:2
102:18 104:2,4	197:2,3,13,14	try 41:13 71:17	21:17 22:19,22
105:23 110:13	197:20,21	100:12 107:22	23:2 26:3 27:2
111:14 113:25	198:11 202:9	109:21 110:23	27:5,12 28:12
114:23 117:1,2	202:14,20,21	152:12 188:22	28:23 29:10,24
118:4,10,11,19	203:6 205:13	206:9 257:25	30:3,14,20
119:9 120:6	209:12,18,23	269:12 272:2	32:11 33:2,3
121:21 122:5	210:11,25	279:18 280:1	35:21 36:8
123:17 126:10	211:1,8,9,14,20	trying 7:23	38:9,20 39:9
131:13,15,19	212:2,12,17,22	18:4 20:12	39:13,16,24
131:20 133:12	212:23,24	34:17 42:18	43:11 44:3,20
140:24 141:6	213:1,3,8,12,16	56:22 63:1	45:16 51:10,24
150:7,13,15	214:10 215:1	79:25 80:1,9	52:11 55:3,5
151:1,22 153:6	215:13,14	81:1,3,7,10	55:10,16 56:6
153:20,22,24	216:18 225:11	82:4 83:15,17	57:20 60:9,14
154:16 155:18	225:19 230:11	112:4,6 116:15	61:4,16,20
155:24,25	230:16,17,19	120:22 127:15	62:2,19,22
160:12,13,15	231:2,3 235:19	127:19 133:16	67:15 68:11
160:17 161:1	235:23,24	135:25 143:10	71:5,9,12,22
161:10,11,11	236:7,8,12,20	145:11,12	72:12 74:10
161:17,18	236:21 239:23	186:20 207:8	75:22 76:7
162:2,22	240:3,4 242:11	223:21 254:23	77:8 78:5
163:19 164:20	247:18 249:4	258:23 282:17	80:22 83:1,7
168:15 169:17	250:21 252:17	291:10	85:7,22 86:23
169:22,23	252:25 253:20	tubular 213:25	94:15,20
170:5,9,10	254:15 255:3	tubules 202:13	106:10,13
176:22,23,24	256:5,10,11	227:15 228:11	107:5 108:1,25
183:9,10,11	257:20,21	235:12	110:4,7,13
184:12,18,19	258:2,3 262:7	tubulointersti...	111:17,19,25
184:21 186:2,3	262:8 277:13	221:12 222:1	118:8 119:7,10
187:23 188:17	277:23 295:12		119:15 123:1,8

123:17 124:15	268:12 273:18	159:22,23,23	under 10:14
124:18 125:10	273:19 286:17	159:24 216:2	80:22 85:14
126:25 127:14	286:20 291:18	typewriting 5:7	106:1 110:20
127:22 128:7	turn 74:9 109:2	typographical	126:14 141:10
130:17,24	172:17 243:14	119:22	148:1 163:2
131:2 132:15	285:22	u	175:1 190:16
133:6 136:13	turned 201:18	u.s. 2:15 293:3	203:5 205:11
136:23 139:11	twenty 147:7	uh 74:19 77:25	222:13 223:21
140:16 141:2	twice 171:1	99:21 120:24	226:13 295:11
142:3,10,25	278:22	225:7	undergoing
146:15,17	two 14:6 15:8	ultimately	237:13
147:6 150:3,9	21:9 31:2,9	196:23 198:1	underlying
150:15,18	42:10 66:17	ultrasound	81:24 177:5
153:15 154:6	104:13,19	270:19	199:23
154:23 156:5	105:1 112:17	ultrasounds	underneath
156:10,25,25	118:15 120:6	270:16	87:2
159:9 160:8	121:1 122:7	unable 165:24	understand
161:14 162:6	127:9 130:18	170:12 176:7	6:15,21 7:4,6
184:10,18	139:20 149:11	181:3,22 182:6	19:13 33:20
185:21 186:5	159:22,23,25	unaware	37:5 41:14
197:10,15	174:4 176:4	201:14	42:2 139:17
198:13 199:5	181:21 189:2,3	unc 75:19 76:2	199:18 222:9
199:14 200:6	189:8,9,13	76:7,18 78:5	239:22
200:16 203:15	197:5 201:8	82:25 106:23	understanding
217:9,18,23	207:24 219:17	107:10 110:4	56:12 80:14
220:13 240:16	222:11 224:14	146:21 147:3	95:5 106:6
241:4,16	224:15 226:22	147:24	117:4 138:19
243:24 244:10	237:20 247:17	uncertain	204:18 238:20
244:12,14	248:12 260:9	155:19 162:20	240:6 245:2
248:24 250:19	274:13,14	162:23	267:19,24
251:3 255:21	275:21,23	uncommon	understood 7:7
258:9 261:7	280:11	200:14	15:1 85:17
262:10 267:12	type 47:12		underwent
267:20 268:9	106:7 159:21		217:23 234:16

238:18 undiagnosed 81:25 unemployabi... 174:5 175:24 176:6,19 unfair 35:8 unfamiliar 186:17 united 1:1,15 1:19 5:18,24 113:15 271:16 units 201:9 university 12:6 12:7,17 17:22 18:1 29:3 48:20 49:4,9 87:25 88:12 89:21 189:11 189:14 192:17 192:21 193:5 198:5 199:11 217:4,13,25 271:18 278:20 unknown 67:9 69:4 72:17 73:2,13 130:1 unnecessary 41:23 unrelated 92:22 untrue 48:12 117:3	update 86:24 updated 30:17 upper 94:24 97:24 185:17 186:1 263:11 ureter 48:1 176:11,22 177:11 271:5 284:7 urinalysis 223:12,17 270:3,5 urinary 95:1 96:15 196:15 urine 209:8 210:16 223:13 223:21,24 224:1 270:6,11 270:13 280:18 282:4,6 urologic 41:25 47:14 81:13 106:23 107:17 urologist 284:19 urologists 47:19,21 88:16 199:11 284:5 urothelial 94:25 97:2,10 97:24 176:10 185:17 186:1 usa 5:15 111:20	usdoj.gov 2:17 2:17 293:5 use 20:9 36:8 101:12 137:7 214:24,24 219:9,11,16,16 223:1 253:14 253:15 289:24 used 20:12 99:7 137:14,17 138:7 149:14 150:22,24 211:19 216:20 222:10,11,12 222:14 223:3 246:25 249:13 254:13 271:16 280:9,22 289:18 291:1,3 useful 252:23 useless 219:25 uses 78:7 194:25 211:11 using 144:19 211:7 212:19 214:13 215:6,7 216:15 224:4 242:25 246:23 247:5 284:6 285:17 usually 223:12 utuc 92:22 201:24	v va 3:20,23 29:7 31:3 172:6,12 173:14,15 176:17 177:1,2 177:7,18,18 178:13,21 179:23,24 181:14 183:23 274:1 value 218:17 219:11,19 values 169:7 218:7,23 219:9 219:10,13 vance 17:18,25 20:22 21:1 25:25 58:5,15 59:17 67:8 68:14 72:15 73:1,13 130:1 133:24 variables 212:12 249:13 variant 274:3 variation 87:5 240:20 241:13 246:18 various 280:24 vary 199:23,24 vascular 222:20 233:4,5 233:10,11
--	---	---	--

234:25 235:20 255:15,17 vasculature 235:2 274:3 vba 173:20 veins 271:4 vendor 70:20 ventures 189:13 verbally 75:5 verbatim 111:18 119:21 119:22 verge 274:23 versed 70:1,13 70:14,25 113:25 114:2 115:15,23,25 116:2,4,7,11,22 117:4,6,7,12,12 117:13,16 119:3 124:1 129:6,12 130:3 130:6 274:10 274:10 275:14 versus 240:24 246:15 vessel 234:24 vessels 222:21 235:11 vestigial 197:1 veterans 171:8 171:17,23 172:9,20,22	173:1 vetted 114:2 vi 32:2 video 1:11 5:10 5:12 6:1 41:3,6 73:20,21,25 74:1,2,6 140:2 140:3,7,10 143:16 215:15 215:16,19,23 216:1,6,9 260:9,14,18,19 260:22,25 261:4 278:6,9 292:12,15 videographer 2:22 view 41:21 viewed 243:3 viewpoint 42:6 viewpoints 20:8 72:11 village 101:1 vinyl 187:22 viral 157:16 281:20 viremia 287:20 virtual 128:14 128:15 virtually 32:23 virus 271:19,22 271:23 272:4 287:24	vis 211:6,6 visible 250:16 visit 106:14,19 108:24 visits 268:23 269:11 vital 195:8 voc 281:10 vocational 3:22 171:24,24 179:22 180:22 181:15 volume 209:15 209:16 vs 5:14 vus 86:25	140:6 155:23 156:3 167:11 169:11 182:13 199:6 247:1 248:9 250:24 260:21 268:2 272:21 285:21 288:15 wanted 81:23 wants 260:20 washington 2:16 293:4 water 1:5,21 5:14 61:3,18 62:8,17,24 63:12 65:6 71:11,20 111:21 112:21 185:22 195:18 196:9,10,19 293:6 294:2 way 50:24 55:8 66:20 73:4 90:9,10 101:17 111:16 112:12 119:25 131:11 139:12 149:15 153:13 154:23 154:24 156:15 156:15 157:6 159:20 162:4 168:16 193:11 196:2 197:5 198:12 204:22
		w w 26:13 wait 73:24 91:23 139:24 255:6 261:15 waiting 40:15 waitlisted 90:2 waived 34:23 37:3,16 walt 19:22 20:4 walter 12:24 20:2 24:20 26:17 35:23 want 36:3 40:10 76:11 77:7 82:14 109:11 138:22	

205:22 211:13 211:17 215:4 216:12 217:2 225:20 226:23 227:9 228:8,8 228:9 232:13 234:1 238:10 243:21 244:7 244:19 254:25 256:12 284:22 wayne 23:23 ways 207:24 210:9,23 211:3 222:11 272:5 289:11 we've 15:22 77:18 173:14 227:3 254:19 weaker 257:17 website 48:24 88:7,20 102:5 103:6 145:3 198:5,9,10 week 54:12 191:15,19 218:6,17 278:22 281:20 weeks 64:16 weight 210:13 247:14 280:15 went 120:2 252:19 287:21 whirring 143:14	whoever's 111:19 wholesale 17:3 wide 240:20 241:12 246:18 widely 211:19 280:22 wiped 200:11 wish 139:15 withdraw 187:2 witness 5:8 6:2 7:11,13 19:2 70:4 274:15 276:24 277:7 277:11 293:12 294:1 295:6,8 295:14,20 woman 104:6 word 12:9,11 19:6 32:4 36:9 63:22 112:13 114:25 124:15 150:22 160:17 223:18 wording 273:25 words 57:4,12 137:12 150:24 198:6 208:19 210:2 work 9:13 20:9 31:25 56:3,11 60:11 61:10,16	62:16,24 63:11 63:15 66:21 69:24 70:9,13 70:25 112:12 115:10 121:14 121:15,16 123:11 141:12 162:7,13,20,21 162:23,24 164:8,20 165:24 166:8 166:18 168:13 168:19 170:12 170:12 171:14 175:7 177:9 178:17,17 179:6,16 181:4 181:22 182:8 182:21 188:25 189:3 191:2,13 191:25 192:15 198:16 202:17 203:3 208:1,14 276:23,24 277:11 worked 50:14 63:19 71:10 189:23 190:1,3 274:9 275:19 275:25 277:21 working 60:22 61:1,6,25 63:3 63:4,18 71:8 71:15 157:20	162:13 163:17 175:11,20 182:25 193:5 220:4 251:8 258:10 275:11 276:19 works 157:12 world 18:19 292:7 worry 220:7 worse 199:7 237:12 289:24 worst 200:4,6 250:1,6 284:1 worthy 216:22 write 72:18 123:12 125:7 133:16 143:10 165:9 writing 16:16 40:20 41:14 112:4 120:5,25 121:5,9,21 122:8,9,12,16 123:14,23 124:1,5,6,10,13 124:24 125:12 126:2,3,16 127:3 133:21 295:11 writings 162:11 written 20:15 31:24 100:14 148:8 177:14
--	--	--	---

177:15 wrong 25:17 178:14,18 197:12 246:3,6 246:25 254:25 wrote 72:19 78:5 120:8 122:21 126:16 151:15 196:14 219:23 246:5 254:4	201:22 216:1 226:7 228:17 229:5 243:9 248:14,14 259:23 275:17 288:21 year 25:3 27:8 30:21 45:18 105:23 157:14 157:23 189:7 191:22 192:9 192:14,19 193:2 194:14 197:20 198:14 198:15 242:3 242:12,13,21 246:23 247:8,9 247:10,10,10 247:12 253:1,3 253:23 254:7 254:11,16 255:13,21 256:1,4 257:6 257:18 258:7,8 258:10,16,23 259:1,2,4,7,8,9 259:11,13,25 260:3,3,4 268:12 271:20 278:24,24 279:2 286:3 288:5,8,10,21 288:22,25 289:2,3,5,8,10	290:21,23 years 45:24 46:4,16,21 47:4,25 49:14 49:24 51:4 70:10,14,14 94:7 153:9 154:13,14 160:8 165:14 189:8,9 203:11 205:10 234:24 237:20,21,21 238:18 239:7 240:19,21,24 240:24,25 241:9,12,17 243:23 244:9 244:17 246:15 246:15,18 251:8 252:10 252:17,18,19 252:21,23 253:5,13,18 259:16 262:17 265:11,12 270:8 280:11 280:11 281:23 289:14,19 290:11 yep 195:7 261:18 yesterday 66:16	younger 257:17 265:9,21 266:17 z zachary 2:3 zero 260:13 289:6 zina 2:20 zina.bash 2:21 zoom 25:12,13 25:23 27:21 41:1 59:21 65:1,3 66:5 123:22 124:17
x			
x 3:1			
y			
yeah 12:14 19:21 34:1 57:6 59:2 60:20,25 61:22 63:10 64:3 69:11 75:24 76:14 82:10 86:17 87:21 92:12 100:20 110:5,7 113:14 123:20 125:21 127:25 139:17 146:2 147:20 148:12 161:2,4 161:13 164:13 166:24 170:11 186:4,22 192:6 192:6,15 194:3 198:12,15			

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.

DISCLAIMER: THE FOREGOING FEDERAL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY.

THE ABOVE RULES ARE CURRENT AS OF APRIL 1, 2019. PLEASE REFER TO THE APPLICABLE FEDERAL RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

VERITEXT LEGAL SOLUTIONS

COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

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