

Exhibit 600

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

IN RE: CAMP LEJEUNE WATER)
LITIGATION) Case No.:
-----) 7:23-CV-897
This Document Relates To:)
ALL CASES)

- - -

VIDEOTAPED DEPOSITION OF WALTER STADLER, M.D., FACP
Wednesday, July 16, 2025

- - -

The videotaped deposition of WALTER
STADLER, M.D., FACP, held at The Rookery Building, 209
South LaSalle Street, Suite 600, commencing at
approximately 9:03 a.m., on the above date, before
Juliana F. Zajicek, Registered Professional Reporter,
Certified Shorthand Reporter and Certified Realtime
Reporter.

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No. 3 Report of Walter Stadler, M.D., 5
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1 (WHEREUPON, certain documents were
2 marked Dr. Stadler Deposition Exhibit
3 No. 1, No. 2, No. 3, No. 4 and No. 5,
4 for identification, as of
5 07/16/2025.)

6 THE VIDEOGRAPHER: We are now on the record. My
7 name is Josh Dominiak. I am a videographer for
8 Golkow, a Veritext Division.

9 Today's date is July 16th, 2025, and the
10 time is 9:03 a.m., as indicated on the video screen.

11 This video deposition is being held at 209
12 South LaSalle Street, Suite 600, Chicago, Illinois
13 60604, In the Matter of In Re Camp Lejeune Water
14 Litigation for the United States District Court for
15 the Eastern District of North Carolina.

16 The deponent today is Dr. Walter M.
17 Stadler.

18 Counsel will be noted on the stenographic
19 record, and our court reporter today is Juliana
20 Zajicek.

21 Will you please swear in the witness and
22 then we may proceed.

23 (WHEREUPON, the witness was duly
24 sworn.)

1 WALTER STADLER, M.D., FACP,
2 called as a witness herein, having been first duly
3 sworn, was examined and testified as follows:

4 EXAMINATION

5 BY MR. MANDELL:

6 Q. Dr. Stadler, my name is Zach Mandell, and
7 I represent the plaintiffs leadership group in this
8 litigation.

9 You understand that, right?

10 A. I do.

11 Q. You have been designated as an expert
12 witness by the United States, the defendant in this
13 case. You understand that, right?

14 A. Yes, I do.

15 Q. What I would ask you is that if at any
16 point in time, I ask you any question that you don't
17 fully understand, I would ask you to tell me you don't
18 understand that question.

19 Is that fair?

20 A. That is fair.

21 Q. It's important you do that because if you
22 don't tell us that you don't understand the question,
23 we're all going to assume you did understand it.

24 Is that fair?

1 A. That is fair.

2 Q. If you need to take a break at any point
3 in time, just let us know. It's not a marathon that
4 way. I might ask, though, that if you are -- that if
5 there's a question pending that you answer the
6 question pending before we take a break. Fair?

7 A. That is fair.

8 Q. I have marked off the record, but for the
9 record, each one of your five exhibit -- reports in
10 this case.

11 MR. MANDELL: You don't need a copy?

12 MR. BU: I have a copy. Thank you.

13 BY MR. MANDELL:

14 Q. The first, we've marked as Exhibit 1 is
15 your report in the Downs case; No. 2, Exhibit 2 is in
16 the Fancher case; Exhibit 3 is in the Howard case;
17 Exhibit 4 is in the Mousser case; Exhibit 5 in the
18 Tukes case.

19 And what I would ask you is, if you could
20 take a look at those briefly and just please for the
21 record let us know if those appear to be the complete,
22 accurate copies of those reports?

23 A. On -- on quick review, they appear to be
24 the complete and accurate copies of those -- of these

1 reports.

2 Q. Okay. Great. And is it fair to say,
3 Dr. Stadler, that all of the opinions that you intend
4 to give in this matter are contained in those five
5 expert reports?

6 A. Yes.

7 Q. I've marked as Exhibit 6 the records we
8 were provided in response to our request for
9 production in this case relating to, among other
10 things, your billing.

11 And does that appear to be all of the
12 records that relate to your billing in this matter?

13 A. While I haven't gone through every single
14 invoice, they -- it appears to be the appropriate
15 record for my billing.

16 Q. And were you provided with the request for
17 documents that we -- we had sent, that we had asked
18 you to bring with you here today?

19 A. I did not bring any documents with me
20 today.

21 Q. Fair enough. Let me rephrase that
22 question.

23 Were you provided with the subpoena for
24 documents, or did you discuss it, and I don't want to

1 know the substance of your discussions with counsel,
2 but were you aware that there was a request that you
3 either bring documents with you today or send to us
4 prior to the deposition?

5 A. I was aware of a subpoena to appear at the
6 deposition. I depended on the Department of Justice
7 lawyers to provide any documents that, again, might be
8 necessary.

9 (WHEREUPON, a certain document was
10 marked Dr. Stadler Deposition Exhibit
11 No. 6, for identification, as of
12 07/16/2025.)

13 BY MR. MANDELL:

14 Q. Okay. Well, why don't we do this, then.
15 If you could take just a minute, look through the --
16 what we have marked as Exhibit 5, and let me know if
17 there is any billing that you are aware of -- and when
18 I say billing, I mean actual invoices or contracts
19 that you have with the Department of Justice related
20 to billing, that type of thing, that isn't located in
21 Exhibit 5 -- 6, which is Bates Number STADLER_USA_782
22 through 812.

23 A. So you mentioned Exhibit 5, but you're
24 referring to Exhibit 6, is that correct?

1 Q. I corrected myself in the middle.

2 A. Yeah.

3 Q. So I apologize for that. But, yes, we're
4 talking about Exhibit 6.

5 A. So to the best of my recollection,
6 everything that I have, all of my billing contracts
7 and invoices are appropriately reflected in these
8 documents.

9 Q. Okay. And what -- is it fair to say that
10 Exhibit 6, and in particular the invoices, reflect the
11 work and the time that you have spent on this case so
12 far, to the best of your ability?

13 A. Yes.

14 Q. And Exhibit 6 would -- is it fair to say
15 would reflect the best evidence of the work and -- and
16 the time that you've spent on the case so far?

17 A. Yes.

18 Q. Meaning, you don't have any independent
19 memory of work that you've done on this case outside
20 of what's in those billing records, is that fair?

21 A. That is fair.

22 Q. Okay. And so -- fair.

23 And in terms of the description of the
24 work that you've done so far in this case, is it fair

1 to say that the descriptions that are contained in the
2 invoices reflect the best evidence that you would have
3 in terms of what work you did, at what time, and for
4 how long?

5 A. That is correct.

6 Q. All right. And then final question on
7 this, is it fair to say that you would not have done
8 work on this matter and not billed for it, is that
9 fair?

10 A. That is correct.

11 Q. Okay. Great.

12 In terms of Exhibit No. 6, there's a
13 document, the very first page, and it says -- it's
14 Stadler -- the Bates number at the bottom right-hand
15 corner is STADLER_USA_782.

16 Do you see that?

17 A. I see that.

18 Q. And do you see here, the top of the
19 document says, "U.S. Department of Justice" and then
20 it's a request -- the title is "Request, Authorization
21 and Modification of Contract for Services of Expert
22 Witness, Litigative Consultant, or ADR Neutral."

23 Do you see that?

24 A. I do.

1 Q. Okay. And in the middle of the page, kind
2 of Number 11, Box 11, it is a summary of what is being
3 asked, as I understand it.

4 Do you see that?

5 A. I see that.

6 Q. And it is a revised total contract funding
7 of \$190,000.

8 Do you see that?

9 A. I see that.

10 Q. Is -- do you have as an understanding that
11 for the billing that you expect to make in this case
12 that that will be approximately \$190,000?

13 A. That is not my understanding. My
14 understanding of this document is that to -- to assure
15 that there are sufficient funds for whatever I might
16 bill. I don't have any anticipation or expectation in
17 terms of what future work might entail.

18 Q. Do you know how much you've billed to
19 date?

20 A. I do not know directly off the top of my
21 head. I would have to review all of the invoices.

22 Q. All right. Do you know where the number
23 190,000 came from?

24 A. I do not.

1 Q. Was -- did you -- did you have to submit
2 any expected work amounts or details -- strike that.

3 Were you aware that there was a request
4 made to modify your contract to make it such that
5 there was \$190,000 of available funding for you?

6 A. I was aware of this modification to the
7 contract.

8 Q. All right. So you were aware that there
9 was a contract being modified to \$190,000 before it
10 was made, is that fair?

11 A. I know that as we did the work, that we
12 needed to modify the contract to assure that there
13 were enough funds present.

14 Q. I see. So is what happened that there was
15 an original contract funding amount and you exceeded
16 that amount, fair?

17 A. My recollection, to the best of my
18 recollection, we were approaching the maximum amount
19 and so, therefore, we modified.

20 Q. So what happened was, there was an
21 original funding amount, you were approaching that
22 amount, and everybody thought, okay, we need to get
23 more money, basically, right?

24 A. That was my understanding from, you know,

1 the -- the lawyers.

2 Q. And was the original funding amount
3 \$40,000?

4 A. According to this, it seems like it was.
5 I don't have an independent recollection of that.

6 Q. So I -- I guess my final question on this
7 is, when that request was made that you were aware of,
8 did you need to provide any details in terms of
9 substantiating an extra \$150,000 of funding for
10 yourself or not?

11 A. I did not.

12 Q. Needless to say, you are aware of the fact
13 that there at this point in time is \$190,000 allocated
14 for your expert witness services in this case, fair?

15 A. That is fair.

16 Q. Okay.

17 MR. MANDELL: Can I have the CV, No. 6?

18 (WHEREUPON, a certain document was
19 marked Dr. Stadler Deposition Exhibit
20 No. 7, for identification, as of
21 07/16/2025.)

22 BY MR. MANDELL:

23 Q. Dr. Stadler, we've marked as Exhibit 7
24 what was provided to us as your curriculum vitae.

1 Could you take a look at that, sir, and
2 just let us know if this appears to reflect your
3 curriculum vitae?

4 A. This does appear to reflect my curriculum
5 vitae.

6 Q. And this says that the date prepared was
7 December of 2024. Do you see that at the top of the
8 first page?

9 A. That is correct.

10 Q. Do you know, sir, if there is a more
11 up-to-date copy of your CV?

12 A. I update my CV on a regular basis, and
13 there may be some minor modifications to publication,
14 there may be some additional publications.

15 Q. Anything in terms of where you work or
16 your regular day-to-day activities?

17 A. No. The current CV reflects my current
18 employment at the City of Hope.

19 Q. Could you -- could you tell us just a
20 little bit, please, about what you just described as
21 your current employment? So tell us, I know you had
22 mentioned City of Hope, what you do for City of Hope,
23 and if you work anywhere else, just briefly.

24 A. I am the chief clinical officer for the

1 City of Hope Chicago, where my role is to build that
2 center and fully integrate it with the City of Hope
3 national system.

4 Q. Okay. And you have an affiliation with
5 the University of Chicago?

6 A. I did. When I took on the -- this new
7 role, I officially retired from the University of
8 Chicago.

9 Q. And when was that?

10 A. That was as of February 1st, 2025.

11 Q. Got it.

12 There are a number of organizations or
13 affiliations that you have on your CV related to
14 entities that deal with kidney cancer, is that fair?

15 A. That's correct.

16 Q. All right. Could you tell us the -- what
17 is the Kidney Cancer Association?

18 A. The Kidney Cancer Association is a patient
19 support group that -- whose function is to support
20 patients and their families who are going through a
21 kidney cancer diagnosis.

22 Q. And is -- is the Kidney Cancer Association
23 an entity for which you believe has a reputable and
24 reliable reputation?

1 A. I do.

2 Q. Okay. And do you -- strike that.

3 What is your affiliation with the Kidney
4 Cancer Association?

5 A. I have been affiliated with them for many
6 decades. Currently I'm a -- I'm on their scientific
7 advisory board as ex-officio and I provide some
8 volunteer services in regards to some of the grants
9 they administer.

10 Q. Could you tell us a little bit about some
11 of these roles? The scientific advisory board, what
12 is that?

13 A. So as a patient support organization, the
14 patients will ask the scientific advisory board on,
15 you know, current standards of care and appropriate
16 treatments for patients, will also ask for advice on
17 the best way to enhance research on improving care for
18 kidney cancer patients.

19 Q. The scientific advisory board, is that
20 also known as the medical steering committee?

21 A. It's also known as the medical steering
22 committee, that is correct.

23 Q. All right. And does the -- the medical
24 steering committee, you -- according to your CV,

1 you've been on that for a significant amount of time?

2 A. That is correct.

3 Q. All right. And how did you first get
4 involved in that?

5 A. I was first involved when the Kidney
6 Cancer Association -- shortly after the Kidney Cancer
7 Association was formed in, I believe, it was in the
8 mid '90s even, I was introduced to them by my then
9 mentor at the University of Chicago.

10 Q. All right. And according to your CV,
11 you've been on the board of directors for the
12 organization?

13 A. I have been on the board of directors in
14 the past, that is correct.

15 Q. And any other involvement that you have
16 with them in terms of an either formal or informal
17 dealings?

18 A. They've supported certain grants for young
19 physicians who might be interested in kidney cancer
20 research, and I've had -- recently had some
21 interactions with those mentees in terms of career
22 guidance and mentorship.

23 Q. Would -- would you agree that the medical
24 steering committee provides strategic guidance to the

1 Kidney Cancer Association and the planning of its
2 medical education activities as well as the
3 supervision of the content of its patient education
4 programs and literature?

5 A. I do, yes.

6 Q. What does that entail, meaning what --
7 what does the medical steering committee or the
8 scientific advisory board, as you called it, do in
9 terms of patient education programs and literature?

10 A. So the Kidney Cancer Association sponsors
11 and puts on various educational events, they also
12 publish patient-facing materials about kidney cancer,
13 and the medical steering committee reviews some of
14 those materials to assure their accuracy.

15 Q. Okay. So let me see if I can understand
16 what you're saying.

17 The Kidney Cancer Association has
18 essentially created this either advisory board or
19 steering committee, and when they have questions about
20 medical issues dealing with kidney cancer, they come
21 to that board and ask for their advice, right?

22 A. That is correct.

23 Q. All right. And so there are times where
24 they will put out patient-facing material, as you've

1 just described, and to the extent that that
2 patient-facing material, you know, requires the
3 expertise of somebody like yourself, or somebody else
4 on the board, they will ask the board for advice on
5 the substance of that literature, fair?

6 A. That is correct.

7 Q. Do you know if the Kidney Cancer
8 Association does any legislative advocacy?

9 A. They do have some advocacy. I know that
10 they do. I've not been directly involved in that.

11 Q. Is there a methodology that's used by the
12 Kidney Cancer Association medical advisory board or
13 the steering committee to try to ensure that
14 literature that they publish to patients and their
15 families, or whoever it is, is reliable and accurate?

16 A. I don't think that there is a formal
17 process, but the medical steering committee is made up
18 of acknowledged experts in kidney cancer who are
19 familiar with and often generate the data for our new
20 treatments and approaches to kidney cancer.

21 Q. I see. So there might not be a formal
22 process or paper or guideline or something like that,
23 but the way that the Kidney Cancer Association ensures
24 that the literature publishes to patients and their

1 families, or any other source, for that matter, is
2 that they get qualified people, people who they
3 believe that are qualified, to -- to do the reviews,
4 right?

5 A. That is correct.

6 Q. Okay. And -- and -- okay.

7 MR. MANDELL: Can you give me Tab 29, please.

8 (WHEREUPON, a certain document was
9 marked Dr. Stadler Deposition Exhibit
10 No. 8, for identification, as of
11 07/16/2025.)

12 MR. BU: Sorry, Mr. McCaffrey, do you have a
13 copy?

14 MR. MANDELL: I -- I have it for you.

15 MR. BU: Oh, okay.

16 BY MR. MANDELL:

17 Q. Doctor, what we've marked as Exhibit 8 --

18 MR. BU: Thank you.

19 MR. MANDELL: Yeah, sure.

20 BY MR. MANDELL:

21 Q. Tell me if you recognize Exhibit 8.

22 A. I -- I don't recognize it per se, but I
23 see that it is a document from the Kidney Cancer
24 Association that is entitled "Veterans."

1 Q. Okay. And have -- strike that.

2 Do you see in the top left-hand corner, it
3 says "Kidney Cancer Association"?

4 A. Yes.

5 Q. And under -- there's a section that's
6 entitled "Veterans" that's at the top of the page?

7 A. Yes.

8 Q. And under that there's a section that says
9 "kidney Cancer Risk Factors."

10 Do you see that?

11 A. I do.

12 Q. And what it says is, under Kidney Cancer
13 Risk Factors, "Your service may have exposed you to
14 some situations that increases your chance of
15 developing illnesses like kidney cancer. These
16 illnesses may appear years or even decades after your
17 service ends."

18 Do you see that?

19 A. I see that.

20 Q. And then it says "Location or wars," and
21 it says, "If you served in the following locations or
22 wars, you may have an exposure that increases your
23 risk of kidney cancer," true?

24 A. I see that.

1 Q. And do you see the -- one, two, three,
2 four -- fifth one down says "Camp Lejeune"?

3 A. I do.

4 Q. Do you agree with that?

5 A. I -- I agree that there is some increased
6 risk of kidney cancer from individuals that were
7 stationed at Camp Lejeune.

8 Q. How would you describe that increased
9 risk?

10 A. I would describe it as a mod- -- modest
11 increased risk with some controversy as to the degree
12 of increased risk.

13 Q. Okay. We'll get to that in a second.

14 Do you see under where it says -- the
15 second section said "Exposures." "Specific exposures
16 you may have experienced during your service that
17 increase your risk of kidney cancer include," and then
18 it says, "Water contamination."

19 Do you see that?

20 A. I see that.

21 Q. Do you agree that water contamination at
22 places like Camp Lejeune, if people experienced that
23 during their service, that that would have increased
24 their risk of kidney cancer?

1 A. It is possible, but it depends on duration
2 and amount of exposure.

3 Q. So let me see if I understand what you're
4 saying. There are some people who were at
5 Camp Lejeune who were exposed to the water there that
6 do have an increased risk of cancer if they were there
7 for a sufficient duration, time, exposure; but there
8 are some people that wouldn't have met that duration,
9 time, and exposure that wouldn't have an increased
10 risk, fair?

11 A. I think that that's fair.

12 Q. Okay. Now, do you see on the very bottom
13 of the page, it says, "Understanding Service-Related
14 Exposures"?

15 A. I see that.

16 Q. And then there's a -- it goes onto the
17 next page, but it says, "Water contamination."

18 Do you see that at the bottom?

19 A. I see that.

20 Q. It goes onto the next page. Are you --
21 I'm sorry, you're on the next page?

22 A. Yes, I'm on the next page.

23 Q. Okay. And the paragraph says, "Water can
24 sometimes be contaminated (polluted) by individual

1 [sic] chemicals. Contaminated water can look, smell,
2 and taste the same as clean water. If you ever drank
3 or bathed in contaminated water, you are at a higher
4 risk of kidney cancer. Some places, like Camp Lejeune
5 and Marine Corps Air Station New River (both in North
6 Carolina), found that their water sources were
7 contaminated for a long time. People who were
8 stationed in these locations are twice as likely to
9 die from kidney cancer."

10 Do you agree with that?

11 A. The -- the literature that I reviewed as
12 part of this case and as documented by other experts
13 would challenge this statement of "twice as likely."

14 Q. So do you agree with this sentence or not?

15 A. I do not agree with that sentence.

16 Q. All right. Do -- do you know, sir, if the
17 medical advisory board or the scientific medical
18 steering committee for the Kidney Cancer Association
19 reviewed this before it was published?

20 A. I don't know. As I stated, I am currently
21 ex-officio, so I don't attend all of the meetings. I
22 certainly did not see this beforehand.

23 Q. Okay. Do you know when this was put up?

24 A. I do not.

1 Q. Okay. So what -- then you had said, I
2 believe, something along the lines of, material that
3 you reviewed and that others have reviewed -- reviewed
4 in this case would challenge this assertion of "twice
5 as likely," is that fair?

6 A. That is fair.

7 Q. All right. Is it your testimony that you
8 did any review of any literature, studies, evidence
9 relating to the Camp Lejeune water and risk of kidney
10 cancer?

11 A. I'm not an epidemiologist, so I am
12 dependent on the epi- -- on the defense epidemiology
13 experts. I've read their reports, and I've read some
14 of the epidemiologic studies that they refer to.

15 Q. What epidemiologic studies have you read?

16 A. So I have read, for example, the Bove
17 study, I've looked at the assessment from, I believe
18 the correct abbreviation is ATSDR, but I may have
19 screwed up the abbreviation.

20 Q. Okay. It sounded to me, correct me if I'm
21 wrong, as if what you were challenging in that
22 sentence was the fact that people might have been,
23 quote, twice as likely to die from kidney cancer.

24 Is that -- is that a fair read of what you

1 were saying?

2 A. That is the major criticism of that
3 paragraph.

4 Q. All right. So do you have a number that
5 you believe is the amount of increased risk, if it
6 isn't two times the amount?

7 A. The epidemiologic studies that I looked
8 at describe hazard ratios on the order of 1.2 to up
9 to 1.4, and confidence intervals that oftentimes
10 crossed 1.

11 Q. So is what you're saying that to the
12 extent that there were people in the category that we
13 were talking about just before that meet the threshold
14 of duration, time, exposure, you don't believe that
15 their risk would be two times as likely; you believe
16 it would be between 1.2 and 1.4, is that fair?

17 A. It would be fair to state that the
18 epidemiologic studies suggest that that is the level
19 of risk, but there is some controversy as I read
20 through the more detailed reports from the defense
21 epidemiology experts.

22 Q. Okay. Do you have -- strike that.

23 Would you agree with me that from the
24 information that you have in this case that the people

1 at Camp Lejeune that would have an increased risk from
2 exposure to the water there would be in the 1.2 to 1.4
3 range, generally speaking?

4 A. So what we're talking about here are
5 population risk factors, not individual sort of risk
6 factors, which is a different aspect.

7 Q. Sure.

8 As you understand the science and the
9 medicine in terms of the population risk factors that
10 we were just discussing, and I'm only using the
11 numbers because you gave them to me, would you agree
12 that the best evidence that you have is that for the
13 people that were at an increased risk of kidney cancer
14 due to exposures at Camp Lejeune, that risk would be
15 between 1.2 and 1 -- 1.4?

16 A. That population risk is on the order of
17 1.2, but some of the studies, the confidence interval
18 on that as a ratio did cross 1, suggesting that there
19 is some uncertainty even in that risk estimate.

20 Q. All right. You had said before 1.2 to
21 1.4, true?

22 A. Correct.

23 Q. All right. So let me just ask the
24 question one more time.

1 Is it fair to say that as you sit here
2 today, the best evidence that you have in terms of the
3 increased risk that would have applied to people who
4 were exposed to the water at Camp Lejeune for the
5 duration, exposure, and amount that you were talking
6 about before, that that increased risk to them would
7 be between 1.2 and 1.4 as a hazard ratio?

8 A. That hazard ratio is a correct hazard
9 ratio, but remember that all of these hazard ratios
10 have confidence intervals on them indicating the
11 degree of scientific uncertainty.

12 Q. Do you have a -- strike that.

13 What is your understanding of what the
14 duration, exposure, amount, the variables that you
15 were talking about before, in terms of how long
16 somebody was at Camp Lejeune or how much they drank,
17 that would put them in the category of people that did
18 have an increased risk versus didn't?

19 A. I don't have any opinion as to that
20 because that requires a detailed analysis of exposure,
21 and I'm dependent on the -- the defense experts in
22 terms of assessing that.

23 Q. Okay. So fair to say that as you sit here
24 today, your testimony is that your belief is that

1 there were some people at Camp Lejeune who were
2 exposed to sufficient amounts to have that increased
3 risk, some weren't; you just don't know the details of
4 which ones were and which ones weren't, fair?

5 A. It's fair in the sense that I'm dependent
6 on the de- -- defense experts to inform me as to what
7 the exposures were.

8 Q. Okay. My question was fair -- strike
9 that.

10 Your testimony -- let me ask it again.
11 Strike that. I'm going back.

12 As you sit here today, your best
13 understanding of the science and the literature is
14 that there were some people at Camp Lejeune who were
15 exposed to the water there that were in sufficient
16 quantities or duration to have an increased risk, some
17 weren't; you just don't know the details of where that
18 threshold is in terms of what amounts of time or
19 duration were sufficient, fair?

20 A. That is fair.

21 Q. Okay. Do you know why the Kidney Cancer
22 Association would put out literature saying that
23 people who were stationed at Camp Lejeune were twice
24 as likely to die from kidney cancer if that's not

1 true?

2 A. As I said, I was not involved in the
3 generation of this document, nor do I under- -- nor do
4 I know when it was generated or how it got to be on
5 the web.

6 Q. Okay. You've -- you've been on the
7 medical steering committee for the Kidney Cancer
8 Association for over 20 years, right?

9 A. That is correct, but as stated, I am
10 currently ex-officio, so I do not attend all of the
11 meetings.

12 Q. You might not attend all of the meetings,
13 but you know generally speaking how literature gets
14 published to patients and their families at the Kidney
15 Cancer Association, true?

16 A. I have a general knowledge on how they put
17 this stuff together.

18 Q. Are you aware as to whether or not there
19 are often inaccuracies in the literature that get put
20 out by the Kidney Cancer Association to its -- the
21 patients or people that are looking to it for advice?

22 A. I have not reviewed every piece of advice
23 that they've given. I would say that in general, they
24 have been accurate. I'm sure, just like any of us,

1 that there are occasional inaccuracies.

2 Q. Okay. Do you think that a risk of two
3 times as likely to die from the exposure at
4 Camp Lejeune is significant?

5 A. I believe it is significant with the
6 recognition that the general population risk of dying
7 from kidney cancer is relatively low, so twice of a
8 low number is still low.

9 Q. And I guess I wasn't necessarily asking
10 about the overall number. My question was geared more
11 towards the amount of risk.

12 As you sit here today, if it were to be
13 true, what the Kidney Cancer Association has published
14 to its patients and -- and the public, that if you
15 were at Camp Lejeune you would be twice as likely to
16 die from kidney cancer, would that be a significant
17 risk?

18 A. A -- a risk factor for cancer that's on
19 the order of -- with a hazard ratio of 2 is generally
20 considered to be significant.

21 Q. Okay. Do you see on the first page of
22 Exhibit 8, it says, "These illnesses may appear years
23 or even decades after your service"? It's the second
24 sentence under the "Kidney Cancer Risk Factors."

1 A. I do.

2 Q. Do you agree with that?

3 A. I agree that the development of a cancer
4 due to an exposure may occur years to even decades
5 later.

6 MR. MANDELL: Can I have 28, please.

7 (WHEREUPON, a certain document was
8 marked Dr. Stadler Deposition Exhibit
9 No. 9, for identification, as of
10 07/16/2025.)

11 BY MR. MANDELL:

12 Q. Dr. Stadler, what we've marked as
13 Exhibit 9, can you take a look at that, please?

14 A. Yes.

15 Q. And do you recognize this document?

16 A. I don't recognize it per se, but it
17 appears to be another document from the Kidney Cancer
18 Association regarding risks of kidney cancer.

19 Q. Okay. Do you see at the top left-hand
20 corner, there was -- there was the -- this -- on this
21 page, it's highlighted "Chemical Exposures."

22 Do you see that?

23 A. I see that.

24 Q. The tab above that is "Veterans."

1 Do you see that?

2 A. I see that.

3 Q. And that's the one we were just looking at
4 with the tab that says "Veterans" at the top?

5 A. I understand that.

6 Q. Okay. Fair.

7 Under Chemical Exposures, there's a
8 section in orange that says "Kidney Cancer Risk
9 Factors."

10 Do you see that?

11 A. I do.

12 Q. And it says, "Some exposures known to
13 increase your risk of kidney cancer include," and then
14 there's a list of eight chemicals that they describe
15 as chemical exposures, true?

16 A. Correct, that's listed there.

17 Q. All right. And do you see on that list,
18 the second bullet point on the left says "benzene"?

19 A. I do.

20 Q. Do you agree with that?

21 A. Some of the epidemiologic studies that
22 I've looked at, including the report from the defense
23 expert, suggests that the risk with benzene is not
24 confirmed.

1 Q. Well, how about putting aside just for a
2 second the defense expert report, okay.

3 Have you ever seen in your own practice,
4 in your own world, benzene being associated with
5 kidney cancer?

6 A. I have not, and when I looked at the
7 literature once again in -- in the context of this
8 case, benzene was not consistently a -- a known cause
9 of kidney cancer.

10 Q. Any idea why the Kidney Cancer Association
11 would publish that benzene is a risk factor for kidney
12 cancer that they describe as known to increase your
13 risk of kidney cancer if it wasn't true?

14 A. I -- I don't know. Once again, I was not
15 involved in generating these documents.

16 Q. Do you know if the medical steering
17 committee was?

18 A. I do not know.

19 Q. Do you know if -- okay.

20 Do you see how on the right-hand side, the
21 third bullet point down says "trichloroethylene
22 (TCE)"?

23 A. I see that.

24 Q. Do you agree with that?

1 A. There -- there have been a number of
2 studies that have suggested an association of TCE with
3 kidney cancer.

4 Q. So you agree with that, true?

5 A. I agree.

6 Q. All right. The -- The line -- the bullet
7 point below that says "vinyl chloride."

8 Do you see that?

9 A. I see that.

10 Q. And do you agree with that?

11 A. I would have to take a look at the studies
12 again. I -- I don't recall off the top of my head the
13 vinyl chloride associations.

14 Q. Okay. So you, as you sit here today,
15 don't have any reason to agree or disagree with it?

16 A. That is correct.

17 Q. Do you know, as you sit here today, what
18 levels of TCE are affil-- -- are associated with
19 increased risk for kidney cancer?

20 A. I don't know the levels in terms of parts
21 per million or exact exposure since I am not an
22 exposure expert. I do know that most of the studies
23 refer to high levels of chronic industrial exposure in
24 industrial settings.

1 Q. Okay. Does that -- where does that --
2 strike that.

3 MR. MANDELL: Can you hand me 30, please.

4 (WHEREUPON, a certain document was
5 marked Dr. Stadler Deposition Exhibit
6 No. 10, for identification, as of
7 07/16/2025.)

8 BY MR. MANDELL:

9 Q. This is 10.

10 A. Yes.

11 Q. Oh, I'm so sorry.

12 MR. BU: Thank you.

13 BY MR. MANDELL:

14 Q. I've marked Exhibit 10. If you could take
15 a look at that document, and let me know if you
16 recognize this document?

17 A. I do not.

18 Q. Okay. Does it a- -- appear to be a letter
19 written on April 7th, 2025 to the defense secretary,
20 Pete Hegseth?

21 A. It does.

22 Q. Can you look on the second page for me.
23 There's a number of signators, true?

24 A. Yes.

1 Q. Okay. And do you see the Kidney Cancer
2 Association on there?

3 A. I do.

4 Q. Do you recognize any of the other names of
5 the signators on this letter?

6 A. I also have had some association with --
7 with a number of these, not everybody, but with a
8 number of these organizations.

9 Q. Could you tell me which ones?

10 A. Going from the top, I have -- I'm -- I'm
11 aware of some of the patients who have created the
12 HLRCC Foundation. I've had some informal associations
13 with the Imerman Angels. I am aware of both KCCure
14 and KidneyCAN, although I'm not involved with them
15 directly. I'm a member of the Society of Urologic
16 Oncology. That's about it.

17 Q. Okay. Do you see on the first page the
18 letter reads, "On behalf of the undersigned
19 organizations representing kidney cancer patients,
20 survivors, their families, and the doctors who treat
21 them, we respectfully urge you to allocate the highest
22 possible funding for the Kidney Cancer Research
23 Program as you enact the fiscal year 2025 continuing
24 resolution."

1 Do you see that?

2 A. I do.

3 Q. Do you know the Kidney Cancer Research
4 Program?

5 A. I actually was on the steering committee
6 for that particular program.

7 Q. When you say "was," are you saying that
8 that's not currently true?

9 A. The program has been eliminated by the
10 recent cuts, and this letter is a letter trying to
11 reinstate that funding.

12 Q. I see.

13 So were you aware that this letter was
14 being sent; you just haven't seen it?

15 A. I was aware that there were initiatives to
16 reinstate this funding. I was not aware that this
17 actual letter had been sent.

18 Q. And you've been on the programmatic review
19 panel for the KCRP?

20 A. Yes.

21 Q. And is it fair to say that you were its
22 chair earlier this year?

23 A. Correct.

24 Q. All right. And do you see how the next

1 paragraph says, "The link between military service and
2 kidney cancer is clear and well established. Military
3 personnel and their family members living on or near
4 bases are at higher risk of developing kidney cancer
5 due to exposure to toxins, including industrial
6 solvents, TCE, and PCE, found in contaminated drinking
7 water, as well as airborne toxins from burn pits."

8 Do you see that?

9 A. I see that.

10 Q. Do you agree -- I know I had asked you
11 about TCE in the prior exhibit.

12 A. Um-hum.

13 Q. Do you see where it says "PCE" here as
14 well?

15 A. I do.

16 Q. Do you agree with that?

17 A. The studies that I looked at, as well as
18 the analysis from Dr. Goodman, suggested that the PCE
19 association is tenuous.

20 Q. So do you agree or disagree with the
21 sentence in this letter sent by -- one, two, three,
22 four, five, six, seven, eight, nine, 10, 11, 12, 13,
23 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26,
24 27, 28 -- 29 different entities of which you were

1 affiliated with many of them, do you disagree with
2 that?

3 A. I don't have any re- -- I don't have any
4 independent knowledge or review of PCE specifically,
5 so I can't agree or disagree.

6 Q. All right. Which defense -- when you say
7 the defense reports, the defense epi reports, which
8 defense epi reports are you referring to?

9 A. I am referring mostly to the report from
10 Goodman.

11 Q. Any others?

12 A. That was the major defense expert report
13 that I re- -- relied on for epidemiological relations.

14 Q. And did you do anything when you were
15 reading that report to verify or not any of the
16 information that was in there?

17 A. The information I read is consistent, was
18 consistent with sort of general overviews about kidney
19 cancer causation that I'm familiar with.

20 Q. All right. Then I guess my question is,
21 how -- how is it -- accept that this letter is -- is
22 true, just for the purpose of this question.

23 If this letter was true, meaning if this
24 was sent by these entities to the defense secretary,

1 how do you explain that all of these entities signed a
2 letter saying that TCE and PCE found in contaminated
3 drinking water put these Marines at higher risk of
4 developing kidney cancer if that's not true?

5 A. I have not challenged the TCE association
6 here, and I have said that I'm just not familiar
7 enough with all of the literature with PCE to say that
8 it is true or untrue.

9 Q. So you don't dis- -- you don't agree with
10 Dr. Goodman's opinion that it's -- that, as you
11 understand it, she's saying PCE wasn't correlated, or
12 whatever the words that you used were, you're not
13 saying that that's true; you're just saying you don't
14 know enough to say it's not true?

15 A. Repeat the question.

16 Q. Sure, sure, yeah. Fair enough.

17 You had said that -- just a minute ago
18 that you believe that you did not do an independent
19 search of all of the literature in terms of PCE, fair?

20 A. That is correct.

21 Q. And is it true that you're not disagreeing
22 with Dr. Goodman or -- or agreeing with her as to PCE
23 and its connection to kidney cancer, is that true?

24 A. That's correct.

1 Q. All right. So my question to you is, when
2 you read that in Dr. Goodman's report, did you do
3 anything to say, "Hold on a second here, is this
4 correct or is this not correct," or did you just
5 blindly follow what she was saying?

6 A. I'm not sure "blindly following" is the
7 correct statement. What I said is I reviewed her -- I
8 reviewed her report about general causation, but then
9 focused most of my attention on the specific cases in
10 front of us.

11 Q. So my question, I think, was a little
12 different, which was -- well, let me ask you this
13 question. Did you read anything in Dr. Goodman's
14 report that you thought to yourself that you might
15 have a disagreement with?

16 A. The -- the report I read from Dr. Goodman,
17 excuse me, was consistent with sort of the gen- --
18 more general literature that I was familiar with, so I
19 didn't have any reason to question or reanalyze
20 anything.

21 Q. Okay. So in this letter when these many
22 different entities are asking the defense secretary
23 for funding, they say they believe PCE is associated
24 with increased risk of kidney cancer, true?

1 A. That's what they say.

2 Q. Do you know what they're basing that
3 opinion on?

4 A. I have no idea.

5 Q. Have you seen any literature in your field
6 that you're aware of that connects PCE to kidney
7 cancer?

8 A. What I'm familiar with are -- is some of
9 the literature we discussed earlier as well as
10 literature on industrial exposures to TCE and solvents
11 in general that don't necessarily distinguish between
12 the different components of the solvents.

13 Q. So do you consi- -- strike that.

14 Do you consider yourself to be somebody
15 who is knowledgeable with regard to the effects of
16 volatile organic compounds on and in relation to
17 kidney cancer?

18 A. I have some general knowledge, but I don't
19 consider myself an epidemiologist or a toxicologist
20 with, you know, deep expertise in that area.

21 Q. Have you ever reviewed literature of any
22 kind with regard to PCE and its effect on kidney
23 cancer?

24 A. Not to my recollection.

1 Q. How about benzene and kidney cancer?

2 A. Just some of the, once again, the general
3 literature sort of on solvent, industrial solvent
4 exposures and risk of kidney cancer, not specific
5 analyses of benzene.

6 Q. Well, when you say "just on general
7 industrial solvent, not anything specific on benzene
8 and kidney cancer," are you saying you've read -- you
9 might have read stuff on benzene but nothing that
10 relates to whether benzene does or does not cause
11 kidney cancer?

12 A. So the -- most of the epidemiologic
13 studies in regards to solvent exposure and kidney
14 cancer risk do not distinguish between the different
15 components of these solvents. That's what I'm most
16 familiar with. I have read the analyses of Goodman in
17 regards to the specific components of the solvents,
18 but I did not independently review some of the things
19 that she referred to.

20 Q. Is the same true for vinyl chloride?

21 A. Correct.

22 Q. All right. Do you see how the next
23 sentence of the Exhibit 10 states, "A 2014 report
24 found that US Marines and their families stationed at

1 Camp Lejeune, North Carolina, have a 35 percent higher
2 risk of contracting kidney cancer than their US
3 counterparts potentially due to contaminated drinking
4 water"?

5 A. I see that.

6 Q. Do you know what report they're talking
7 about?

8 A. I suspect that is some of the -- well,
9 there's a reference here, No. 1, that's the Bove
10 study, that demonstrated a hazard ratio of 1.3 in
11 comparison to Camp Pendleton per- -- personnel.

12 Q. Is it 1.35?

13 A. It might be. You'd have to correct -- I'd
14 have to look at the article specifically.

15 Q. All right. Fair to say that these
16 entities would not have cited the Bove 2014 study with
17 regard to its data in terms of the amount of increased
18 risk of exposure to Camp Lejeune water and kidney
19 cancer if they didn't think that it was a reliable
20 study?

21 A. Well, I can't read everybody's mind who
22 signed on to this, but presumably they believed that
23 this was a reputable -- a reputable source.

24 Q. Do -- you've read it, that -- that study?

1 A. I've read that study.

2 Q. All right. Do you believe that it's a
3 reputable and reliable source?

4 A. I believe it's a reliable and reputable
5 source.

6 Q. Okay. There was nothing about the study
7 that you found that would have -- strike that.

8 I wanted to ask you this question. On the
9 second page of the letter, I don't know if you
10 mentioned this or not, but I wanted to just ask you.
11 The second item down, the second signator down says,
12 the American Urologic Association.

13 Do you have affiliation with them?

14 A. I correct myself, I'm a member of the AUA
15 as well.

16 Q. Do you have any responsibilities with the
17 AUA outside of just being a member?

18 A. I do not.

19 Q. Has the Kidney Cancer Association ever
20 funded any of your literature or research?

21 A. They funded some of my research I believe
22 in the 1994 when I was a young assistant professor.

23 Q. Okay. How -- how many times has the
24 Kidney Cancer Association -- strike that.

1 Any other times than the '90s?

2 A. No.

3 Q. Do you know how many total times that
4 they've funded your research or work?

5 A. Once.

6 Q. Have you ever talked with anybody at the
7 Kidney Cancer Association about Camp Lejeune water
8 exposure?

9 A. I have not.

10 Q. We -- we mentioned just a little while
11 ago, we were talking about the fact that you are on
12 the Kidney Cancer Research Program's programmatic
13 review panel, right, or -- or were?

14 A. That's correct.

15 Q. And could you tell us about that, please?
16 Tell us, what does the programmatic review panel do?
17 What is their purpose?

18 A. So the Kidney Cancer Research Program is a
19 component of the DOD medical research infrastructure,
20 and that infrastructure was funding various research
21 activities, including within kidney cancer. The panel
22 I was on was charged with making funding decisions
23 following peer review of the submitted grants.

24 Q. You said "funding decision following

1 peer-reviewed grants"?

2 A. Correct. So more specifically,
3 researchers submitted grants to the Kidney Cancer
4 Research Program. Those grants underwent, like,
5 usually peer review and were ranked. And then the
6 panel I was on made the final decision as to which one
7 of those grants would be funded based on, you know,
8 available funds and the peer-review analysis.

9 Q. Okay. And you have been on the
10 programmatic review panel since 2022?

11 A. That sounds about right.

12 Q. And when -- you were named chair of that
13 panel?

14 A. I was named chair on that panel earlier
15 this year with anticipation of -- of filling out the
16 term for this coming year. Shortly thereafter,
17 funding to the program was cut.

18 Q. The responsibility -- how long were you
19 chair for?

20 A. Probably seven days or something like that
21 before the funding was cut.

22 Q. Fair enough.

23 Is it fair to say that one of the
24 responsibilities of the programmatic review panel is

1 to oversee what is referred to as the "strategic plan"
2 for the Kidney Cancer Research Program?

3 A. That is correct.

4 Q. Okay. And tell -- tell me -- strike that.

5 Is it fair to say that there -- the
6 programmatic review panel meets at least once a year,
7 and at one of those meetings, they review the
8 strategic plan for the Kidney Cancer Research Program?

9 A. That was one of the roles, and that's --
10 that was a meeting frequency, correct.

11 Q. Is it fair to say that the strategic plan
12 for the Kidney Cancer Research Program is one that
13 articulates the most critical needs in kidney cancer
14 and the research it seeks to promote?

15 A. That is fair.

16 Q. The goals are to increase understanding of
17 the biology of kidney cancer, true?

18 A. If I recall correctly, that was in there.

19 Q. Develop novel therapy strategies for
20 treatment of kidney cancer?

21 A. Yes.

22 Q. Improve patient care for kidney cancer?

23 A. Yes.

24 Q. Grow the field and decrease collab- -- and

1 increase collaboration in the area of kidney cancer?

2 A. Correct.

3 Q. All right. And the strategic plan, it's
4 an actual document, right?

5 A. It was a document.

6 Q. Okay. You say "was," meaning because
7 there's no more funding?

8 A. Because the program is closed.

9 Q. Right.

10 A. And I presume it's -- you'd have to go to
11 the dark web to find it.

12 Q. Fair enough.

13 So you as part of the programmatic review
14 panel -- since 2022?

15 A. Yes.

16 Q. -- would have at least once a year
17 reviewed the strategic plan generally and the document
18 at that meeting?

19 A. Yes.

20 Q. Is there a methodology that the Kidney
21 Cancer Research Program or the programmatic review
22 panel uses to ensure that the literature it publishes
23 or the strategic plan specifically is reliable and
24 accurate?

1 A. I'm not sure that there is a specific
2 process. The review panel is made up of acknowledged
3 experts in the field, as well as patient
4 representatives, to make sure their views were
5 included as to what we consider to be the most
6 important issues to address.

7 MR. MANDELL: Can I have 77.

8 (WHEREUPON, a certain document was
9 marked Dr. Stadler Deposition Exhibit
10 No. 11, for identification, as of
11 07/16/2025.)

12 BY MR. MANDELL:

13 Q. What we've marked as Exhibit 11, the front
14 of it says "Kidney Cancer Research Program Strategic
15 Plan," true?

16 A. Yes.

17 Q. This is the document that we were
18 referring to before?

19 A. Correct, although I see it's dated April
20 '21. I'm not sure I was involved with this specific
21 document.

22 Q. Okay. If you go to the Kidney Cancer
23 Research Program, the website for it, I will state to
24 you that when there's a link to the document, it gives

1 you this one. So you don't -- just for purposes of
2 this question, just accept that as true, okay?

3 A. Fair enough.

4 Q. All right. So fair to say that -- strike
5 that.

6 Do you see on the -- if you could turn to
7 the third page. It says, "Research and Funding
8 Environment"?

9 A. I see that.

10 Q. One, two, three, four paragraphs down,
11 middle of the paragraph, it says, "Other unique
12 occupational exposures that cause kidney cancer, such
13 as ionizing radiation or chemical and/or hazardous
14 materials, can occur during active service, though the
15 disease may not appear until later in life."

16 True?

17 A. I see that.

18 Q. "This results in the veteran" -- "in
19 Veterans being more frequently affected than their US
20 civilian counterparts." And then it says, "According
21 to a 2014 report by the Center for Disease Control and
22 Prevention, US Marines and their families stationed at
23 Camp Lejeune, North Carolina, have a 35 percent higher
24 risk of contracting kidney cancer than civilians due

1 to contaminated drinking water," true?

2 A. I see that statement.

3 Q. Do you believe that that is referring to
4 the same Bove study that we were just talking about in
5 the letter to Secretary of Defense Pete Hegseth?

6 A. I -- I presume it does since it uses the
7 same numbers.

8 Q. Okay. And I should have asked you this
9 question. Are you aware, as somebody who was on the
10 programmatic review panel and who was the chair for
11 albeit maybe a short period of time, whether there is
12 an updated version of this strategic plan?

13 A. Not to my knowledge.

14 Q. Okay. So as far as you know, this would
15 be the most updated version, is that fair?

16 A. Assuming that, as you stated, you
17 downloaded this recently, I would say that this is --
18 with that caveat, that it is the most updated version.

19 Q. Okay. And so fair to say that you would
20 have reviewed this document at the annual meetings
21 that you would have had for the programmatic review
22 panel?

23 A. I presume we saw this document in some
24 version, that is fair to say.

1 Q. Okay. Did you ever tell anybody that the
2 2014 Bove study was not a reliable study at any point
3 in time?

4 A. No, I have not.

5 Q. Okay. So fair to say -- strike that.

6 And the programmatic review panel and the
7 Kidney Cancer Research Program and yourself wouldn't
8 have allowed this to be published if you didn't
9 believe it was an accurate and reliable study, fair?

10 A. That's fair.

11 Q. Did you see in Dr. Goodman's report any
12 reference to any of the studies done by Dr. Bove or
13 the ATSDR?

14 A. I would have to talk a look at that
15 report. I believe she did reference the Bove study,
16 but I -- I don't recall ex- -- the exact language.

17 Q. All right. Do you recall whether or not
18 Dr. Goodman sites the Bove studies in also -- strike
19 that.

20 Do you recall whether or not Dr. Goodman
21 sites the Bove studies, including the Bove 2014 study,
22 favorably or unfavorably?

23 A. To the best of my recollection, she sites
24 the Bove study, and in her conclusion states that TCE

1 has been associated with renal cancer.

2 Q. I see. So you -- your understanding of
3 Dr. Goodman's report and analysis, her opinions, is
4 that she reviewed the Bove studies and took from that
5 at least one part, that TCE causes kidney cancer, is
6 that what you're saying?

7 A. So I would have to read the exact language
8 that she utilized. I think that to the best of my
9 recollection, she said that there was an association
10 of kidney cancer and TCE.

11 Q. Do you believe that that was based upon,
12 in part, the Bove studies, including Bove 2014?

13 A. So I know that Dr. Goodman analyzed lots
14 of studies, referred to lots of studies in her report.
15 I don't recall how she weighted that report, that --
16 that publication, the Bove publication, vis-à-vis the
17 other publications she reviewed.

18 Q. Would it surprise you if Dr. Goodman
19 referred to all of the Bove studies, including the
20 2014 study as unreliable?

21 A. I don't recall her language regarding
22 that, and I would have to review the report again to
23 see exactly how she described it.

24 Q. And I'm -- I'm not trying to be incredibly

1 specific with the word choice here, but as a general
2 proposition, would it surprise you if Dr. Goodman
3 referred to the Bove studies, including the Bove 2014
4 study, as a study that generally shouldn't be used in
5 the analysis because it's unreliable? Would that
6 surprise you as a general proposition as you sit here
7 today?

8 A. I don't have an opinion one way or the
9 other.

10 Q. Okay. You're -- I think you had mentioned
11 that you're affiliated with the Bladder Cancer
12 Advocacy Network?

13 A. I -- yes.

14 Q. You were on the advisory board for fif- --
15 for 17 years?

16 A. I was on the advisory board for a number
17 of years, yes.

18 Q. And what does the Bladder Cancer Advisory
19 Board do?

20 A. Similar to the kidney cancer scientific,
21 the medical advisory group provides general advice to
22 the patient organization, also makes advice and
23 decisions regarding funding of research.

24 Q. Do you have any understanding as to

1 whether or not the Bladder Cancer Advocacy Network has
2 published anything related to Camp Lejeune and its
3 exposures and their relation to either kidney cancer
4 or bladder cancer?

5 A. I'm not aware of anything, but my
6 association with them has been more tenuous over the
7 last several years.

8 Q. Okay. Do you know who Dr. Richard Clapp
9 is?

10 A. Richard Clapp?

11 Q. Yeah.

12 A. Not immediately, no.

13 Q. Okay. For efficiency's sake, let me just
14 ask you whether you would agree or disagree with this
15 sentence:

16 "What they found was that comparing
17 Camp Lejeune to Camp Pendleton, there was an overall
18 statistically significant increase in deaths due to
19 cancer."

20 A. I believe that's referring to some of
21 the -- the Bove study and similar, and that statement,
22 if referring to the -- to that study, is correct.

23 MR. MANDELL: Can you just read that last part,
24 sorry.

1 (WHEREUPON, the record was read by the
2 reporter as requested.)

3 MR. MANDELL: Fine.

4 BY MR. MANDELL:

5 Q. And as you understand it, is that correct
6 as to kidney cancer and bladder cancer?

7 A. My understanding of the Bove study is that
8 there was an increased risk in blad- -- in kidney
9 cancer but not necessarily in bladder cancer.

10 Q. You're -- I think you had said that you're
11 affiliated with the American Urologic Association,
12 true?

13 A. I am.

14 Q. Any understanding as to whether or not the
15 American Urologic Association publishes literature --
16 strike that.

17 Do you have any affiliation -- I think I
18 had asked you this question, but I want to just
19 double-check.

20 Do you have any responsibilities with
21 regard to the American Urologic Association other than
22 just being a member?

23 A. I do not.

24 Q. All right. You've presented at their

1 conferences?

2 A. I have presented at their conferences.

3 Q. Anything other than that? Have you
4 published literature on their behalf, have you had
5 research funded by them, have they been involved in
6 any of your research or funding, that type of thing?

7 A. No, no other associations.

8 Q. Any idea if the Urologic -- American
9 Urologic Association has published anything relating
10 to the exposures at Camp Lejeune and kidney cancer?

11 A. I have no idea.

12 Q. Would it surprise you if there were
13 materials from the American Urologic Association
14 stating that there were increased risks from the
15 exposure at Camp Lejeune to kidney cancer?

16 A. I would not necessarily be surprised if
17 there was something there.

18 Q. Okay.

19 MR. MANDELL: Do you want to take a five-minute
20 break?

21 THE VIDEOGRAPHER: We are now off the record at
22 10:15 a.m.

23 (WHEREUPON, a recess was had
24 from 10:15 to 10:25 a.m.)

1 THE VIDEOGRAPHER: We are back on the record at
2 10:25 a.m.

3 BY MR. MANDELL:

4 Q. Dr. Stadler, you're familiar with the
5 concept of equipoise, true?

6 A. I am.

7 Q. And you've used that concept in your
8 literature, true?

9 A. I have, yes.

10 Q. What -- what does equipoise mean to you?

11 A. Equipoise generally means that prior to
12 the conduct of a study or in the con- -- in the
13 context of current knowledge, that one has -- one has
14 equal confidence in two alternative hypotheses.

15 Q. Is it fair to say that that would be
16 synonymous with or one could define as -- as likely as
17 not, at least as likely as not?

18 A. My understanding is that there's legal
19 definitions for that. So I can't comment on the legal
20 definitions. What I would say is that equipoise means
21 that one can, as I said, equ- -- equal weight to one
22 hypothesis or the -- or the alternative hypothesis.

23 Q. Sure, okay.

24 And you have used that concept in your

1 literature, is it fair to say, because you believe
2 that it's a valid scientific concept to use?

3 A. Equipoise is a valid scientific concept,
4 right.

5 Q. You -- is it fair to say -- okay. Strike
6 that.

7 How do you use equipoise in your practice?

8 A. So the most commonplace I use equipoise is
9 when designing clinical trials, and in that sense,
10 there is reasonable equipoise in a controlled study
11 that the outcome is -- is -- would be similar in both
12 arms.

13 THE COURT REPORTER: I'm sorry, similar in?

14 THE WITNESS: Similar in both arms. Sorry.

15 BY MR. MANDELL:

16 Q. Do you know how many times you've
17 published literature using the concept of equipoise
18 or -- or citing to equipoise as a standard?

19 A. I -- I have no idea.

20 Q. Is it multiple?

21 A. Multiple, probably.

22 Q. Over many years?

23 A. Over many years.

24 Q. Did you attempt to apply an equipoise or

1 as-likely-as-not standard to any of your opinions in
2 this case?

3 A. So my opinions were based on the likely
4 contributors to cause of an individual patient's
5 cancer.

6 Q. So did you attempt at all to apply an
7 equipoise or at least as-likely-as-not standard to
8 your opinions in this case?

9 A. I'm not quite sure what you mean by, you
10 know, sort of that question.

11 Q. Okay. Do you have an understanding --
12 strike that.

13 What is your understanding as to the
14 standard that you -- that applies to the opinions that
15 you give in this case?

16 A. So in general, and in this particular --
17 these cases, I looked at potential causes for kidney
18 cancer that are likely, and I -- I would leave it sort
19 of at that. I didn't -- I didn't provide -- I didn't
20 use any other legal standards.

21 Q. And how do you define "likely"?

22 A. So in general, I would pro- -- define
23 likely as at least 50 percent likely.

24 Q. When you say at least 50 percent, does

1 that mean 50 percent?

2 A. Once again, I don't think we can be that
3 exact in medicine. What I would say is when I look at
4 causation for an individual patient, I would say that
5 it is at least 50 percent -- that a particular
6 causative exposure is at least 50 percent, is at least
7 50 percent likely to be relevant.

8 Q. All right. So you had said before when
9 you were defining equipoise that you would look at two
10 different hypotheses and say, is there as -- as likely
11 a chance of one as the other.

12 Do you remember that?

13 A. Yes.

14 Q. All right. So when you used the
15 definition of the standard that you're talking about
16 as you apply it to this case, if you had -- and I'm
17 going to make it a little more concrete.

18 If you had two potential causes of a
19 person's kidney cancer and you thought that they --
20 one hypothesis was as likely as the other hypothesis,
21 would you consider that that was what you would refer
22 to as causal?

23 A. So that makes -- I think your question
24 makes the assumption that there is a known cause for

1 every single patient.

2 Am I interpreting your question correctly?

3 Q. Not necessarily. And let me ask it a
4 different way. Let's say -- strike that.

5 I believe I know what you're saying, so
6 let me ask you a question and you tell me if it makes
7 sense to you.

8 As you look at a patient, if you believe
9 that there was as likely a hypothesis that the
10 patient's kidney cancer was caused by, let's say,
11 environmental exposures as it being idiopathic, would
12 you have written in your report that you thought that
13 either or both of those would be a cause of the kidney
14 cancer?

15 A. I -- I think that that's fair. In other
16 words, if I thought that it was equally likely that a
17 cause was idiopathic or due to a specific exposure, I
18 would have stated that.

19 Q. Okay. Meaning -- okay.

20 So meaning in your reports where you would
21 have found that there was a particular risk factor
22 that was associated with kidney cancer, you would have
23 put any of them in that category that used that
24 definition, true?

1 A. I think that that's fair. And
2 specifically as an example, in the Tukes report it was
3 my opinion that, you know, genetic causes were the
4 most likely cause, more likely than anything else.

5 Q. Okay. But, for example, that -- that --
6 let's take a hypothetical situation, okay. Let's say
7 that you thought for Mrs. Tukes, that it was as likely
8 that Mrs. Tukes was genetic as being idiopathic, or as
9 being Camp Lejeune water; would you have put those
10 three things as what you determined to be the causes,
11 or not?

12 A. In general under that hypothetical
13 situation, the answer is yes.

14 Q. Okay. So you would equate the standard
15 that you're using in this case -- strike that.

16 You've done a bunch of work for
17 pharmaceutical companies?

18 A. I have.

19 Q. What type of work do you do for them?

20 A. A number of different work. I have been
21 sponsored by pharmaceutical companies to conduct their
22 clinical trials, I have given consulting advice in
23 terms of drug development, and I also sit on a number
24 of data safety monitoring boards to provide oversight

1 in terms of patient safety in large Phase III trials.

2 Q. Is it fair to say that you've made a
3 substantial amount of money doing that work?

4 A. I have supplemented my income over the
5 years doing that kind of work. I would just state
6 that the work I do with pharmaceutical companies in
7 regards to clinical trials involve contracts that go
8 to the institution and not to myself.

9 Q. Do you get benefit from the institution if
10 a particular contract goes to the institution as
11 opposed to directly to you at the outset?

12 A. So they are very different. Things that
13 go to me personally are things that I do as, in
14 essence, an independent physician who has certain
15 expertise in providing advice. When I do clinical
16 trials, I have done that with patients that have
17 visited the institution, so that's an -- that is an
18 activity that I do as part of my university employment
19 or appointment.

20 Q. So you're aware of Open Payments?

21 A. I am well aware of Open Payments.

22 Q. Do you know how much Open Payments says
23 that you've made over the years from pharmaceutical
24 companies?

1 A. I know that Open Payments will distinguish
2 between the funding to the institution and the funding
3 to me personally. I haven't looked there recently. I
4 don't know what it says.

5 Q. If, when looking for you -- strike that.
6 Is what you're saying that if you go to
7 Open Payments, you can look for an individual person
8 versus an institution?

9 A. You can look for both.

10 Q. And the amount -- so if I typed in
11 "University of Chicago," it would give the amount of
12 money for any of the clinical trials that you've done
13 for which the money would have been sent directly to
14 the University of Chicago?

15 A. I believe so.

16 Q. And if I were to type in your name, that
17 would be money that goes to you directly?

18 A. In general, that is correct.

19 Q. Okay. Would it sound about right to you
20 if that number for you personally was in the order of
21 3-1/2 to \$4 million?

22 A. Over what period, time period?

23 Q. 2017 to 2018 to the present.

24 A. It seems a little bit high since per my

1 recollection of my tax records, I made on the order of
2 about a hundred thousand dollars a year on consulting,
3 so.

4 Q. Okay.

5 MR. MANDELL: Can you give me 9C.

6 (WHEREUPON, a certain document was
7 marked Dr. Stadler Deposition Exhibit
8 No. 12, for identification, as of
9 07/16/2025.)

10 BY MR. MANDELL:

11 Q. We've marked Exhibit 12, Dr. Stadler.

12 MR. BU: Thank you.

13 BY MR. MANDELL:

14 Q. Could you tell me if you are familiar at
15 all with this general printout here?

16 A. Yes, I am.

17 Q. All right. Is this what we were just
18 talking about?

19 A. This is what we were talking about. On
20 the second page the \$3 million refers to associated
21 research funding. That is funding that goes to my
22 institution.

23 Q. Okay.

24 A. The general payment is more reflective of

1 payment to me.

2 Q. Okay. So is what you're saying that even
3 though this would be a search for your name if --
4 accept my representation that there was a search made
5 for your name, which it says at the top there, on the
6 first page.

7 A. Correct.

8 Q. What you're saying is on the second page,
9 the breakouts between general payment, research
10 payment, associated research funding, you're saying
11 you think the associated research funding goes to an
12 institution and not yourself?

13 A. That is correct.

14 Q. So of that three-and-a-half million
15 dollars, do you get -- strike that -- would that have
16 all gone to one institution?

17 A. Yes, because I have been at the University
18 of Chicago for 30 years. This reflects my work at the
19 University of Chicago.

20 Q. So do you as a result of making the
21 University of Chicago three-and-a-half million dollars
22 get any, first, financial benefit from that?

23 A. I do not. I had a salary and I got the
24 same salary.

1 Q. Do you get any other type of benefit from
2 the University of Chicago outside of, let's say,
3 direct financial benefit to you?

4 A. So I would say that this research funding
5 is one of many sources of research funding for the
6 work that I did as a -- as a faculty member, and
7 obviously my research productivity was monitored and
8 research product -- this is part of the metric for
9 research productivity.

10 Q. Do you know where you fall in the metrics
11 of research productivity at the University of Chicago
12 in terms of, like, three-and-a-half million dollars?
13 Is that in the high category, the medium, the low?

14 A. I have no idea. I know that, you know,
15 based on my publication record, I was a well-respected
16 senior faculty member at the university.

17 Q. And have you -- you know what a conflict
18 of interest is, right?

19 A. I do.

20 Q. And is it fair to say that you've written
21 on conflict of interest?

22 A. I've written on conflict of interest.

23 Q. When you've written on conflicts of
24 interest, is it fair to say that -- that you've

1 written that there is extensive literature, as you
2 believe, that states that even trivial remuner- --
3 remunerations introduce bias for the individual?

4 A. I think that there is literature to
5 suggest -- to suggest that, yes.

6 Q. And do you agree with that?

7 A. Yes.

8 Q. And do you believe that multibillion
9 dollar pharmacy companies -- pharmaceutical companies
10 have successfully used these gifts to induce the use
11 of their products?

12 A. That's a -- that's a different question.
13 I would summarize a complex area to say that
14 pharmaceutical companies as like any other industry
15 will seek to enhance the sale of their products.

16 Q. Would you agree with the sentence -- or
17 the statement that, "A multibillion dollar
18 pharmaceutical marketing industry has successfully
19 used pens, lunches, tote bags and other trivial gifts
20 to induce uses of their products"?

21 A. I think that that's fair.

22 Q. Have you been induced to use products
23 based off of gifts from pharmaceutical companies?

24 A. Being aware of the biases, I've tried very

1 hard not to, and I have tried everything in my power
2 to make decisions based on available evidence.

3 Q. Have you written that as far as you're
4 concerned, it is inescapable that financial conflicts
5 of interest influence how providers choose treatments?

6 A. You may be referring to something you
7 found that I wrote, but in general, it is correct that
8 we all have our biases.

9 Q. And you would agree that that includes
10 you, true?

11 A. I certainly have my biases.

12 Q. Would you agree that accepting -- strike
13 that.

14 Would you agree that financial
15 compensation to somebody like yourself constitutes a
16 bias?

17 A. By itself, not necessarily. I think that
18 there are specific aspects. I, for example, have
19 stated that a lot of my work right now is as an
20 independent member of a data safety monitoring
21 committee to provide oversight on clinical trials to
22 international pharmaceutical companies.

23 Q. Have you ever written that when somebody
24 like yourself is in the position of having to choose

1 between accepting financial compensation or not, with
2 relating to like a research project, have you ever
3 equated that to sainthood?

4 A. Not to my recollection.

5 Q. Have you ever stated to your
6 understanding, "Expecting individuals with such
7 expertise to forego the personal economic gains
8 commensurate with their skills is utopian"?

9 A. I believe there was an article I once
10 wrote where you're taking that, you know, sentence
11 from.

12 Q. And -- so yes?

13 A. I guess the answer is yes.

14 Q. Okay. Have you ever written that we
15 venerate saints because there are -- there are so few
16 of us who always place the interests of the greater
17 good above their own"?

18 A. Presumably, yes.

19 Q. And is what you're saying -- strike that.
20 Do you put yourself in the saint category?

21 A. My wife doesn't and I wouldn't either.

22 Q. So is it fair to say -- strike that.

23 Have you ever written on the difference
24 between funding for sponsored research versus

1 investigator initiated research or studies?

2 A. I have.

3 Q. And you've written that there's a
4 difference between the two, right?

5 A. I believe there is.

6 Q. Meaning when there is sponsorship from an
7 entity like a pharmaceutical company, that's different
8 than if you came up with the research project yourself
9 and -- and initiated it through, like, the University
10 of Chicago or something, true?

11 A. That is correct.

12 Q. And is it true that you've written that
13 when you have funding from sponsored entities, like
14 pharmaceutical companies, you have more bias?

15 A. There's a tendency to have more bias in
16 part because that's contracted work.

17 Q. Have you -- have you ever been involved in
18 a situation in which you were doing work for a
19 pharmaceutical company in which they gave you a slide
20 deck of slides to do a presentation?

21 A. I have in the past.

22 Q. And is that one of the biases that you
23 believe exists when you work for pharmaceutical
24 companies, meaning they give you information to

1 promote their products, fair?

2 A. I think that where I've been personally
3 involved is when I've received material for
4 presentation, I have always tried to make sure that
5 that material is as accurate and unbiased as possible.
6 I have multiple examples where I have not presented
7 what was originally given to me and asked it to be
8 modified.

9 Q. Have you ever stated that when you engage
10 in these sponsored projects from pharmaceutical
11 companies, that your intellectual contribution is low
12 or modest?

13 A. I believe that intellectual contributions
14 are -- are low to modest and that our major
15 responsibility as faculty for those studies is to
16 protect the patients and assure the scientific
17 validity.

18 Q. And when you say that in those situations
19 your intellectual -- strike that.

20 Have -- have you ever stated that the
21 reason why you engage in those sponsored projects is
22 because it's good for your CV, it keeps deans happy,
23 but they're not real contributions to the literature?

24 A. I may have said that in some ways almost

1 facetiously, in that in comparison to individual
2 investigator-initiated research, this has a much lower
3 intellectual -- this is a much lower intellectual
4 contribution.

5 Q. And -- and why? What do you mean by that?

6 A. Well, in the sense that a company may have
7 a concept, may have designed a trial, may actually
8 collect the information on the trial, they at the end
9 of the day have made a much greater intellectual
10 contribution than the individual physician who may be
11 enrolling the patients.

12 Q. But your name is on the study, right?

13 A. My name is still on the study.

14 Q. I see. And have you ever referred to that
15 research as not being true research?

16 A. I have referred to that research as being
17 contract work and less valuable than independent
18 research activities.

19 Q. Do you have an equity interest in any
20 pharmaceutical companies?

21 A. I have no equity interest in the
22 pharmaceutical industry. I do have equity in a
23 biotech called Fortress Biotech that has no value at
24 the current time.

1 Q. Have you -- do you or have you ever had an
2 equity ownership in Abbott Labs?

3 A. My wife had equity in Abbott Labs that I
4 became part of when we married 30 years ago. I don't
5 know, five, ten years thereafter, I asked her to sell
6 that equity because of potential conflicts of interest
7 with my job.

8 Q. You have -- we marked as Exhibit 6, I
9 believe, your billing in this case?

10 A. That is correct.

11 Q. And you've -- is it fair to say you've
12 made a substantial amount of money so far in this
13 case?

14 A. I have made a reasonable amount of money
15 in this case so far.

16 Q. All right. And we know that the
17 allotment, so to speak, is from the government for
18 your work into the future, is \$190,000, true?

19 A. That's what we discussed.

20 Q. Have -- has that ever caused you on any
21 occasion to disclose that as a conflict of interest,
22 meaning the money that you're making from the
23 government in this case?

24 A. I have disclosed the money I have been

1 making in this case to both the University of Chicago
2 when I worked there and currently to the City of Hope
3 as additional outside income.

4 Q. Is there anything publicly that you've
5 done that with?

6 A. I -- when I have given talks, I have noted
7 in my talks, and in my disclosures, that I have
8 received money from the Department of Justice. I have
9 not provided a lot of details in that.

10 Q. What -- like, give me an example of a talk
11 that you're -- that you're referring to.

12 A. I gave a talk recently at the -- in
13 Minneapolis on an update for some of the bladder
14 cancer presentations at the most recent American
15 Society of Clinical Oncology meetings from Chicago.

16 As part of my disclosure, I noted that I
17 had been remunerated by the Department of Justice.

18 Q. And that was a -- is that a public doc- --

19 A. It's public.

20 Q. Like, is there a public slide show or
21 public --

22 A. Yes.

23 Q. Any other ones you can think of?

24 A. In terms of talks, I'm trying to recall if

1 there was anything else recent, but I disclosed that
2 sort of general remuneration from the Department of
3 Justice as part of my DSMB activities that I'm on, as
4 well as some things like editorial committees that I'm
5 on.

6 Q. In your reports that we've marked as
7 Exhibit 1 through 5 -- you kept those out front,
8 that's good -- you state that you rely on different
9 expert reports, but one of those expert reports is a
10 Dr. LaKind.

11 Do you know who Dr. LaKind is?

12 A. I do not know them personally.

13 Q. I just mean, like, do you know -- that was
14 an imprecise question.

15 You don't know Dr. LaKind personally,
16 true?

17 A. Correct.

18 Q. Do you know what Dr. LaKind's role is in
19 this case?

20 A. If -- if I recollect correctly, Dr. LaKind
21 provided assessments of exposure.

22 Q. And did you -- strike that.

23 Did you utilize those assessments of
24 exposure in your opinions?

1 A. So in part, yes, in the sense that
2 Dr. LaKind's opinion was that the degree of exposure
3 was generally insufficient for the -- for causation
4 purposes.

5 Q. Do you know what Dr. LaKind's
6 qualifications are in terms of being able to make a
7 conclusion that the exposure levels at Camp Lejeune
8 were not -- or for these plaintiffs were not
9 sufficient?

10 A. I -- I read the general description of
11 expertise, but I don't recall exactly what that was.

12 Q. So -- strike that.

13 Do you know what milligrams per kilogram
14 per day means?

15 A. I know what it means.

16 Q. Do you know what it means in terms of
17 significance?

18 A. I know it's a -- you know, it's a common
19 measure of exposure. If you're asking a question
20 about, you know, specific exposures here, I can't
21 comment in terms of actual numbers.

22 Q. Do you know how to convert milligrams per
23 kilogram per day to micrograms per kilogram per day?

24 A. I could probably do the math.

1 Q. Okay. Would you have enough information
2 to be able to do the math, I guess, without trying to
3 research it?

4 A. I can convert milligrams to micrograms.
5 If you ask me in terms of significance of either
6 micrograms or milligrams, depending on where the
7 decimal point is for a specific exposure, I couldn't
8 do that.

9 Q. Right. But do you know if milligrams per
10 kilogram per day is used for the same exposure
11 assessment as micrograms per kilogram per day?

12 A. I have no idea except for the fact that
13 one is a few decimal places different than the other.

14 Q. Do you know what milligrams per meters
15 cubed is?

16 A. I have a general understanding of what
17 that means.

18 Q. Do you know what it's used for in terms of
19 an exposure analysis?

20 A. I presume that that refers to airborne
21 exposures, but beyond that, I can't comment.

22 Q. Do you know if it's used -- what type of
23 airborne exposures it's used for?

24 A. I don't know for sure.

1 Q. Okay. Do you know what micrograms per
2 meters cubed is?

3 A. It sounds like it's another airborne
4 exposure metric.

5 Q. Do you know if it's used for same airborne
6 exposures as milligrams per meters cubed?

7 A. Once again, there's just a decimal's
8 difference between those two, but I know nothing more
9 than that.

10 Q. Okay. So as far as you're concerned, they
11 would be used for the same type of airborne exposures?

12 A. As far as I know, but I am not -- I am not
13 an expert in exposure.

14 Q. Okay.

15 MR. MANDELL: Can I have -- yeah, give me one
16 second. 16.

17 (WHEREUPON, a certain document was
18 marked Dr. Stadler Deposition Exhibit
19 No. 13, for identification, as of
20 07/16/2025.)

21 MR. MANDELL: Thanks.

22 BY MR. MANDELL:

23 Q. I've marked as Exhibit 13 a report from
24 Dr. LaKind relating to Allan Howard.

1 Do you see that at the front?

2 A. I see that.

3 Q. Okay. Could you turn to Page 75 for me.

4 A. 75 of 162, there I am.

5 Q. Got it?

6 A. Yes.

7 Q. All right. Did you read this document?

8 A. I will -- I don't recall all details of
9 the document. I know it was provided to me. I read
10 through the summary and I perused the rest, but I did
11 not read it in detail.

12 Q. Okay. Do you see in the upper third,
13 there's a bunch of bullet points, and then in the
14 bottom third, there are some more bullet points?

15 A. I see that.

16 Q. All right. And do you see how it says,
17 like, for the first bullet point, "Daily exposure
18 estimates via inhalation for PCE range from .065
19 to .16 micrograms per kilogram per day and via dermal
20 contract -- contact from .15 to .19."

21 Do you see that?

22 A. I see that.

23 Q. What does that mean to you?

24 A. That is an estimate of how much PCE

1 Mr. Howard was exposed to or likely exposed to, based
2 on the prior paragraph.

3 Q. Do you -- imprecise question again on my
4 part.

5 What does it mean in terms of the
6 substance of your opinions?

7 A. I have great difficulty in specifically
8 linking these numbers to my opinion. I'm dependent on
9 Dr. LaKind's overall conclusion that the levels here
10 were insufficient for kidney cancer causation.

11 Q. All right. So do you see all of the
12 bullet points on Page 75 and 76?

13 A. I see that.

14 Q. Would your answer be the same if we were
15 to go through each of them one by one?

16 A. It would be the same.

17 Q. Okay. And so essentially what you're
18 saying is, you -- you don't understand what even is in
19 Dr. LaKind's report, other than the fact that you
20 believe Dr. LaKind is saying that these exposures were
21 not sufficient enough to cause kidney cancer, true?

22 A. That is fair.

23 Q. I -- out of efficiency's sake, if we were
24 to go through the other four plaintiffs' reports --

1 this is just for Mr. Howard. If we were to go through
2 the other four plaintiff reports for the other four
3 plaintiffs for Dr. LaKind, would your answers be the
4 same as to those?

5 A. It would be the same.

6 Q. Okay. Thank you.

7 Do you know what the FAST model is?

8 A. I do not.

9 Q. Do you know how Dr. LaKind got data from
10 exposure to showers?

11 A. I do not.

12 Q. How about for dermal?

13 A. I do not.

14 Q. How about for inhalation?

15 A. I do not.

16 Q. How about for ingestion?

17 A. I do not.

18 Q. Did you think it was necessary for your
19 opinions to have or rely on an expert who looked at
20 the exposures for each individual plaintiff and
21 compared that to the risk or causal relationship to
22 developing kidney cancer?

23 A. It was -- the exposure history and the
24 exposure estimates as provided by the toxicologist was

1 one of the things that I utilized for my causation
2 opinion.

3 Q. Right. So the answer to my question was
4 yes?

5 A. Yes.

6 Q. Okay.

7 I lied. Can -- can you pull back out
8 Exhibit 13 just for a second, and turn to Page 75.

9 MR. BU: I'm sorry, can you give me the page one
10 more time, Zach?

11 MR. MANDELL: 7 -- 75.

12 BY MR. MANDELL:

13 Q. I'm going to ask a general question, which
14 is: Of all of the units of measurement that are found
15 on Pages 75 and 76, have you ever seen any of those
16 units of measurement used in epidemiology studies to
17 determine exposure?

18 A. I have not to my recollection. The
19 epidemiology studies that I specifically looked at did
20 not provide exposure histories to this level of
21 detail.

22 Q. Did you ever see -- strike that.

23 I think you had said toward the beginning
24 of the deposition that one of the things that you

1 looked at in terms of the epidemiology was the Bove
2 studies?

3 A. Correct.

4 Q. And the studies from ATSDR?

5 A. Correct.

6 Q. The studies relating to Camp Lejeune,
7 right?

8 A. Correct.

9 Q. Did you see or you -- were you provided
10 ever with exposure metrics that allowed you to draw a
11 comparison between these five plaintiffs that you
12 looked at and the Camp Lejeune epidemiology?

13 A. Not to my recollection.

14 Q. Did you ever ask for that?

15 A. I did not.

16 Q. Did you believe that it was -- strike
17 that.

18 Is it fair to say, then, that you did no
19 analysis of the exposures of these five plaintiffs as
20 it compared to the Camp Lejeune epidemiology?

21 A. That is correct.

22 Q. Do you know if any expert for the
23 Department of Justice did that?

24 A. My understanding from the LaKind report,

1 and there was another exposure expert, that they --
2 they provided the estimates for exposure of these
3 particular plaintiffs.

4 Q. Is it your understanding that those
5 experts as part of what they did for their opinions
6 was compare the exposures of these five plaintiffs to
7 the Camp Lejeune epidemiology?

8 A. I don't know how they -- whether they
9 compared it -- let me put it this way. I don't know
10 whether their exposure history -- their exposure
11 analysis compared these plaintiffs' exposure to others
12 at Camp Lejeune.

13 Q. Do you think -- regardless of whether you
14 know whether they did or didn't, do you think that
15 that's something that would have been a significant
16 thing to do, understanding that we are dealing with
17 plaintiffs who were at Camp Lejeune?

18 A. I don't have an opinion one way or the
19 other. I looked at each one of these plaintiffs
20 somewhat independently in terms of my assessment for
21 causation.

22 Q. Well, when you were looking at them
23 independently, did you either your -- we know you
24 didn't yourself, but did you ever seek to look to see

1 whether any other expert had compared any one of the
2 individual plaintiffs to the epidemiology from
3 Camp Lejeune?

4 A. I did not look for any of that
5 information.

6 Q. Why not?

7 A. Because the information that I was
8 provided, as well as what I looked at individually,
9 suggested that the degree of ex- -- the degree and
10 duration of exposure was such that it was -- that the
11 Camp Lejeune exposure was not the most likely cause of
12 these patients' own cancer.

13 Q. And where is it that you got the data that
14 each one of the individual plaintiffs' exposures was
15 not sufficient in terms of the duration or amounts,
16 what you just said?

17 A. The exposure and duration of exposure, as
18 I said before, I was highly dependent on the analysis
19 of the toxicologist, as well as the epidemiologist who
20 looked at all of the epidemiology data.

21 Q. So when you say "the toxicologist," who
22 are you referring to?

23 A. Dr. LaKind and I believe there was one
24 other exposure expert.

1 Q. I see. When you say the epidemiologist,
2 who are you referring to?

3 A. Mainly Dr. Goodman.

4 Q. All right. Do you have an understanding
5 that Dr. Goodman looked at any one of these five
6 individual kidney cancer plaintiffs and made any
7 assessment about their exposures?

8 A. I don't know.

9 Q. Did you have as a basis of your opinion
10 that she did and found that they weren't sufficient?

11 A. My understanding of Dr. Goodman's
12 testimony was that she testified about the
13 epidemiology and not about exposures.

14 Q. Okay. So you would agree that -- strike
15 that.

16 Do you agree that Dr. Goodman did not look
17 at any of these five plaintiffs, or do you think she
18 did?

19 A. I don't know if she specifically looked at
20 these cases or not.

21 Q. Do -- was that -- was that relevant at all
22 to your opinions in terms of whether or not the
23 epidemiologist who was looking at the epidemiology
24 studies looked at the patients or not?

1 A. What was relevant to me was the overall
2 epidemiologic opinion, and as I stated in my reports,
3 a more comprehensive look at individual patient in
4 terms of what all of the different potential causes
5 might be for that individual patient.

6 Q. All right.

7 THE VIDEOGRAPHER: Do you mind putting that clip
8 down.

9 MR. MANDELL: Oh, I'm so sorry. Yeah, sorry
10 about that.

11 THE VIDEOGRAPHER: Thank you.

12 MR. MANDELL: No problem.

13 BY MR. MANDELL:

14 Q. So let me just see if I can sum up where
15 we are so far. Is it fair to say that you do not have
16 any understanding one way or the other as to when
17 any -- as to whether any expert for the defendant in
18 this case, the Department of Justice, compared any one
19 of the five kidney cancer plaintiffs to any
20 epidemiology study, fair?

21 MR. BU: Objection; form.

22 You can answer.

23 BY THE WITNESS:

24 A. So to my knowledge I -- let me put it this

1 way. I do not know if any defense expert compared the
2 characteristics of any one of these plaintiffs to the
3 more general Camp Lejeune population.

4 BY MR. MANDELL:

5 Q. Okay. How about -- and I appreciate that
6 answer. I'm going to try to -- strike that.

7 How about any other epidemiology outside
8 of the Camp Lejeune epidemiology? Same answer, true?

9 A. I -- I don't know if they did any of that.

10 Q. So yes?

11 A. Correct.

12 Q. What -- what is it that you believe was
13 done from an exposure standpoint relating to these
14 five plaintiffs as it compared to whether or not these
15 five plaintiffs were considered at higher risk for
16 kidney cancer or not?

17 A. So my understanding of the toxicologist's
18 report is that they made estimates regarding exposure,
19 especially to TCE, for these specific plaintiffs and
20 compared that to exposures that have been associated
21 with kidney cancer.

22 Q. Do you know what exposures are known to
23 be assoc- -- associated with kidney cancer outside
24 of -- strike that.

1 Do you know what exposures they looked at
2 in terms of ones being associated with kidney cancer?

3 A. I -- I don't know what levels they
4 actually compared it to.

5 Q. And how did you use that, that assumption
6 on your part, that there was an expert who looked at
7 estimates of exposure for each of these five kidney
8 cancer plaintiffs and compared those to exposures
9 associated with kidney cancer, how did you use that?

10 A. So in each one of the cases, I considered
11 all of the different potential causes for their kidney
12 cancer and used the estimated exposures and the
13 conclusions of the defense experts as one data point.

14 Q. Did you use that as the data point to not
15 have Camp Lejeune water exposure on any one of the
16 five differential diagnoses that you did for these
17 five plaintiffs?

18 A. Can you repeat that question?

19 Q. Sure.

20 Did you use that assumption on your part
21 as to what those experts said as a basis for not
22 including Camp Lejeune exposures on any one of the
23 differentials that you did for each of these five
24 plaintiffs?

1 A. So for each of the five plaintiffs, the
2 exposure estimates, along with the epidemiologic
3 analyses, suggested that the Camp Lejeune water was
4 not a significant contributor to their cancer.

5 Q. But, again, let me just see if I
6 understand. The epidemiology evidence that you saw
7 wasn't particular to any one of these plaintiffs,
8 true?

9 A. It was relevant in the sense that the
10 epidemiologic studies included patients similar to
11 these as far as we can tell.

12 Q. But just my question is, you would agree
13 that any -- you had -- strike that.

14 You have not read any report from an
15 epidemiologist that looked at the levels -- strike
16 that -- the exposures of these individual plaintiffs,
17 right, these five?

18 A. So the exposure of these plaintiffs was --
19 or the likely exposure, I depended on the toxicology
20 experts.

21 Q. Okay. That --

22 A. Yeah.

23 Q. That's what I'm saying.

24 A. Correct.

1 Q. So in terms of your differential for each
2 of the plaintiffs and each one of the plaintiffs'
3 individual exposures, you were using the assumption
4 that you just told us about, that the toxicologist
5 said that these levels for these plaintiffs weren't
6 associated with kidney cancer as the reason to not
7 include that on your differential, fair?

8 A. That -- that is fair.

9 Q. Okay. Have you seen anywhere information
10 as to if one were to plot, so to speak, each of these
11 five plaintiffs and their exposures with the exposures
12 from the Camp Lejeune epidemiology, where that would
13 land?

14 A. I have no idea.

15 Q. Did you look at the water modeling that
16 was done related to the toxins that were in the water
17 at Camp Lejeune?

18 A. Not in detail.

19 Q. Did you look at it at all?

20 A. I perused the reports, but was highly
21 dependent on the final conclusions.

22 Q. Do you know the levels in the water of any
23 of the chemicals at any given time for any of these
24 plaintiffs?

1 A. I do not off the top of my head.

2 Q. You don't put that in -- anywhere in your
3 reports, right?

4 A. I do not.

5 Q. Is it fair to say that the methodology
6 that you used in this case was such that before you
7 even started your differential, you didn't have
8 Camp Lejeune water on that differential, true?

9 A. So I think that that's incorrect. And
10 part of my differential included all potential
11 exposures, including smoking, including toxic
12 exposures to environmental toxin exposure.

13 Q. Okay. Let -- let me say it a different
14 way. Maybe the words -- let me say it a different
15 way.

16 When you were going about your
17 differential, you didn't do any independent analysis
18 at all as to whether or not the exposures that these
19 five plaintiffs had to the Camp Lejeune drinking water
20 would have meant that it should have been on your
21 differential; for all five of them, you did not --
22 you -- you as a methodology looked at the
23 toxicologist, Dr. LaKind, and said, Well, Dr. LaKind
24 says that these aren't sufficient, so I'm not putting

1 them on my differential, true?

2 A. So it is correct that when I considered
3 all of the different potential causes, I excluded
4 Camp Lejeune in large degree because of Dr. LaKind's
5 exposure analysis.

6 Q. And I -- I don't mean to be -- strike
7 that.

8 Do you know what a part per billion is?

9 A. Mathematically.

10 Q. Okay. What -- what does that mean?

11 A. That means that, you know, in -- that the
12 concentration is such that it is, you know, one out of
13 ten to the minus 9th.

14 Q. Did you ever look at any of the
15 plaintiffs' experts' reports on exposure?

16 A. I perused some of those reports and
17 understand that they came to some very different
18 ultimate conclusions.

19 Q. Did you see in any of those reports
20 whether or not any of the exposure metrics that were
21 used were exposure metrics that either could or could
22 not compare to the Camp Lejeune epidemiology?

23 A. I do not recall and did not compare the
24 metrics from one set of experts to another set of

1 experts.

2 Q. I assume that the -- your answer would be
3 the same in terms of comparison to any epidemiology,
4 whether it be Camp Lejeune or otherwise, true?

5 A. That is correct.

6 Q. You said that you did review the -- the
7 Camp Lejeune Bove studies, true?

8 A. I did look at those.

9 Q. So what was the purpose for your review of
10 those documents?

11 A. It was -- be -- it was to understand what
12 the literature might be in regards to the epidemiology
13 of the -- this particular -- the epidemiology
14 associated with this particular case.

15 Q. Okay. One last question on this. Do you
16 believe, as you sit here now, that you would have the
17 knowledge to apply the exposures for these five
18 plaintiffs to the Camp Lejeune epidemiology?

19 A. I don't think I would have that knowledge.

20 Q. How about any epidemiology?

21 A. No.

22 Q. In your reports, you discuss that you in
23 part rely on the expert opinions of a Dr. Lipscomb.

24 Who is Dr. Lipscomb?

1 A. Now you're challenging my memory. I
2 believe it was another exposure expert, but I would
3 be -- I'm open to being corrected.

4 Q. Okay. Do you -- I think the Tukes report
5 is number --

6 A. 5.

7 Q. -- 5. Could you just pull out Number 5?

8 A. Correct.

9 Q. If you look at Page 12, Number 5.
10 Category Number 5 at the bottom.

11 A. Yes.

12 Q. Do you see how the last sentence says,
13 "See also Goodman and Lipscomb reports"?

14 A. I do.

15 Q. So, fair to say you were -- you were
16 relying on Dr. Lipscomb?

17 A. That is correct.

18 Q. And believed that Dr. -- Dr. Lipscomb's
19 opinions -- strike that.

20 You agree with Dr. Lipscomb's opinions?

21 A. Yes.

22 Q. Okay. Do you remember what it was that
23 Dr. Lipscomb stated -- strike that.

24 What is it you understand Dr. Lipscomb's

1 opinions to be?

2 A. To be honest, I don't recall. I would
3 have to take a look at that report again.

4 Q. Okay. Did -- have you read his
5 deposition?

6 A. I don't recall if I read his deposition
7 per se.

8 Q. All right. Let me ask you a question and
9 see if you agree with this, and I'll -- oh, that's
10 okay.

11 MR. MANDELL: Can I have number 26.

12 (WHEREUPON, a certain document was
13 marked Dr. Stadler Deposition Exhibit
14 No. 14, for identification, as of
15 07/16/2025.)

16 MR. BU: Thank you.

17 BY MR. MANDELL:

18 Q. Exhibit 14, would you agree with me, is
19 the deposition transcript of a Dr. John Lipscomb?

20 A. Yes.

21 Q. And you think you read this, true?

22 A. I don't know if I've read this actual
23 deposition. I believe I read the report. I do not
24 believe that I read the deposition.

1 Q. Okay. Could you turn to Page 130 for me,
2 please. And it's Line 4:

3 Question -- are you there?

4 A. Yes.

5 Q. Question: "Okay. Would you be able to
6 know for an individual what their level of absorption
7 would be?"

8 There was an objection.

9 The Witness: "Risk assessment is not a
10 science directed at the individual level. Regulatory
11 risk assessment is done at the population level."

12 Do you see that?

13 A. I see that.

14 Q. And you agree with that?

15 A. I have no reason to disagree.

16 Q. Okay. As far as your opinions in this
17 case, you would be accepting of that, fair?

18 A. I would be accepting of that.

19 Q. Okay. And then if you could turn to
20 Page 136, Line 15 starts:

21 "Okay. In your -- in your 34 years,
22 though, you haven't seen anybody determine specific
23 causation based on a risk assessment?"

24 There was an objection.

1 The Witness: "I haven't, and the reason I
2 haven't is because EPA and ATSDR specifically indicate
3 that risk assessment values, including those for
4 cancer, cannot be used to assess the quantified risk
5 above an expose -- an exposure or the true risk of
6 cancer."

7 That's what I said -- did I read that
8 correctly?

9 A. You read that correctly.

10 Q. And would your answer be the same for
11 that, which is you agree with that?

12 A. I would have to agree with the -- with the
13 expert.

14 Q. Okay. Thank you. You can put that aside.
15 That was Number --

16 A. 14.

17 Q. -- 14.

18 Did you read, review, and rely on the
19 reports of Dr. Bailey?

20 A. Yes.

21 Q. Do you know who Dr. Bailey is?

22 A. Dr. Bailey, if I recall correctly, also
23 did some exposure assessments.

24 Q. Do you know what exposure assessments

1 Dr. Bailey did?

2 A. I would have to review the report again.

3 Q. Do you know if Dr. Bailey utilized a risk
4 assessment, regulatory risk assessment analysis, for
5 these five plaintiffs, individuals -- these five
6 individual plaintiffs?

7 A. I don't recall.

8 MR. MANDELL: Do you want to take a five-minute
9 break?

10 MR. BU: Sure.

11 THE VIDEOGRAPHER: We are now off the record at
12 11:29 a.m.

13 (WHEREUPON, a recess was had
14 from 11:29 to 11:40 percent a.m.)

15 THE VIDEOGRAPHER: We are back on the record at
16 11:40 a.m.

17 BY MR. MANDELL:

18 Q. Dr. Stadler, did you -- strike that.
19 Nowhere in your reports do you define what
20 a substantial exposure is, true?

21 A. No, I do not.

22 Q. Did you do any analysis as to whether any
23 of these plaintiffs' exposures were considered
24 substantial or not?

1 A. I did not do any independent analysis.

2 Q. Do you know how much water Jacqueline
3 Tukes drank while she was at Camp Lejeune?

4 A. I have no idea.

5 Q. Do you know where she drank that from?

6 A. I do not.

7 Q. Do you know whether -- how often she
8 showered?

9 A. I do not.

10 Q. Do you know where she showered?

11 A. I do not.

12 Q. Do you know the water sources for any of
13 her exposure through showers?

14 A. I do not.

15 Q. Do you know the water sources for any of
16 her exposures through inhalation?

17 A. I do not.

18 Q. Dermal?

19 A. No.

20 Q. Same is true for Mr. Mousser?

21 A. Correct.

22 Q. The same is true for Mr. Howard?

23 A. Correct.

24 Q. The same is true for Mr. Fancher?

1 A. Correct.

2 Q. The same is true for Mr. Downs?

3 A. Correct.

4 Q. Do you know when Mr. Fancher was on base?

5 A. It is in my report, but I don't have
6 independent recollection.

7 Q. Is the same true for the other five -- or
8 the other four?

9 A. Correct.

10 Q. Did -- did the time period on base play
11 any role in your opinions in this case other than just
12 it was a fact?

13 A. Mainly it was a fact.

14 Q. When you were -- when you were forming
15 your opinions in this case, did you consider exposures
16 to any of the toxins that were known to be in the
17 water at Camp Lejeune in situations other than the
18 times that the plaintiffs were exposed to those toxins
19 at Camp Lejeune?

20 A. I focused my analysis on the individual
21 cases and their particular exposures.

22 Q. I guess my question is, did you look at
23 whether or not -- strike that.

24 Do your -- do you view your role in this

1 case as mainly providing information as to kidney
2 cancer generally?

3 A. I view my role as providing expertise on
4 kidney cancer in general and in terms of causation for
5 the specific individual.

6 Q. Do you believe that you are qualified to
7 give full opinions on causation for these five
8 individual plaintiffs?

9 MR. BU: Objection; form.

10 You can answer.

11 BY THE WITNESS:

12 A. For -- for these five cases, I considered
13 as a clinician the different potential causes in that
14 particular patient.

15 Q. Have you ever stated that -- the
16 following: "I am -- in the Department of Justice
17 case, I am mainly the expert to provide information on
18 kidney cancer. I also provide, at least to the extent
19 of my expertise, some information on causation."

20 A. I --

21 Q. Have you ever said that?

22 A. I presume I did say that.

23 Q. What do you mean by that? Strike that.

24 When you say, "to the extent of your

1 expertise you provide some information on causation,"
2 what do you mean by that?

3 A. What I mean by that is that I am not an
4 epidemiology or toxicology expert, but I am a expert
5 in kidney cancer, care of patients, and routinely have
6 conversations with patients regarding the cause of
7 their cancer.

8 Q. So what is the limits of your expertise,
9 as you see it, in terms of providing information on
10 causation for these plaintiffs?

11 A. The limit is really in terms of the exact
12 details of exposure for which I'm highly dependent on
13 the toxicologists.

14 Q. Anything else?

15 A. I have -- I would say that I have less
16 expertise in epidemiology than the epidemiologic
17 experts.

18 Q. Anything else?

19 A. I think that more or less covers it.

20 Q. Okay. How do you define the term
21 "idiopathic"?

22 A. Idiopathic is that essentially we're not
23 sure and we don't know.

24 Q. Do you believe that the term "idiopathic"

1 is a term of exclusion? Do you know what I mean -- do
2 you understand my question?

3 A. I -- I understand your question, and I
4 think for the most part that is correct.

5 Q. So would you agree with the process of
6 when you're going about a differential diagnosis, you
7 try to rule in or rule out the potential causes, and
8 if you don't find a cause, that's the process of
9 exclusion, true?

10 A. That is fair.

11 Q. All right. So could you turn to, for
12 example, Page 13 or -- 13 of your Fancher report.

13 It's the last sentence down towards the
14 bottom -- or actually, at the bottom.

15 "In other words" -- are you on -- tell me
16 when you are there, Page 13?

17 A. Yes.

18 Q. All right. It says, "In other words, it
19 is far more likely than not that Mr. Fancher would
20 have developed his cancer even in the absence of any
21 exposures. Plaintiffs' experts not only fail
22 to convincingly -- convincingly rule out idiopathic
23 cause, they ignore it altogether."

24 Do you see that?

1 A. I do.

2 Q. You read the plaintiffs' experts' reports,
3 true?

4 A. I did.

5 Q. And they did find a cause for the cancer,
6 true?

7 A. They opined on a cause, correct.

8 Q. Right.

9 So would you agree with me that as a
10 methodology, they wouldn't have even gotten to the
11 point of calling it idiopathic because they found a
12 cause before that, true?

13 A. So in terms of methodology, I think that
14 is correct. I, however, would, as per my opinions, I
15 believe that they jumped to those conclusions without
16 sufficient justification.

17 Q. So you would agree -- strike that.

18 The answer to my question was yes?

19 A. Methodologically, if you come to a
20 conclusion of a cause, then, you know, idiopathic
21 would not be in the list anymore.

22 Q. Okay. So you don't -- when you say here
23 that they ignore idiopathic altogether, that's not
24 actually true, right?

1 A. What I mean by that is that they -- they
2 presume that an exposure is a causation and don't
3 consider the fact that, as in this case, many of the
4 patients would likely get cancer even without an
5 exposure, and so, therefore, that would be idiopathic.

6 Q. Well, I think I understand that you
7 believe you have some differences of opinions with
8 them in terms of the cause, true?

9 A. That is correct.

10 Q. All right. But in terms of the sentence
11 that we just read, "Plaintiffs' experts not only
12 failed to convincingly rule out idiopathic cause, they
13 ignore it altogether," that's not actually a fair
14 criticism of that because they -- although I
15 understand that you disagree that Camp Lejeune water
16 was a cause, they do believe it's a cause and,
17 therefore, they didn't ignore it, true?

18 A. I don't -- the -- the way I would
19 interpret my -- my statement is to say that when one
20 does this kind of differential diagnosis, one has to
21 have, I believe, the appropriate humility to
22 acknowledge that one may not know what the cause is,
23 and that's what I mean by this.

24 Q. But if you believe that there is a cause,

1 you don't rule out idiopathic because you have a
2 cause, true?

3 A. Under the assumption that you firmly
4 believe that you have a cause, then idiopathic falls
5 off the list.

6 Q. Right. Do you have any reason other than
7 to believe that the plaintiffs' experts strongly
8 believe that -- that the Camp Lejeune water was the
9 cause of each of these five kidney cancer plaintiffs?

10 A. Ask the question again, please.

11 Q. Yeah. Do you have any reason to believe
12 that the kidney cancer -- the experts for the
13 plaintiffs, as to these five kidney cancer plaintiffs,
14 don't actually strongly believe that the Camp Lejeune
15 water was a cause of their kidney cancers?

16 A. I -- I have no reason to question their
17 beliefs. I disagree with their conclusions.

18 Q. Fine. My -- so I'm going to ask the
19 question again.

20 Understanding that you have no reason to
21 disagree with their beliefs that the Camp Lejeune
22 water was a cause of each of the five kidney cancer
23 plaintiffs' kidney cancers, you would agree that they
24 did not ignore idiopathic as a cause, true?

1 A. In the construct that you created, that's
2 a fair statement.

3 Q. Okay. Do you have any sources,
4 literature, articles, textbooks, journals, that type
5 of thing, that support the definitions of "idiopathic"
6 as you use them in your reports?

7 A. I use the general medical definition
8 insomuch as most patients or many patients that we see
9 with cancer, we don't assign a cause to, and we call
10 that idiopathic.

11 Q. So as a general principle, is your answer
12 that you can't cite me any of those types of sources?

13 A. This would be part of general sort of
14 medical practice and expertise.

15 Q. So no, you can't?

16 A. I guess the answer is no.

17 Q. Okay. I want to ask you about a couple of
18 specific sentences. For Mr. Howard, it's Exhibit 3,
19 if you could turn to Page 6. The -- the top part, the
20 first full paragraph on Page 6. It's only three
21 lines, but...

22 A. Um-hum.

23 Q. It says, "Finally, given these issues, it
24 must be recognized that the exact etiology or even the

1 most likely etiology of any specific cancer in any one
2 individual can be difficult or impossible to
3 ascertain. As a result, the cause for the vast
4 majority of cancers is idiopathic, i.e., unknown."

5 Do you have any source that you could cite
6 me, literature, journal, textbook, article, anything
7 like that, that stands for that proposition?

8 A. I do not have a specific reference to that
9 effect. I do reference in my reports that the
10 attributable cause for kidney cancer specifically for
11 the most common, obesity and smoking, are 29 and
12 18 percent, meaning that the vast majority, we don't
13 have an attributable cause.

14 Q. You would agree that there are patients
15 that you see for which they don't have a history of
16 every exposure to a potentially carcinogenic substance
17 in their knowledge, true?

18 A. That is fair.

19 Q. Right. Meaning, there might be somebody
20 who had an exposure, for example, to trichloroethylene
21 that just doesn't know they were exposed to
22 trichloroethylene, true?

23 A. That may be true, but there's an
24 underlying assumption here that cancer -- all cancers

1 are related to some kind of exposure.

2 Q. So do you disagree with that?

3 A. I disagree with that.

4 Q. All right. So let me back up just one
5 step.

6 You do not have a source for those two
7 sentences that we just read on Page 6 of Allan
8 Howard's report, true?

9 A. I don't have a specific source, that is
10 correct.

11 Q. Okay. And do -- do you -- let me see if I
12 can try to understand this.

13 Do you define "idiopathic" as something
14 that can be in and of itself an individual or
15 independent cause, or is it that it's just a situation
16 where you said, where you're not sure and we don't
17 know and it's a process of exclusion?

18 A. So "idiopathic" by definition is -- is not
19 a cause per se. Idiopathic means there's no way we
20 can know.

21 Q. Okay. Fine.

22 So -- fair.

23 Could you turn to Page 8 of Allan Howard's
24 report, two -- two more pages, and I'm looking at the

1 first full paragraph after the number 9.

2 A. Um-hum.

3 Q. And it's the second -- I think it's the
4 second-to-last sentence. It starts with "Finally."

5 Do you see that?

6 A. Yes.

7 Q. All right. It says, "Finally, and as
8 discussed above for cancer in general, risk factors
9 increase the odds of developing a cancer, but it is
10 not possible to distinguish the causative roles, if
11 any, of specific risk factors in an individual
12 patient. As such, the cause or etiology for most
13 patient's specific cancer is unknown ('idiopathic' in
14 medical parlance)."

15 Do you see that?

16 A. I do.

17 Q. Is the answer the same, that you have no
18 source, literature, journal, guideline, textbook,
19 anything to support that sentence?

20 A. This would be -- this would refer to my
21 general knowledge and expertise as a -- as a medical
22 oncologist who sees lots of cancer patients.

23 Q. And let me ask -- so let me ask you this
24 question. Do you know if there are any sources that

1 say the opposite of that? Medical, scientific
2 literature, journals, textbooks?

3 A. Off the top of my head, I wouldn't -- I
4 wouldn't know.

5 Q. All right. Is the same true for the
6 sentence we read on Page 6?

7 A. I believe so.

8 Q. If you could turn to Fancher --
9 Mr. Fancher's report on Page 12. The first full
10 paragraph, the first sentence, "Importantly, as noted
11 above, most renal cancers, even if there are
12 predisposing factors, must be considered...idiopathic
13 in nature. That is simply because the vast majority
14 of patients who have the most significant risk factors
15 (i.e. smoking and obesity) do not develop renal cancer
16 and even patients, like Mr. Fancher, who have no clear
17 risk factors, develop renal cancer."

18 Do you see that?

19 A. I do.

20 Q. And do you have any source, medical source
21 that you consider to be reliable or authoritative,
22 anything like that, for that statement or state- --
23 those statements?

24 A. I, once again, have to refer to some of

1 the statements that say the attributable risk for
2 kidney cancer for the most important risk factors,
3 smoking and obesity, are 29 and 18 percent
4 respectively.

5 Q. Right. So let me see if I understand what
6 you're saying. Is what you're saying that the fact
7 that some of the literature says, as you interpret it,
8 that smoking only -- or kidney cancer is caused by
9 smoking -- strike that.

10 Is what you're saying that you interpret
11 the literature to mean that 29 percent of the kidney
12 cancer cases are caused by smoking?

13 A. So the population attributable risk, yes,
14 about 29 percent is smoking. Smoke -- I'm -- I want
15 to make sure that I say the right thing in terms of
16 the smoking and obesity. I know the numbers are 29
17 and 18 percent. I'm just not sure which numbers
18 associated with --

19 Q. You're looking in your report, right?

20 A. Yeah.

21 Q. Take your time.

22 Just tell us when you get to where you
23 think you want to be.

24 A. So on, for example, on Page 8, the top of

1 the -- in Fancher here, "Major factors are obesity for
2 which the population attributable risk in North
3 America is 29 percent and smoking" --

4 Q. You're on Page 8?

5 A. Yeah, Page 8.

6 Q. And where are you?

7 A. First full paragraph.

8 Q. Okay, yep.

9 A. So obesity, population attributable risk
10 is 29 percent; smoking attributable risk is
11 18 percent.

12 Q. But is what you're saying, as you
13 interpret that literature, as you've stated it here,
14 what -- what -- is what you're saying, that of all of
15 the kidney cancer cases, 18 percent of those are
16 caused by smoking?

17 A. Yes.

18 Q. Okay. So I want to just jump back to
19 where I was, which is on Page 12, if you need to go
20 back to that --

21 A. Yeah, that's fine.

22 Q. -- that's fine, but my question is, when
23 you say, "That is simply because the vast majority of
24 patients who have the most significant risk factors do

1 not develop renal cancer," are you saying that because
2 there isn't a risk factor that breaches 50 percent of
3 the attributable risk of the population as you're
4 talking about, that that somehow means that the vast
5 majority of patients have idiopathic disease?

6 A. What I'm saying is that just because one
7 has the risk factor does not mean that one gets the
8 cancer, and that even patients without those risk
9 factors get the cancer; so, therefore, just because
10 you have a risk factor does not automatically mean
11 that that is the cause in that specific patient.

12 Q. But -- so how do you go about determining
13 whether or not smoking is the cause for any one
14 individual?

15 A. So if the -- if the risk is very high and
16 there are few other causes, then I -- and then I do
17 attribute the risk, perhaps classic is smoking and
18 small cell lung cancer. In essence, almost no
19 non-smokers will ever get lungs -- lung cancer, and
20 the risk of smoking and developing small cell lung
21 cancer is more on -- on the order of 20-fold and not
22 necessarily 1.5 or 1.6, as what we're talking about
23 here with these.

24 Q. Well, how about in kidney cancer cases?

1 A. So in kidney cancer cases, it's very
2 difficult to assign causation in any one individual,
3 and I think one of the few that I did this in was for
4 Tukes, for which the clinical presentation and history
5 was highly consistent with what I believe was a
6 genetic cause.

7 Q. And we're going to -- we'll get to that in
8 a second, but I guess my question is, let's say you
9 had a plaintiff or a patient who had kidney cancer --

10 A. Correct.

11 Q. -- and they also smoked. What is the
12 threshold where you say, Well, now I think that
13 smoking caused his kidney cancer or her kidney cancer?
14 How do you do that if your position is, well, the vast
15 majority of patients who smoke don't get kidney
16 cancer, or the vast majority of patients who have
17 kidney cancer haven't smoked or it isn't caused by
18 smoking? How do you do that then?

19 A. So a lot of it is based on dose and
20 exposure. So if I have a patient who is morbidly
21 obese and has, you know, smoked for -- a pack a day
22 for 20, 30 years, I can very -- I can more confidently
23 tell that patient that it is likely due to his smoking
24 and obesity.

1 If I have a patient that smoked, you know,
2 when they were in college, a half a pack per day, I
3 don't necessarily attribute their smoking history to
4 their cancer either.

5 Q. Okay. Is there any guideline or
6 methodology that you use in terms of making those
7 judgment calls?

8 A. I think that the guidelines that I use in
9 general is the strength of the association, whether
10 patients without those exposures also get cancer, and,
11 in essence, you know, the -- the hazard ratio.

12 So, you know, the extreme example, once
13 again, is the -- what I said earlier was small cell
14 lung cancer. That is -- we can confidently say in
15 patients, smoking caused that.

16 Q. So do you have -- how would you make that
17 assessment for kidney cancer? Meaning, do you feel
18 that there are any risk factors for kidney cancer that
19 you would say would be enough so that you could say
20 those could be the cause of somebody's cancer?

21 A. It would be extremely unusual for me to
22 say that for any individual cancer.

23 Q. For any individual person?

24 A. For any individual person, correct.

1 Sorry.

2 Q. Because we were talking about --

3 A. Yeah.

4 Q. -- kidney cancer --

5 A. Yes, correct.

6 Q. Right, right.

7 A. In the individual person, sorry, correct.

8 Q. Just -- just so I'm clear, in those very
9 unusual situations, or whatever the word was that you
10 used, rare situations or unusual situations, where for
11 kidney cancer you think you would actually be able to
12 say something was a cause, would you agree with me
13 that that would be a judgment call on your part?

14 A. Correct, that's a judgment call.

15 Q. There is no metric that you would use for
16 any risk factor with some type of level of exposure or
17 something like that, true?

18 A. That is correct.

19 Q. So there would be nothing that we could
20 look to, for example, to say hypothetical plaintiff A,
21 you know, had exposure to Camp Lejeune water, smoking,
22 and was obese, there's -- there's nothing we can point
23 to to say -- or you can point to to say, Well, at this
24 level of smoking, this is when I would have said

1 smoking was related versus Camp Lejeune water versus
2 obesity, true?

3 A. There is no bright white line.

4 Q. Okay. Well, not only is there no bright
5 white line, but there's no line, right, for you?

6 A. There -- there's no absolute line.

7 Q. Can you take a look at your Howard report
8 on Page 12. I'm looking at the -- the section
9 number 2. It says "Smoking."

10 A. Um-hum.

11 Q. The second sentence -- well, the first
12 sentence says, "Mr. Howard only had a 'brief' smoking
13 history while in the military. Like many cancers
14 associated with environmental exposure, brief
15 short-term smoking has not been reliably linked to
16 renal cancer," true?

17 A. Correct.

18 Q. And do you have a definition for brief?

19 A. In -- in this particular case, it was at
20 best a few years.

21 Q. So is it fair to say that you -- okay.
22 Could you pick up Exhibit 1, the Downs
23 report.

24 Well, let me ask you first, just before we

1 go there, when you say a few years, what -- how do you
2 define that?

3 A. Two, three.

4 Q. How about five?

5 A. We're getting into a handful now, but it's
6 still a few.

7 Q. So five would be considered brief?

8 A. Brief in general, yes.

9 Q. All right. Downs, Page 12. Under
10 smoking, it says, "Mr. Downs had a brief smoking
11 history while in the military, but the exact duration
12 is somewhat unclear. If he did smoke 1.5 pack per day
13 for 15 years as documented in certain parts of the
14 medical record it could be contributory. Even one
15 pack per day for five years increases the risk for
16 developing renal cancer, although the degree of
17 contribution decreases with total exposure and length
18 of time since quitting," true?

19 A. Correct.

20 Q. Mr. Downs -- strike that.

21 Do you know what Mr. Downs says in terms
22 of what his smoking history was?

23 A. If I recall correctly, in his deposition
24 he stated he only smoked in the military.

1 Q. Okay. Do you know what he said in terms
2 of how many packs per day or how many years?

3 A. I -- I don't -- I don't recall, but I do
4 recall that the statements in his deposition versus
5 one -- some of the statements in the medical record
6 did not align.

7 Q. Do you have any reason to dispute if
8 Mr. Downs testifies that he only smoked for about five
9 years, not the 15 years in a couple of the medical
10 records?

11 A. I -- I acknowledge, as I say in my report,
12 I acknowledged that that might be the truth. I just
13 simply know that patients' recollection of exposure is
14 sometimes not always accurate, and I have some
15 contradictory evidence within the medical record.
16 That's all I know.

17 Q. Okay. You would agree that you don't
18 attribute any causal role of smoking to Mr. Downs's
19 kidney cancer, true?

20 A. So I said that if it was longer, it could
21 be contributory, but if it was as short and as little
22 as he testified, then that contribution would be
23 minimal and I would not attribute it as a cause.

24 Q. But you state in your report that you

1 don't attribute any type of causal association to the
2 kidney cancer, true?

3 A. Causal association of the smoking?

4 Q. Correct.

5 A. Correct, that's what I state.

6 Q. Okay. You cite in your -- for example, in
7 Downs, Page 7, you cite a study, and it -- it's
8 actually one of my favorite studies in the case, it's
9 the Mandell study, and you cite that study for --
10 under Number 6.

11 Do you see that?

12 A. I see that.

13 Q. All right. And you cite that study for
14 the proposition that occupational exposures to
15 cadmium, asbestos, petroleum byproducts, and
16 trichloroethylene are associated with renal cell
17 carcinoma, true?

18 A. Correct.

19 Q. Do you know if in that study there are
20 statistically significant increased risks for
21 patient -- for participants in that study who were
22 exposed to dry cleaning substances?

23 A. I don't recall the details of the study.
24 My recollection, and as I state here, is that that

1 study mostly referred to occupational exposures, and
2 if I recall correctly, dry cleaning was one of the
3 occupations.

4 Q. Do you have an understanding as to whether
5 or not dry cleaning is associated with any particular
6 chemical?

7 A. I know that it is associated with multiple
8 of these chemicals, but I cannot quote exactly which
9 one -- chemicals.

10 Q. Do you know if dry cleaning is associated
11 with any chemical more than others?

12 A. I don't know.

13 Q. Okay. Is there any particular reason why
14 you chose not to put dry cleaning and/or associated
15 chemicals with dry cleaning in your Number 6 if the
16 source for that is the Mandell study?

17 A. The Mandell study referred to occupational
18 exposures, and I didn't list all of the occupations
19 that were -- that were listed there.

20 Q. Well, how did you choose some and not
21 others? Why -- why did you choose some and not
22 others?

23 A. I didn't refer to any particular
24 occupation here.

1 Q. Okay. So do you know if in that study
2 they used occupations or exposures to particular
3 chemicals or products?

4 A. I'm -- my recollection is that they refer
5 to specific occupations but not specific products, but
6 I'd have to review the actual article again to, you
7 know, look at the details.

8 Q. Okay. You believe this is a high-quality
9 study?

10 A. I reference it. I think it is high
11 quality.

12 Q. So let me ask you this question. For your
13 opinion that occupational exposures through cadmium,
14 asbestos, petroleum, byproducts and TCE are associated
15 with renal cell carcinoma, do you have any cite other
16 than the Mandell study?

17 A. I -- I have the Mandell study, and as I
18 stated in the beginning of my reports, I've also
19 referred to sort of summary, textbooks, articles about
20 kidney cancer in general that reference Mandell and --
21 and others.

22 Q. I guess what I'm saying is, in this case,
23 in this report for Mr. Downs, you list one citation
24 for the proposition that these different products

1 cause or are known to be associated with renal cell
2 carcinoma, true?

3 A. I reference that particular study, but,
4 you know, in my introduction I also reference -- there
5 are some of the more general references that I've
6 used.

7 Q. Do you have any citation that you -- and
8 if you want to look in your report, please -- that
9 specifically says cadmium, asbestos, by -- petroleum
10 byproducts or TCE is causally associated with renal
11 cancer other than Mandell?

12 A. I would have to --

13 MR. BU: Objection to form.

14 You can answer.

15 BY THE WITNESS:

16 A. I would have to review all of the
17 references and everything specifically.

18 Q. So let me ask it the other way.

19 Would you agree with me that your citation
20 to this Mandell study is sufficient for you to be able
21 to say cadmium, asbestos, petroleum byproducts and TCE
22 are associated with renal cancer?

23 A. In the context of also reviewing other
24 materials, including the general materials and

1 including the epidemiology expert reports, this is a
2 sufficient reference. It is not the sole reference I
3 relied on.

4 Q. So if we were to go about trying to
5 determine what references you did utilize for this
6 Number 6 here, how would we do that?

7 A. We could go back to the general references
8 that I referred to, and we can go back to the
9 epidemiology reports from Goodman, et al.

10 Q. Well, when you say the general references,
11 the general references, correct me if I'm wrong, do
12 not specifically mention cadmium or asbestos or
13 anything like that, right?

14 A. The general references refer to overviews
15 and chapters on kidney cancer where some of those risk
16 factors are noted.

17 Q. But you don't know whether they are or
18 not, as you sit here today, true?

19 A. I know that those were -- that those
20 general risk factors for kidney cancer are in those
21 chapters. If you ask me whether those review -- what
22 references those review chapters refer to, I can't
23 tell you that.

24 Q. Okay. Can -- you have Downs, are you

1 looking at Downs, the Downs report?

2 A. Yes, I have Downs.

3 Q. All right. If you can turn to Page 15,
4 please. I'm looking now at the second full paragraph
5 under Specific Responses.

6 A. Okay.

7 Q. The first sentence says, "I also agree
8 with Dr. Lotan that cancer is a multistep process that
9 takes multiple years," and then you say, "See Lotan
10 report," true?

11 A. Correct.

12 Q. All right.

13 MR. MANDELL: Can I have 15, Tab 15.

14 (WHEREUPON, a certain document was
15 marked Dr. Stadler Deposition Exhibit
16 No. 15, for identification, as of
17 07/16/2025.)

18 MR. MANDELL: I had a matchup too.

19 MR. BU: Yeah.

20 BY MR. MANDELL:

21 Q. This is Exhibit 15. And what I ask you
22 is, I just want to make sure I understand what you're
23 talking about.

24 So if you turn to Page 23 of Dr. Lotan's

1 report.

2 A. Yes.

3 Q. If you look under the paragraph that
4 starts "Longer latency periods"?

5 A. Yes.

6 Q. It says, "Longer latency periods are
7 consistent with the science because mutated
8 carcinogens cause mutations in cells for the rest of a
9 person's life. Human cancers develop due to
10 accumulation of genetic and epigenetic alterations."

11 I read that correctly?

12 A. Correct.

13 Q. You agree with that?

14 A. In general that's fair.

15 Q. Okay. And then at the bottom of the
16 page --

17 A. Yes.

18 Q. -- there's a sentence that starts, "The
19 timing analysis in the study."

20 Do you see that?

21 A. Yes, yes.

22 Q. It says, "The timing analysis in the study
23 suggested that 'driver mutations often precede a
24 diagnosis by many years, if not decades.' As such,

1 cancer risk related to carcinogenic exposure such as
2 TCE would only increase with time, including at times
3 50 years out, similar to Mr. Downs. It makes little
4 sense to claim that a cancer occurred too long after a
5 mutagenic exposure to be causally connected to that
6 exposure because the cells continue to mutate for
7 life."

8 Do you agree with that?

9 A. So I -- I don't agree that the cells
10 continue to mutate. What I agree with is that the
11 interval between exposure and development of a cancer,
12 you know, can be long, okay. That we don't have -- I
13 don't have any -- any issues with.

14 Q. So you do not have any time period within
15 which you would say, the exposure happened too long
16 ago to cause a kidney cancer, true?

17 A. What I would say is that, once again, the
18 most important issues are dose and duration of
19 exposure for any particular toxin.

20 Q. Okay.

21 A. And the longer the -- the duration is
22 since that exposure, be it smoking, be it
23 environmental exposure, risks decrease over time.

24 Q. So, just so I'm clear, you do not have any

1 opinion as to a number of years that any particular
2 exposure has to occur within, to be causally related
3 to kidney cancer, true?

4 MR. BU: Objection; form.

5 You can answer.

6 BY THE WITNESS:

7 A. That's fair.

8 BY MR. MANDELL:

9 Q. Okay. You are not a medical oncologist,
10 true -- excuse me.

11 You are a medical oncologist, true?

12 A. That is correct.

13 Q. Okay. You do not make final decisions in
14 your practice as to surgeries that patients should
15 undergo or not undergo, true?

16 A. I will -- I will make recommendations
17 regarding surgery, I will discuss that with surgeons;
18 final decision regarding surgery is generally made by
19 the surgeon.

20 Q. Right. So would you agree with my
21 statement that you in your practice do not make final
22 decisions in terms of the surgeries that a patient
23 should undergo or not undergo, true?

24 A. That -- that is correct.

1 Q. You leave those decisions to the surgeons,
2 true?

3 A. In general, correct.

4 Q. And, for example, for a surgery like a
5 kidney transplant, that decision would be made by a
6 kidney transplant surgeon -- the ultimate decision is
7 made by the kidney transplant surgeon, true?

8 A. That is correct.

9 Q. That's because the kidney transplant
10 surgeon has more knowledge and experience as to the
11 need for the surgery than you, true?

12 A. I would say that's fair.

13 Q. Do you --

14 MR. MANDELL: Can I have 53, please.

15 (WHEREUPON, a certain document was
16 marked Dr. Stadler Deposition Exhibit
17 No. 16, for identification, as of
18 07/16/2025.)

19 BY MR. MANDELL:

20 Q. What we marked as Exhibit 16 is the
21 Rehabilitation Analysis of Jacqueline Tukes by Michael
22 Shahnasarian.

23 Do you see that?

24 A. I see that.

1 Q. Have you ever seen this document before?

2 A. I don't recall having seen this.

3 Q. Could you turn to Page 19 for me.

4 Are you there?

5 A. I am.

6 Q. Do you see at the bottom of Page 19, it
7 says, "Consultations with Disease Experts: Dr. W.
8 Stadler and Dr. D. Johnson"?

9 A. Yes.

10 Q. Did you have a consultation or multiple
11 consultations with a Dr. Shahnasarian?

12 MR. BU: So, Dr. Stadler, you can answer that
13 yes or no, but you should not get into the substance
14 of your communications with other DOJ experts.

15 BY THE WITNESS:

16 A. I did have a brief conversation.

17 BY MR. MANDELL:

18 Q. Have -- if you could, take a second and
19 take a look at Page 19, the -- this section to the end
20 of it on the be -- be -- the top of the next page, and
21 just tell me when you've had a chance to look at it.

22 A. Up to "Summary and Impressions"?

23 Q. Yeah.

24 A. Yes, I saw that.

1 Q. Okay. Does this accurately reflect the
2 consultation that you had with Dr. Shahnasarian?

3 A. It appears to.

4 Q. Okay. Was there other substance that you
5 talked about with Dr. Shahnasarian outside of what is
6 here?

7 MR. BU: So, Dr. Stadler, I'm going to instruct
8 you not to share the substance of your communications
9 with Dr. Shahnasarian. If you are able to respond
10 with that instruction, you may.

11 BY THE WITNESS:

12 A. I -- I did not have any other discussions
13 with Dr. Shahnasarian.

14 BY MR. MANDELL:

15 Q. Okay.

16 MR. MANDELL: Can I have 54, please. Actually,
17 that's okay. I'm going to...

18 BY MR. MANDELL:

19 Q. Would you agree with me that when you're
20 performing a differential diagnosis that it's
21 important for you to know the risk factor, the
22 strength of each risk factor?

23 A. Yes.

24 Q. So, for example, if -- one of the things

1 that you do with a differential diagnosis is you look
2 at the different risk factors but also the strength of
3 those, true?

4 A. Correct.

5 Q. Are there any guidelines or metrics or
6 literature that you use, anything we could look to to
7 see how you, Dr. Stadler, assess the strength of any
8 particular risk factor or not?

9 A. I don't think that there is any specific
10 guidelines, aside from some of the more general things
11 we've discussed today.

12 Q. Have you ever heard of the Bradford Hill
13 criteria?

14 A. I have.

15 Q. And what is your understanding of that?

16 A. My understanding of the Bradford Hill
17 criteria are a set of criteria that epidemiologists
18 utilize for assessing likely causation on -- of a
19 particular exposure in a population.

20 Q. And essentially what -- tell me if I'm
21 wrong. As you understand it, those criteria are
22 intended to, among other things, indicate a strength
23 of association between a particular chemical and a
24 disease, true?

1 A. Those criteria, amongst other things, do
2 lay out strength of association as one of the criteria
3 for assessing causation in a population.

4 Q. All right. Would you agree that that is a
5 relevant factor in a differential diagnosis of whether
6 or not that particular chemical causes a particular
7 outcome?

8 A. It's a relevant factor. Importantly, it
9 applies to causation in a population. There are
10 different things to consider in the context of an
11 individual patient.

12 Q. But when you're considering the causation
13 of an individual, you're using on some level the
14 general causal link between a chemical and a disease,
15 right?

16 A. That is correct.

17 Q. Right. So when you're assessing, for
18 example, let's say hypothetical plaintiff A has a
19 smoking history, you would want to know what the
20 strength of association is between smoking and the
21 disease that they have, let's say kidney cancer, true?

22 A. That is correct.

23 Q. Right. Because if there is a disease that
24 has a stronger association, you might weigh that

1 heavier on your differential, true?

2 A. That is correct.

3 Q. So you wouldn't criticize a plaintiffs'
4 expert for taking a look at the Bradford Hill criteria
5 understanding -- if they were doing it in order to
6 give weight to different factors, true?

7 A. If they use those criteria in a manner to
8 give weight to different factors, that would be
9 rational.

10 Q. And appropriate to do in a differential
11 diagnosis, true?

12 A. It would be appropriate within a
13 differential diagnosis.

14 Q. Great. Could you tell us a little bit
15 about your expert witness background? How many -- how
16 many times have you worked as an expert witness?

17 A. So as an expert witness, most recently I
18 acted as a expert witness for Sandoz in a patent
19 infringement case, defending Sandoz's marketing for
20 docetaxel. Aside from that, I have done some medical
21 malpractice, although it's probably been about ten
22 years since I've done that. I've worked on both
23 the -- on the plaintiff as well as the defendant side.
24 And then probably 20 years ago or more, I was a expert

1 on the defendant's side for a class action lawsuit for
2 a -- for a drug called zoledronate.

3 Q. So how -- do you have an estimate of the
4 total number of cases that you've worked on?

5 A. If we look at the total number of cases
6 over the period of about 25 to 30 years, maybe it's a
7 dozen.

8 Q. You had said that you worked on the --
9 the -- strike that.

10 The class action that you were just
11 talking about, who were you retained by?

12 A. I was retained by the pharmaceutical
13 manufacturer of zoledronate to defend them.

14 Q. You had said that you worked on several
15 medical malpractice cases, some for the plaintiff,
16 some for the defense.

17 Do you know how you would do that
18 breakdown in terms of percentage?

19 A. It's about 50/50.

20 Q. Do you remember any plaintiffs' law firms
21 that you worked with for medical malpractice cases?

22 A. It's been almost ten years or more, so,
23 no, I do not.

24 Q. Do you remember any defendants' law firms

1 that you worked on?

2 A. I do not.

3 Q. Do you know how many times you've given
4 deposition in any one of those cases as an expert
5 witness?

6 A. I've given a deposition maybe half a dozen
7 times or so, maybe a little bit more.

8 Q. How many times at trial?

9 A. I've been at trial -- I've been at trial
10 once, I believe, once for the Sandoz case. It was
11 a -- it was a bench trial. The only other
12 recollection that I have in terms of trial was as a
13 treating physician and not as an expert witness.

14 Q. Have you ever been deposed outside of the
15 context of expert witness work?

16 A. I've been deposed as a treating physician
17 for other medical malpractice cases.

18 Q. How many times?

19 A. Maybe half a dozen.

20 Q. Were any of those where you were a
21 defendant in the case?

22 A. No.

23 Q. All of the other times, you were just
24 somebody who had been involved in the care?

1 A. Correct.

2 Q. Have you ever been -- have you ever had a
3 lawsuit filed against you, whether or not you had a
4 deposition taken?

5 A. No.

6 Q. Have you ever had any disciplinary issues
7 with any medical boards or that type of thing?

8 A. No.

9 Q. Have you ever worked on any other cases
10 with the Department of Justice?

11 A. No.

12 Q. Has the federal government funded any of
13 your research?

14 A. I've had funding from the DOD, and I've
15 had funding from the NCI.

16 Q. Could you tell us about that?

17 A. The DOD, I've had funding as part of
18 the -- when we talked about the Kidney Cancer Research
19 Program, they also have a prostate cancer research
20 program, and I've had some funding through that for
21 prostate cancer research. From the NCI, I've been
22 involved with NCI-sponsored clinical trials, and I'm
23 trying to remember, the last NCI grant I had was quite
24 some time ago.

1 Q. Do you have any idea -- strike that.

2 Can you give us an estimation of the
3 amount of the funding?

4 A. Not off the top of my head.

5 Q. How about a magnitude of it? Are we
6 talking thousands of dollars, hundreds of thousands,
7 millions?

8 A. Many of these grants, if you include
9 indirect costs, are on the order of probably a few
10 million, once again, to the institution.

11 MR. MANDELL: Okay. Do you want to take a quick
12 break?

13 MR. BU: Sure.

14 THE VIDEOGRAPHER: We are now off the record at
15 12:40 p.m.

16 (WHEREUPON, a recess was had
17 from 12:40 to 1:15 p.m.)

18 THE VIDEOGRAPHER: We are back on the record at
19 1:15 p.m.

20 BY MR. MANDELL:

21 Q. Dr. Stadler, during the break did you have
22 occasion to talk about your testimony with anybody?

23 A. I did not.

24 Q. All right. I want to ask you some

1 questions about some of the specific plaintiffs. So
2 if you could take out your -- or you don't have to
3 take out your report, but I want to ask you about
4 David Downs.

5 A. Okay.

6 Q. So is it fair to say that your opinion as
7 to Mr. Downs is that you believe that the cause of his
8 kidney cancer is idiopathic?

9 A. That is correct.

10 Q. Is it fair to say that there are no other
11 risk factors or any type of whatever, if you define it
12 a different way, that are causally associated with his
13 kidney cancer?

14 A. What I state is that his smoking could
15 possibly be contributory, but I would have to continue
16 to say that his -- that his kidney cancer -- the cause
17 of his kidney cancer is idiopathic.

18 Q. You've given take -- testimony in cases
19 like this as we've discussed before, right?

20 A. Yes.

21 Q. And you -- when you use those words,
22 "Possibly contributory," you're denoting that that --
23 you can't say that to any degree of scientific
24 certainty or medical certainty, true?

1 A. That is correct, right.

2 Q. So you're not going to come into court and
3 say that any smoking for Mr. Downs was as likely as
4 not or more likely than not contributory to his kidney
5 cancer, true?

6 A. That is correct.

7 Q. All right. And for Mr. Downs, you did not
8 include any exposures to the water at Camp Lejeune on
9 your differential diagnosis, true?

10 A. I considered it as part of the
11 differential diagnosis, but I don't -- I do not
12 believe that it is causative.

13 Q. And is your testimony that the sole
14 basis -- or strike that.

15 Your testimony is that the reason you did
16 not consider that is because you believe that
17 Dr. LaKind did an analysis of the exposures and -- for
18 Mr. Downs, and came to a conclusion that Mr. Downs'
19 exposures did not rise to the level of something that
20 would have been causally associated with kidney
21 cancer, true?

22 MR. BU: Objection; form.

23 You can answer.

24 BY THE WITNESS:

1 A. That is correct. Similar to the limited
2 smoking exposure, the limited exposure as assessed by
3 Dr. LaKind, I would not consider to be causative.

4 BY MR. MANDELL:

5 Q. Is there any other basis for your opinion
6 that the Camp Lejeune water was not of a level that
7 would be causative other than your belief that
8 Dr. LaKind said that?

9 A. It's both the dose and exposure as
10 assessed by Dr. LaKind and, as we discussed earlier,
11 the strength of the association as -- as per
12 Dr. Goodman and the other epidemiologic studies we
13 discussed.

14 Q. On Page 12 of your Downs report, forgive
15 me for the need to just go through these one by one,
16 but I think we're there, but I'm just going to go
17 through them one by one and ask you, if this case were
18 to come to trial, you are not going to give any
19 testimony that there's any causal relationship between
20 obesity and Mr. Downs' kidney cancer, true?

21 A. Correct.

22 Q. Smoking and Mr. Downs' kidney cancer,
23 true?

24 A. Correct.

1 Q. Hypertension and Mr. Downs' kidney cancer,
2 true?

3 A. Correct.

4 Q. Chronic kidney disease and Mr. Downs'
5 kidney cancer, true?

6 A. True.

7 Q. Diabetes and Mr. Downs' kidney cancer,
8 true?

9 A. True.

10 Q. Occupational exposure to cadmium,
11 asbestos, and by -- petroleum byproducts, true?

12 A. True.

13 Q. Heavy use of non-steroidal
14 anti-inflammatory drugs, acetaminophen or phenacetin,
15 true?

16 A. Correct.

17 Q. Genetic predisposition syndromes, true?

18 A. True.

19 Q. Chronic infection or inflammation, true?

20 A. True.

21 Q. And those are all of the risk factors that
22 you prescribe for renal cell carcinoma, true?

23 A. Correct.

24 Q. So is it fair to say that the entirety of

1 your opinion in this case comes down to, as far as the
2 Camp Lejeune water, a reliance on other experts, is
3 that fair?

4 A. Both other experts, but the epidemiologic
5 literature that I reviewed in terms of strength of
6 association, as well as some of the other literature
7 that we discussed where things like TCE and -- and
8 petroleum byproducts were most strongly associated in
9 the context of occupational exposures.

10 Q. So when you say that -- when you say that
11 you looked at some of the epidemiology studies, did --
12 did you do your own independent analysis and did that
13 form any part of the basis of your opinion, or are you
14 relying on the other experts?

15 A. I'm not an epidemiologist, but I read some
16 of the epidemiology studies, and so I did rely on
17 those independent studies, plus the experts
18 themselves.

19 Q. So what -- what studies did you rely on
20 for the proposition that Mr. Downs' expert --
21 Mr. Downs' exposure to the water at Camp Lejeune, in
22 whatever forms those took, were not sufficient?

23 A. The -- I was highly dependent on the
24 exposure experts for the degree of exposure, but this

1 also was consistent with the literature I reviewed
2 that suggested that occupa- -- high levels of
3 occupational exposure to agents like this were
4 associated with -- strongly associated with kidney
5 cancer.

6 Q. But it's not consistent with the
7 literature you looked at from Bove and the ATSDR,
8 true?

9 A. The Bove and ATS- -- ATSDR said that there
10 was a modest association, but as I testified earlier,
11 it's sort of also the strength of the association that
12 I looked like -- at to determine whether it was
13 causative in this particular case.

14 Q. How do you define the strength of the
15 association in terms of being causative or not?

16 A. So it is the strength of the association
17 in the context of a -- a cancer that occurs in these
18 patients even without exposure and in the context of a
19 risk factor that has a hazard ratio of only on the
20 order of 1.3 to 1.4.

21 Q. I see. So let me ask two different
22 questions.

23 Are you saying that a risk hazard ratio of
24 1.3 to 1.4 is not something that you find to be

1 significant enough to have a causal relationship?

2 A. It has a cause -- I find that it's
3 significant enough to have a causal relationship in
4 a -- in a population. It's very difficult to
5 definitively associate that with cause in an
6 individual patient.

7 Q. And you never attempted to do that with
8 those studies, true?

9 A. I never attempted to directly link the
10 degree of exposure that the -- that Mr. Downs had with
11 some of those studies.

12 Q. Right. Do you have an understanding as to
13 whether or not those studies provide metrics to be
14 able to do that?

15 MR. BU: Objection; form.

16 You can answer.

17 BY THE WITNESS:

18 A. I don't know.

19 BY MR. MANDELL:

20 Q. Okay. So you -- so -- strike that.

21 So as to Mr. Downs, you rejected the
22 possibility that his exposure to Camp Lejeune water
23 was contributory or causal of his kidney cancer, and
24 you did that despite not even attempting to understand

1 where Mr. Downs' exposure would fall in the studies
2 that analyzed other members or other people that were
3 exposed at Camp Lejeune, true?

4 A. Ask the question again.

5 Q. Sure. I'm going to break it up into small
6 parts.

7 You rejected the -- you rejected the fact
8 that Mr. Downs' exposure to the water at Camp Lejeune
9 could be causally related to his kidney cancer, true?

10 A. What I stated is that it's not likely to
11 be the cause.

12 Q. So you think that it's -- that there's a
13 degree of chance that it was related, but you just
14 don't believe it was of a high enough magnitude?

15 A. I would say that that's fair.

16 Q. Okay. How would you describe the degree
17 of likelihood that his exposure to the water at
18 Camp Lejeune was causally related to his kidney
19 cancer?

20 A. I would say it was similar to the
21 possibility that his smoking was related to his
22 cancer. Both of these exposures were brief of
23 relatively low doses. Both of them are possibly
24 related but unlikely.

1 Q. Where do you get that his exposures were
2 low doses?

3 A. The low dose exposure, I'm -- as we said
4 before, I'm dependent on the -- both on the assessment
5 of the toxicologist who did formal dose assessments
6 and the articles in which there was strong association
7 being -- that most of those articles were from
8 patients who had occupational exposures.

9 Q. Right. And so this is my next -- the next
10 question that I was going to ask, which is, you made
11 those conclusions and opinions without knowing where
12 David Downs fits within the actual cohort of people
13 that were at Camp Lejeune and whether his exposure was
14 low, as you say, or high, true?

15 A. I did not independently assess his
16 exposure, and I'm dependent on how the exposure
17 experts interpreted that.

18 Q. Okay. And so, for example, if there was
19 exposures that Mr. Downs had to one or all of the
20 chemicals that were in the high exposure categories,
21 as the literature from Camp Lejeune and Dr. Bove would
22 put that, you wouldn't have known that, true?

23 A. I would not know that independently.

24 Q. Do you think that that would be a fact

1 that might go to the strength of association between
2 the Camp Lejeune water exposure and Mr. Downs' kidney
3 cancer?

4 A. It might. However, since I'm not a expert
5 on exposure, environmental exposures, I'm dependent on
6 the analyses of others to tell me that.

7 Q. Right. You weren't given any metrics of
8 exposure that would have allowed you to compare it to
9 the Camp Lejeune epidemiology, true?

10 A. I was given the analysis of the toxicology
11 experts who assessed that.

12 Q. Are you -- do you believe that the
13 toxicology experts that you're referring to analyzed
14 Mr. Downs' exposure as it compared to the Camp Lejeune
15 epidemiology, specifically the Bove studies?

16 A. I have no idea.

17 Q. So, as part of your opinions in this
18 case -- strike that. I'll ask the question again. Do
19 you think -- a different -- the previous question.

20 Do you think that that would have been
21 relevant for you in terms of knowing the strength of
22 association, whether or not either you or the
23 toxicology experts, as you talk about them, did that
24 analysis and found that fact?

1 MR. BU: Objection; form.

2 You can answer.

3 BY MR. MANDELL:

4 Q. Did you understand the question?

5 A. I -- I understand the question, but, you
6 know, once again, I -- you know, I don't review all of
7 the details of the toxicologists' report. What I am
8 dependent on to a large degree is their assessment of
9 the degree of exposure and its relationship to kidney
10 cancer causation.

11 Q. I guess my question is a little different,
12 which is, you've read the Camp Lejeune studies, true?

13 A. Correct. Correct.

14 Q. You know they exist, fair?

15 A. Correct.

16 Q. And my question to you is, as you were
17 going through your analysis to say, wait a second,
18 should we include Camp Lejeune water exposure on this
19 differential or not, would you have thought that it
20 might be important to know where Mr. Downs would fit
21 on the exposure metrics that are given in the studies
22 that analyze Camp Lejeune exposure?

23 A. So I have no reason to believe that
24 Mr. Downs' exposure was any greater than the average

1 Camp Lejeune resident or significantly less, and the
2 degree of exposure, as per the toxicology experts, was
3 such that it -- that I don't think it had a
4 significant contributory cause.

5 Q. Okay. And so as I said, you've -- strike
6 that.

7 As I asked you just a minute ago, if
8 Mr. Downs' exposure for one or all of the chemicals
9 was in the highest category of exposures under the
10 Camp Lejeune epidemiology, is that a fact that you
11 might have wanted to know?

12 A. If he was in one of the highest, that
13 would have been relevant.

14 Q. Okay. Do you know the precise analysis of
15 what Dr. Goodman did in terms of trying to figure out
16 whether one or all of these chemicals caused kidney
17 cancer?

18 A. I know that she reviewed all of the
19 relevant literature and the methodology that went into
20 each of the studies. I know there was an extensive
21 number of studies that she looked at in terms of the,
22 you know, primary data that was reviewed, but beyond
23 that, I'm not sure I can give you the details.

24 Q. Okay. Let me see if I can -- see if I

1 understand what you're saying.

2 You know that she looked at some studies,
3 right?

4 A. Correct.

5 Q. And you know that she looked at the
6 methodology of some of the studies, right?

7 A. Correct.

8 Q. But you don't know what the specifics of
9 any of those studies are, true?

10 A. I did not review all of the studies that
11 she looked at, that is correct.

12 Q. And you don't know the methodology with
13 which she used to analyze the methodology in any of
14 those studies, true?

15 A. I understand sort of the basic
16 epidemiologic principles that she utilized, but I
17 don't know the details of her analysis.

18 Q. Okay. And do you know any of the
19 specifics in terms of what studies she found to be
20 reliable, what studies she found not to be reliable?

21 A. I -- I would have to go back to her report
22 to see that.

23 Q. Did you ever do any analysis of that?

24 A. I reviewed her report, I looked at -- I

1 know that she considered some studies to be more
2 reliable than others. I can't quote all of the
3 studies exactly.

4 Q. Is it your testimony that you read each of
5 the Dr. Goodman reports -- or strike that.

6 You read Dr. Goodman's report relating to
7 kidney cancer?

8 A. Correct.

9 Q. Okay. Did you read any of her other
10 reports?

11 A. I read her report on bladder cancer.

12 Q. Okay. Do you have any understanding of
13 the precise analysis that was done by Dr. LaKind in
14 terms of what exposures each of these plaintiffs had
15 and how they either did or did not meet sufficient
16 levels to be causally related with kidney cancer?

17 A. I -- I have some very general
18 understanding, but very little specific understanding
19 of their analysis.

20 Q. Okay. I think we went over that before,
21 right?

22 A. Correct.

23 Q. Generally speaking, you just looked at the
24 summary section?

1 A. For the most part for the exposures, I
2 focused on the summary section, that is correct.

3 Q. All right. Can you -- okay.

4 And would that be true for any other
5 experts that did anything with exposure?

6 A. Correct.

7 Q. If you -- for Mr. Downs, if you could turn
8 to Page 15, in your report for Mr. Downs, you do an
9 analysis -- actually, on Page 12 and a little bit on
10 Page 15, you do an analysis of his smoking history,
11 true?

12 A. Yes.

13 Q. So if you would put smoking history and
14 Camp Lejeune water exposure history in the same
15 general category of risk, why -- why would you not
16 have done any analysis of his Camp Lejeune water
17 exposure?

18 A. Very simply because my analysis of his
19 Camp Lejeune water exposure was dependent on the
20 toxicologist's estimate of ex- -- of his ex- -- of his
21 exposure, similarly to the fact that his -- his,
22 Mr. Downs', testimony and medical record was what I
23 depended on for his smoking exposure.

24 Q. So do -- do you believe that you are more

1 qualified to render an opinion or judgment about
2 smoking history than you are about Camp Lejeune water
3 exposure history?

4 A. I am probably better at assessing smoking
5 exposure because I do that on a daily basis with
6 patients. I certainly don't do analyses of toxin
7 exposures in the environment.

8 Q. Could you pull up Mr. Fancher's report,
9 please, it's Exhibit 2, and tell me -- tell me
10 whenever you are there.

11 A. Page what?

12 Q. I just said Exhibit 2 --

13 A. Okay.

14 Q. -- but do you have it -- you have it in
15 front of you?

16 A. Yeah.

17 Q. So I'm going to go to the same section of
18 your report on Page 11 and 12.

19 A. Okay.

20 Q. All right. So it -- your differential
21 diagnosis section starts at the bottom of Page 11, it
22 goes on to Page 12, true?

23 A. Correct.

24 Q. So would you agree that for Mr. Fancher,

1 you will not be giving any opinions that any potential
2 risk factors of renal cell carcinoma apply in terms of
3 being causally related to Mr. Fancher's kidney cancer?

4 A. That is correct.

5 Q. You -- you will not be testifying that
6 obesity is in any way causally related to his kidney
7 cancer, true?

8 A. True.

9 Q. Smoking, the same?

10 A. Correct.

11 Q. Hypertension, the same?

12 A. Yes.

13 Q. Chronic kidney disease, the same?

14 A. Yes.

15 Q. Diabetes, the same?

16 A. Yes.

17 Q. Exposure -- occupational exposure to
18 cadmium, asbestos, and petroleum byproducts?

19 A. Yes.

20 Q. True?

21 A. Yes.

22 Q. Heavy use of non-steroidal
23 anti-inflammatory drugs, acetaminophen, and
24 phenacetin?

1 A. Phenacetin.

2 Q. True?

3 A. True.

4 Q. What is it?

5 A. Phenacetin.

6 Q. Phenacetin, true?

7 A. Correct.

8 Q. Genetic predisposition syndromes --

9 A. Correct.

10 Q. -- not causally related, true?

11 A. Correct.

12 Q. Chronic inflam- -- infection and
13 inflammation, not -- not causally related, true?

14 A. True.

15 Q. All right. And --

16 MR. BU: Dr. Stadler, just make sure you wait
17 until after Mr. Mandell is finished with his question
18 before you respond.

19 MR. MANDELL: Thanks.

20 BY MR. MANDELL:

21 Q. And as to the decision for you to not have
22 the Camp Lejeune water as something that you believe
23 would be potentially causally related to Mr. Fancher's
24 kidney cancer, you excluded that from the differential

1 because of your reliance on other experts?

2 A. To a large degree, yes.

3 Q. And is it the same as with Mr. Downs, that
4 you reviewed some of the epidemiology but you're more
5 so relying on the experts?

6 A. Correct.

7 Q. And I should have asked you this for
8 Mr. Downs, but can -- did you review any epidemiology
9 outside of the Bove studies and ATSDR studies relating
10 to Camp Lejeune?

11 A. I don't recall having read any other
12 specific studies.

13 Q. All right. So the only studies you chose
14 to read for your opinions in this case were those
15 Camp Lejeune epidemiology studies, true?

16 A. That is correct, and that's following
17 review of, as I said, the general literature on kidney
18 cancer causation as summarized in textbooks.

19 Q. So what you did was, you looked -- you
20 have a knowledge base from being in this field for a
21 period of time, true?

22 A. Correct.

23 Q. You looked at the general causation expert
24 reports, true?

1 A. Correct.

2 Q. And you said to yourself, The epidemiology
3 that I need to review are the five Camp Lejeune
4 studies, ATSDR studies, true?

5 A. Correct.

6 Q. Why were those of that significance to you
7 to read?

8 A. Because they specifically referred to the
9 cases that are the subject here today.

10 Q. Okay. And I assume the relevance of that
11 is because, generally speaking, when you're trying to
12 look for exposures, you want to look at the exact
13 population, if you can, because it provides the best
14 data, true?

15 A. That is fair.

16 Q. Okay. And I assume the same is true for
17 Mr. Fancher as it is for Mr. Downs, which is that you,
18 yourself, did not conduct any analysis as to whether
19 any exposures Mr. Downs had, where those fit into the
20 Camp Lejeune ATSDR epidemiology that you read, true?

21 A. We're referring to Mr. Fancher here?

22 Q. Right.

23 A. And the answer is true.

24 Q. Oh, did I say Mr. Downs?

1 A. You said Mr. Downs.

2 Q. Oh, I apologize for that. Thank you for
3 correcting me. You knew what I was saying?

4 A. I knew what you were saying, that's why
5 I --

6 Q. So additionally, you are not aware of
7 whether any of the toxicologists that you're
8 talking -- that you've mentioned so far that did any
9 type of exposure analysis, whether or not they took it
10 upon themselves to determine whether or not
11 Mr. Fancher fit into any of -- where Mr. Fancher fit
12 into any of the Camp Lejeune epidemiology, true?

13 A. That is correct.

14 Q. Would you also agree that to the extent --
15 strike that.

16 Would it be important, just as it was with
17 Mr. Downs, to know if Mr. Fancher was in exposure
18 levels of the population as described in the Bove
19 studies that were associated with increased hazard
20 ratios?

21 A. Once again, I'm dependent on the
22 toxicology experts to take a look at that to the best
23 of, you know, their ability, and I was dependent on
24 their summaries.

1 Q. Right. But you read their summaries but
2 don't know if they applied any exposure that
3 Mr. Fancher had to the exposure metrics in the
4 Camp Lejeune epidemiology, true?

5 A. I don't know that, correct.

6 Q. Right. And that's not in your reports
7 anywhere?

8 A. That's not in my reports.

9 Q. So my question, I guess, again would be,
10 to the extent, and I'm asking you a hypothetical here,
11 to the extent that it's true that Mr. Fancher fell
12 into exposure categories in the Camp Lejeune
13 literature that were associated with increased hazard
14 ratios, is that something that you would have wanted
15 to know, or a fact that would be relevant to your
16 opinion?

17 A. So you asked whether his exposure was in
18 essence similar to the individuals in the Camp Lejeune
19 Bove studies. And I -- based on the toxicologists,
20 based on the epidemiology reports, I have no reason to
21 believe that he wasn't in that category.

22 Q. When you say "that category," are you
23 talking about a category that was not associated --
24 associated with an increased hazard ratio?

1 A. I -- I assumed he was in a category that's
2 associated with an increased hazard ratio. I don't
3 know to what degree though.

4 Q. So how do you know if it was something
5 that was to a degree that would have been causally
6 related to kidney cancer?

7 A. Once again, my testimony is highly
8 dependent on the strength of the association, and
9 similar to where I discount any smoking association
10 in -- in other individuals than -- than Mr. Fancher, I
11 discount the exposure -- the toxin exposure as
12 causative.

13 Q. But with -- but with the smoking history,
14 you know from your years of experience what the
15 strength of associations are for different smoking
16 patterns, true?

17 A. Correct.

18 Q. You don't know what they are for
19 Camp Lejeune water exposure, true?

20 A. For Camp Lejeune water exposure, what we
21 have is a risk factor of about 1.3, which we've talked
22 about before.

23 Q. Right.

24 A. A hazard ratio.

1 Q. Right. But as we talked about before,
2 that can be associated with increased risk of a causal
3 level depending on duration and dose, true?

4 A. So it can be associated with an increased
5 risk, but we were talking about whether that increased
6 risk rises to the level of being a likely cause in
7 this individual patient.

8 Q. And my question to you is, while you might
9 have that information as to smoking, you don't have
10 that as to Camp Lejeune water exposure because you
11 don't do that in your day-to-day practice, true?

12 A. I -- I did not do that independently.

13 Q. Right. So what you did was, you looked at
14 some of the other experts' reports, right?

15 A. Correct.

16 Q. And you read the epidemiology you thought
17 was the most relevant, true?

18 A. Correct.

19 Q. And -- but what you didn't do was attempt
20 to see where the plaintiffs fit into the epidemiology
21 that you thought that was the most relevant, true?

22 A. That is fair.

23 Q. Okay. And you don't know, and it's not in
24 any of your reports, what any of the other experts

1 said about that, true?

2 A. I know that the plaintiff experts had a
3 different interpretation on the exposure and the
4 degree of exposure.

5 Q. But my question is, you don't know if any
6 of the exposure experts from the Department of
7 Justice, any of the toxicologists that you were
8 talking about, whether they did any analysis of
9 whether or not Mr. Fancher, or any of the other four
10 kidney cancer plaintiffs, where they fit into those
11 Camp Lejeune studies, true?

12 A. I don't know whether the exposure experts
13 considered them to be typical or atypical of the
14 patients that were in the -- the subjects that were in
15 the Camp Lejeune Bove study. I made a presumption
16 that they considered it to be similar.

17 Q. But wouldn't that be a fact that would go
18 directly to strength of association in terms of
19 whether they were typical or atypical?

20 A. The strength of the association really has
21 to do with a lot with the hazard ratio of 1.3 and the
22 confidence interval on that, and that confidence
23 interval is relatively wide. There's no reason for me
24 to believe that any of the exposure analysis fell

1 outside of that particular hazard ratio/confidence
2 interval.

3 Q. But that's speculation on your part
4 because you don't know the answer to it, true?

5 A. I don't know what kind of analyses they
6 did.

7 Q. Right. And, so, therefore, that's
8 speculation on your part, true?

9 A. I -- I go back to what I said, is that I'm
10 dependent on the toxicologists' exposure analysis and
11 how they interpreted that exposure analysis.

12 Q. So my question is, it would be speculation
13 on your part, though, in terms of whether or not
14 Mr. Fancher -- it's a -- Mr. Fancher's exposure was
15 typical or atypical, true? Because you don't know
16 that from reading their reports and you didn't do any
17 independent analysis?

18 A. I did not do any independent analysis, and
19 I don't know whether that exposure is typical or
20 atypical.

21 Q. Right. If you look at Mr. Fancher's
22 report, on Page 14.

23 A. Yes.

24 Q. The last paragraph on the -- well, the

1 first paragraph -- the first full paragraph on the top
2 of the page says, "Finally, plaintiff experts
3 overemphasize the role of any toxin exposure in
4 Camp Lejeune water" -- excuse me, let me restart that.

5 "Finally, plaintiff experts overemphasize
6 the role any toxin exposure in Camp Lejeune water may
7 have played, despite incomplete information on true
8 exposure, differences in opinions from expert --
9 from exposure experts regarding level of exposure, and
10 very small levels of increased risk, all the while
11 minimizing the role of other risk factors such as
12 low-level smoking or mild obesity may play."

13 I read that correctly?

14 A. Correct.

15 Q. Isn't it true that you don't know that
16 information too, as we just discussed?

17 A. That is correct.

18 Q. So you're -- and you're assuming they
19 don't know it, right?

20 A. I -- they did not discuss that in -- they
21 did not discuss these differences of opinions in their
22 reports.

23 Q. Is it your testimony that the plaintiffs'
24 experts do not discuss opinions as to levels of

1 exposure in the water at Camp Lejeune and what levels
2 are associated with what risks?

3 A. I would have to read the reports to --
4 to --

5 Q. And if that is true, then your statement
6 here wouldn't be correct, fair?

7 A. My statement here is that there is
8 incomplete information and differences in opinion from
9 exposure ex- -- experts regarding level of exposure,
10 that's what I'm saying.

11 Q. So why is it that you chose to believe the
12 defendant's experts on -- on exposure but not the
13 plaintiffs' experts on disclosure?

14 A. I had -- I had -- when I wrote my reports,
15 I had the defendant exposure reports in hand. I
16 didn't have these other reports until I got the -- the
17 expert reports from the plaintiff experts, and that's
18 where some of this material was.

19 Q. So is what you're saying that the reason
20 why you chose to use the defendant's experts' reports
21 on exposure levels, because those were the ones that
22 you had?

23 A. I had those originally, but I -- I also --
24 what I state here is that there's differences of

1 opinion, and I can't judge which, you know, opinion in
2 terms of exposure is correct.

3 Q. So let me see if I understand.

4 You know that there are defendant's
5 experts on exposure levels, true?

6 A. Correct.

7 Q. You know that there are plaintiffs'
8 levels -- experts on exposure levels, true?

9 A. Correct.

10 Q. You believe there are differences of
11 opinions between the two?

12 A. I believe there are some differences in
13 opinion as to the relevance of that exposure, correct.

14 Q. And you chose to use the defendant's
15 experts, even though you don't have the information to
16 be able to discern who is right and who is wrong,
17 true?

18 A. Not only is it the degree of exposures,
19 but it's also the strength of -- you know, the
20 strength of the association.

21 Q. But you don't have the expertise to make
22 those judgment calls, according to you, true?

23 A. I don't have the expertise to assess the
24 degree of exposure, and what I know, not only from the

1 exposure experts and the epidemiology, is the strength
2 of the association and that the -- that dose and
3 exposure make a difference.

4 Q. So let me try to break this down for you.
5 I need a sheet of paper to do it.

6 You do not have the expertise to discern
7 whether -- who is correct in terms of the levels of
8 exposure that are consistent with being causally
9 related to kidney cancer as it pertains to the
10 Camp Lejeune water, true?

11 A. That is correct.

12 Q. Okay. Despite that, you chose to use the
13 defendant's experts' levels, true?

14 A. That was one of the things that I
15 utilized, correct.

16 Q. Right. Then you said the second thing you
17 utilized was the strength of association, true?

18 A. Correct.

19 Q. But you've said already today that the
20 strength of associations you've seen in the
21 Camp Lejeune epidemiology, and other epidemiology, are
22 such that it could be causal depending on the dose and
23 the duration, true?

24 A. Could be, correct.

1 Q. Okay. And then you said, you looked at
2 the dose and duration as the third thing, true?

3 A. Correct.

4 Q. But you don't know the dose and you don't
5 know the duration for any of these plaintiffs, fair?

6 A. I do not know the exact dose and -- and
7 duration aside from what others have testified.

8 Q. All right. So if you don't have the
9 knowledge to discern the levels, and the strength of
10 association is one that could be causally related, you
11 just need to know the dose and the duration, and you
12 don't know the dose and duration, why did you choose
13 the defendant's experts over the plaintiffs?

14 A. I think that it is the totality of the
15 evidence that I am looking at and looking at whether a
16 exposure is likely the cause in an individual patient.
17 And the other parts of the testimony that I gave is
18 that the majority of patients with kidney cancer have
19 an unknown cause regardless of their prior exposure.

20 Q. And I'm going to ask you about the rest of
21 the plaintiffs in a minute, but for this question, I'm
22 not asking you about the differentials that you did.
23 I'm asking -- or I'm not asking about the specifics of
24 that outside of this one point, which is you've chosen

1 as part of your differential to accept the defendant's
2 experts' positions on the exposure levels necessary
3 and the exposure levels for each of the individual
4 plaintiffs, true?

5 A. I've accepted their analysis of exposure.

6 Q. Right. And you, despite not having enough
7 knowledge from your background or facts about the dose
8 and duration of exposure in this case, despite not
9 having that, which would make it not possible for you
10 to discern who's right and who's wrong, you chose to
11 use the defendant's experts' opinions, true?

12 A. I've used the defendant's experts'
13 opinions on dose and exposure, that is correct.

14 Q. Why?

15 A. Because I am not the expert.

16 Q. But you know that there are experts on
17 behalf of both the plaintiff and the defendant that
18 have differing opinions, true?

19 A. Correct.

20 Q. So why use -- why unilaterally choose the
21 defendant's experts -- strike that.

22 Do you have an understanding that the
23 plaintiffs have experts in exposure, toxicology, and
24 epidemiology?

1 A. Yes.

2 Q. Do you have an understanding that those
3 experts are saying that the Camp Lejeune water did --
4 that that exposure to Camp Lejeune water was at
5 sufficient levels to cause kidney cancer?

6 A. Yes.

7 Q. And you have an understanding that there
8 are experts on behalf of the plaintiff that are saying
9 that each one of these five plaintiffs did have
10 exposures at levels that were sufficient to cause
11 their kidney cancer?

12 A. Yes.

13 Q. And you rejected those, true?

14 A. I didn't reject those opinions. I was
15 asked in -- that what is it likely that this
16 individual's cancer was caused by this exposure, even
17 if that exposure was theoretically sufficient.

18 Q. But you don't -- you -- you test- --
19 correct me if I'm wrong, you testified earlier that
20 you, as you went down your differential, when you got
21 to Camp Lejeune water, you excluded that solely on the
22 basis of other experts, right?

23 A. So in my differential diagnosis, I looked
24 at what are known as occupational exposures that would

1 be fit into these environmental exposures, and both
2 the -- both the defendant ex- -- exposure experts as
3 well as the literature suggest that it was much higher
4 levels of exposure that are used -- that one can say
5 are causally associated in an individual patient.

6 Q. Right. And the plaintiffs' experts
7 disagree with that, right?

8 A. The plaintiffs' experts do disagree with
9 that.

10 Q. Right. You don't have the expertise to
11 make a determination of who is right and who is wrong
12 on that, true?

13 A. I don't have an ex- -- I don't have
14 independent ways of assessing right or wrong between
15 those experts, but I also know that most of the other
16 epidemiologic studies looking at exposure and kidney
17 cancer were in pa- -- in individuals who had high
18 occupational levels of exposure.

19 Q. Well, the only studies you're aware of
20 that you actually read were the Camp Lejeune studies,
21 true?

22 A. The specific studies I read were from the
23 Camp Lejeune, but that doesn't -- we referred to the
24 MABEL study before that I referred to that I looked at

1 as well. And so I think that there are other studies
2 looking at occupational exposures.

3 Q. But the only ones you read were related to
4 Camp Lejeune, true?

5 A. The ones that I read in detail were the
6 one -- were the epidemiologic studies from
7 Camp Lejeune.

8 Q. Right. So my question still is the same,
9 which is, if you don't have the expertise to determine
10 whether the defendant's experts on this issue are
11 correct or the plaintiffs' experts on this issue are
12 correct, why did you just choose the defendant's
13 experts?

14 MR. BU: Objection to form.

15 You can answer.

16 BY THE WITNESS:

17 A. So the defendant's experts -- I will say
18 again, the defendant's experts' assessment of exposure
19 was one of several things I utilized to assess
20 causation.

21 BY MR. MANDELL:

22 Q. No, and we went through the --

23 A. Right.

24 Q. -- three different things you did,

1 right -- or excuse me. We went through the three
2 different categories of things that you believe you
3 used, true?

4 A. Correct.

5 Q. I'm happy to go through them again, but
6 the conclusion of that was, you didn't have enough
7 expertise to determine the levels or the facts in
8 terms of dose and duration.

9 So if that's true, why would you have
10 chosen the defendant's experts' positions over the
11 plaintiffs' experts' positions?

12 MR. BU: Objection; form.

13 You can answer.

14 BY THE WITNESS:

15 A. You're -- you're making the presumption
16 that my -- that the vast majority of the decision is
17 based on the exposure, but it's also exposure as
18 well -- as well as the strength of the evidence. And
19 the strength of the evidence has to do with the
20 epidemiologic studies that looked at a hazard ratio of
21 1.3 to 1.4.

22 BY MR. MANDELL:

23 Q. Right. And we've gone through this at
24 length, but you've said that that exposure, that

1 strength of association can be causally associated
2 with kidney cancer. So if that's true, you said you
3 would need to know the dose and the exposure. You've
4 said you don't know the dose and the exposure.

5 So the question is, you have two expert
6 sets. You've got the defendants saying, Well, I don't
7 think the levels are enough. You've got the plaintiff
8 experts saying, I think these levels are enough. Why
9 choose the defendant's experts over the plaintiffs'
10 experts?

11 MR. BU: Objection; form.

12 You can answer.

13 BY THE WITNESS:

14 A. I think we've -- we've discussed this. I
15 don't know if there's anything more that I can say.

16 BY MR. MANDELL:

17 Q. Okay. And if -- if this case goes to
18 trial, there will be nothing else more that you would
19 have to say on that issue at trial, true?

20 A. That is correct.

21 Q. You say on Page 12 of the Fancher
22 report -- at the very bottom, it says, "Additionally,
23 Mr. Fancher has not suffered any significant long-term
24 health consequences of his renal cancer," true?

1 A. Correct.

2 Q. Do -- do you have an understanding as to
3 this flank bulge that Mr. Fancher has?

4 A. Yes, I do.

5 Q. What's your understanding of that?

6 A. My understanding is that this is a
7 surgical complication known as a flank hernia or
8 surgical hernia.

9 Q. Do -- do you have an understanding as to
10 whether or not that causes him pain?

11 A. My understanding, if I recollect correctly
12 from his deposition, that does cause him discomfort
13 and pain.

14 Q. And I was going -- I was going to ask
15 about discomfort.

16 So when you say that he hasn't suffered
17 any long-term health consequences, would you agree
18 that that's a long-term health consequence that is of
19 significance to Mr. Fancher?

20 A. I -- I've seen lots of patients with these
21 kind of flank hernias. While it is a consequence, it
22 is typically something that can be managed with
23 binders and girdles.

24 Q. Do you have an understanding as to whether

1 those binders or girdles are a pleasant experience for
2 the patients?

3 A. I -- they're not pleasant.

4 Q. Right. So how do you -- so did you
5 consider that when you wrote that there were no
6 significant long-term implications of his kidney
7 cancer?

8 A. It is a bit of a interpretation of medical
9 significance. Considering in the context of other
10 patients like this that I've seen, I consider it an
11 issue but not a significant medical issue.

12 Q. All right. And -- strike that.

13 Let me ask you this, most respectfully, if
14 that was happening to you, would you consider that to
15 be of significance?

16 A. I would consider it to be of significance,
17 but I don't consider it a significant medical
18 complication.

19 Q. Mr. Howard's report, Exhibit 3. I'm going
20 to go to the same section, Page 12.

21 Would you agree with me that there are no
22 risk factors for Mr. Howard that you would assign any
23 causal association to in your risk factor list that
24 you have here with regard to renal cell carcinoma?

1 A. That is correct.

2 Q. All right. So if the case goes to trial,
3 you will not be giving any opinions that there is any
4 obesity that played any part in Mr. Howard's renal
5 cell cancer, true?

6 A. True.

7 Q. Smoking, true?

8 A. True.

9 Q. Hypertension, true?

10 A. True.

11 Q. Chronic kidney disease, true?

12 A. True.

13 Q. Diabetes?

14 A. True.

15 Q. True. Occupational exposure to cadmium,
16 asbestos, petroleum byproducts, true?

17 A. True.

18 Q. Heavy use of non-steroidal
19 anti-inflammatory drugs, acetaminophen and phenacetin?

20 A. True.

21 Q. By the end of this, I'll get it.

22 Genetic predisposition syndromes, true?

23 A. True.

24 Q. Chronic infection and inflammation, true?

1 A. True.

2 Q. The only thing that you have for
3 Mr. Howard in terms of a likely cause is an idiopathic
4 diagnosis because you didn't find anything else, true?

5 A. That is correct.

6 Q. And would the same discussion that we had
7 with regard to Mr. Downs and Mr. Fancher apply to
8 Mr. Howard, that the reasoning for why you didn't have
9 Camp Lejeune water on his differential is because of
10 your reliance on other experts, true?

11 A. Correct.

12 Q. And that's despite the fact -- strike
13 that.

14 For Mr. Howard, you did not do anything to
15 try to figure out where his exposures fell in terms of
16 the metrics used by the only epidemiology that you
17 looked at, the Camp Lejeune studies, true?

18 A. Correct.

19 Q. And you don't know from any of the other
20 experts in the case, the toxicologists, or anybody
21 else for that matter, where Mr. Howard would have
22 fallen in those exposure categories, true?

23 A. Correct.

24 Q. And if Mr. Howard's exposure was in levels

1 that were -- categories that were associated with
2 increased hazard ratios, that's something you would
3 have wanted to know, true?

4 A. Once again, I, as -- as was stated
5 previously, I had no reason to believe that his
6 exposure levels were outside of the range that was
7 reported in the -- in the epidemiology studies.

8 Q. Right. But if he -- if he did have
9 exposure levels associated with increased hazard
10 ratios, that's something you would have wanted to know
11 about, true?

12 A. The -- we've discussed this before, that
13 exposure levels were likely similar to what's been
14 reported in the -- in the epidemiology studies.

15 Q. So you would have wanted to know what
16 those were because those were the epidemiology
17 literature that applied to the exact population at
18 issue, true?

19 MR. BU: Objection; form.

20 You can answer.

21 BY THE WITNESS:

22 A. I think we've discussed these. We've
23 asked these questions before.

24 BY MR. MANDELL:

1 Q. So yes?

2 A. Fair enough.

3 Q. Okay. "Fair enough" meaning yes?

4 A. Yes.

5 Q. Okay. I should have asked this before,
6 but let me just do a kind of broader question here.

7 For any of the three individuals that
8 we've talked about so far, Mr. Downs, Mr. Fancher,
9 Mr. Howard, there's no risk factors that you're aware
10 of that would be in any way causally related, outside
11 of the list that you have in your report, true?

12 A. That's correct.

13 Q. Could you pull out your report for
14 Mr. Mousser, please.

15 On Page 13, right above the -- the section
16 that says, "Responses to Plaintiffs' Experts"?

17 A. Correct.

18 Q. There is a paragraph, and it says, "As
19 such, Mr. Mousser's UTUC" -- upper tract urothelial
20 carcinoma, correct?

21 A. Correct.

22 Q. -- "is unlikely to be related to
23 Camp Lejeune exposures and is far more likely than not
24 to be -- far more likely than not related to prior

1 smoking and possibly an undiagnosed chronic
2 inflammatory condition of the right kidney," true?

3 A. Correct.

4 Q. You cannot say to any degree of certainty
5 whether any chronic inflammatory condition was
6 causally related to his kidney cancer, true?

7 A. I -- I can't be certain, because some of
8 that is based on -- on simply the pathologic analysis
9 of his normal kidney when he had the nephrectomy, and
10 some of the -- the history of prior hematuria, details
11 of which were not necessarily always clear in the
12 medical record.

13 Q. Right. There wasn't enough information,
14 true?

15 A. That would be fair.

16 Q. So -- let me ask it a different way.

17 Is it fair to say that there was not
18 enough information for you to make any opinion to any
19 reasonable degree of certainty that an undiagnosed
20 chronic inflammatory condition was related to
21 Mr. Mousser's upper tract urothelial carcinoma, true?

22 A. So -- ask the question again. Sorry.

23 Q. Sure. You, as you sit here now, do not
24 have enough information to be able to say to a

1 reasonable degree of medical certainty whether it is
2 as likely as not or more likely than not that
3 Mr. Mousser's undiagnosed chronic inflammatory
4 condition was causally related to his cancer, true?

5 A. That is true.

6 Q. Okay. So to the extent this case goes to
7 trial, you will not be giving any opinions that there
8 was any causal relationship between this undiagnosed
9 chronic inflammatory condition of the right kidney, as
10 you understand it, and his cancer, fair?

11 A. As I state, it's possibly related. If we
12 say is it more likely than not, that would be -- I
13 could testify to that.

14 Q. Right. You couldn't say that to any
15 degree of certainty, true?

16 A. I couldn't say that to a degree of
17 certainty.

18 Q. Right. Okay. And is -- is one of the
19 reasons why you say that because there wasn't this
20 microscopy or immunofluorescence and electron
21 microscopy done at the surgery time?

22 A. In -- in part. So what I would say is
23 that the pathologic analysis on the normal kidney that
24 was done in conjunction with the medical history that

1 was available suggests that there may have been a -- a
2 preexisting inflammatory condition. That's all I can
3 say.

4 Q. But you just -- but is the reason why you
5 can't say to any degree of certainty because they
6 didn't do some of this additional testing?

7 A. In part because they didn't do some of the
8 additional testing.

9 Q. Got it.

10 And you, as you sit here today, do not
11 know the extent of hematuria that Mr. Mousser had
12 between 1984 and 2013, true?

13 A. That is correct.

14 Q. And from 2013 until his diagnosis in 2020?

15 A. That is correct.

16 Q. You do say that you think that Mr. --
17 strike that.

18 How do you describe the relationship
19 between any smoking that Mr. Mousser had and his
20 cancer?

21 A. Let me re- -- let me review here again
22 exactly what I said.

23 So unlike renal cancer, the strength of
24 association between smoking and upper tract urothelial

1 cancer is much stronger. I have to look again at
2 exactly the hazard ratio, but more on the order of 4
3 or 5 rather than 1.4. And the population attributable
4 risk, rather than being what we talked about,
5 18 percent, is more like 50 percent.

6 And then thirdly, Mr. Mousser was a
7 smoker, especially in the Marines, and so, therefore,
8 I conclude that this is at least possibly related to
9 his cancer.

10 Q. So you just used the word "possibly
11 related." Is it fair to say that you can't say to any
12 degree of scientific or medical certainty that his
13 smoking is related to his cancer?

14 A. It's difficult to be absolutely certain
15 about anything in this business, but I would say that
16 his smoking was much more likely related to his cancer
17 than any exposure to Camp Lejeune water.

18 Q. Well, now you're comparing the smoking to
19 the Camp Lejeune water. That's different than whether
20 it's the most likely cause of his cancer, true?

21 A. That is fair.

22 Q. So is what you're saying that you think
23 that Mr. Mousser's smoking history is more likely the
24 cause than Camp Lejeune water, but that you can't say

1 that his smoking history is to any degree of certainty
2 the actual cause of his kid- -- of his cancer?

3 A. I --

4 Q. Do you understand what I'm saying?

5 A. I understand what you're saying. It is --
6 smoking is certainly a lot more likely than
7 Camp Lejeune water. I think it's more likely than not
8 that smoking is causative of his cancer. If you're
9 asking me, can I be certain that it's a cause of his
10 cancer, I can't be certain.

11 Q. Well, why do you say "it's more likely"?
12 You just a second ago you used the word "possibly."

13 A. We may be splitting words in terms of
14 "possible" because there are legal definitions in
15 regards to medical definitions. I will stick with my
16 report that says "more likely than not."

17 Q. Do you -- can you say to a 50 percent or
18 more likelihood, if you're weighing these options, if
19 you're weighing smoking versus idiopathic versus
20 Camp Lejeune water versus this whatever else, can --
21 can you say that the smoking was 50 percent or more
22 related to the cancer; not is it more than the
23 Camp Lejeune water, but is it 50 percent or more a
24 cause of his cancer?

1 A. I would say yes.

2 Q. Okay. What's the basis for that?

3 A. The basis of that is the degree of
4 smoking, which, you know, was what I would call rather
5 significant, the fact that about 50 percent of all
6 urothelial concerns are -- are associated with smoking
7 according to studies, and then the hazard ratio --
8 which I think I have here somewhere, let me see if I
9 can find it. Yeah, the relative risk, the hazard
10 ratio is 4 for smoking.

11 Q. What are you looking at?

12 A. I'm on Page 7 of my report on Mousser.

13 Q. So on Page 7, you have one study that has
14 a risk -- hazard ratio of 4, true?

15 A. Correct, correct.

16 Q. Is that what you're basing your opinions
17 on, that one study that has a hazard ratio of 4?

18 A. That is one example, and also the fact
19 that the smoking-related risks persists even in
20 patients who have discontinued smoking. I reference
21 that as well.

22 Q. You had said that you believed that
23 Mr. Mousser's smoking history was, quote, "rather
24 significant."

1 How do you define "rather significant"?

2 A. I have to review the details. I --

3 Q. How about -- you can take your time and
4 review the details if you'd like, but I -- I just kind
5 of mean, how do you generally define that?

6 A. In -- in general, patients who have, you
7 know, smoked a pack a day for, you know, more than
8 five years, in general that would be considered
9 significant.

10 Q. Do you have any evidence that Mr. Mousser
11 smoked more than a pack a day for five years, for more
12 than five years?

13 A. So I don't have exact details on his
14 smoking. What I gave was sort of approximates, but he
15 does have a smoking history --

16 Q. Are you looking at your report?

17 A. I'm looking at my report on Page 11.

18 Q. Okay.

19 A. I'm sorry. I also know that he --

20 Q. Can you just give me one second --

21 A. Sorry.

22 Q. -- just to get there? Sorry.

23 A. Sorry.

24 Q. Tell me where you are on Page 11.

1 A. I'm on the second-to-last paragraph on the
2 bottom of Page 11.

3 Q. Yes.

4 A. That he smoked daily when he worked at
5 National Car Sales and that he smoked while he was in
6 the Marines.

7 Q. So do either of those give you a history
8 of smoking one pack per day for over five years?

9 A. I don't have that exact number. You asked
10 before for an approximate number, and I gave you that.

11 Q. So --

12 A. In terms of risk.

13 Q. -- do you -- what was his -- what was --
14 what was Mr. Mousser's smoking history as you assumed
15 it to be in his history? What was -- what was that
16 smoking history?

17 A. What I have is here as I've documented it.
18 I don't have a pack per day because the records were
19 somewhat inconsistent.

20 Q. Okay. Do you have any understanding, as
21 you sit here today, of what Mr. Mousser's smoking
22 history was while he was in the Marines?

23 A. If I recall correctly, it was -- there was
24 some documentation to that effect, but I don't recall

1 exactly what that was right now.

2 Q. Okay. If there is documentation that
3 Mr. Mousser smoked less than a pack a week, would that
4 have any influence over your decisions at all?

5 A. It -- it could have some influence over
6 the decision -- over my analysis with the
7 understanding that most people's recollection of
8 exposures can be variable.

9 Q. So if Mr. Mousser smoked less than a pack
10 a week, more like a pack every ten days, that would be
11 something that you would find to be not significant,
12 true?

13 A. If -- if Mr. Mousser smoked only a pack
14 every, you know, ten days, and if there was no other
15 smoking history beyond sort of the Marines, that would
16 be less significant, that is correct.

17 Q. And in terms of Mr. Mousser's -- you had
18 mentioned the smoking daily. Do you have any idea of
19 the actual amount of smoking that Mr. Mousser engaged
20 in in this 2012 timeframe that you reference in your
21 report?

22 A. I don't know that. All I know is what was
23 in the -- in the depositions, and I would have to go
24 back to those details.

1 Q. Okay. And you're -- are you talking about
2 the dep- -- the deposition of Mr. Mercer, who you
3 reference here in the report?

4 A. I believe so.

5 Q. Okay. Do you remember at all as you sit
6 here today what Mr. Mercer said in terms of whether or
7 not he had an understanding of the total amount that
8 Mr. Mousser smoked or didn't smoke in 2012?

9 A. I -- I don't recall the exact details of
10 that testimony.

11 Q. Okay. But, for example, like -- strike
12 that.

13 Would the same general applicable smoking
14 significance apply as you stated in terms of his time
15 back in the Marines, that would apply similarly to the
16 2012 timeframe?

17 A. It would apply similarly.

18 Q. Okay. You agree that upper tract
19 urothelial cancer is a kidney cancer, true?

20 A. It is a cancer that arises in the kidney,
21 but it's a completely different cancer than renal
22 cancer.

23 Q. In your report, if you can turn to Page 6,
24 Mr. Mousser, at the -- right under heading B.

1 A. Yep.

2 Q. It says, "Kidney cancer is generally
3 described as a single entity in broad epidemiologic
4 studies," and then you cite a study, Siegel, Giaquinto
5 and Jemal, right?

6 A. Correct.

7 Q. "However, it is critical to note that this
8 broad description represents a variety of distinct
9 malignancies composed of multiple histologic subtypes
10 arising from the kidney. The most common are renal --
11 renal carcinoma and upper tract urothelial
12 carcinoma -- cancer," true?

13 A. Correct.

14 Q. UTUC is a kidney cancer, true?

15 A. It is a kidney cancer.

16 Q. And you would agree with me that upper
17 tract urothelial carcinoma is most often grouped with
18 kidney cancer in the epidemiology, true?

19 A. It is grouped with kidney cancer or renal
20 cancer in the epidemiology studies.

21 Q. All right. And so as you are approaching
22 reviewing epidemiology studies, would you agree with
23 me that it would be entirely reasonable to utilize the
24 epidemiology that is utilizing the disease at issue?

1 A. So the answer is no because the
2 epidemiology studies on kidney cancer are dominated by
3 renal cancer diagnoses. Upper tract urothelial
4 cancers make up only a very small minority of cases in
5 those studies. So whatever conclusions are made in --
6 in those epidemiologic studies do not necessarily
7 apply to upper tract urothelial cancer.

8 Q. You would agree that upper tract
9 urothelial is not the same thing as urothelial cancer
10 of the bladder, true?

11 A. It is much more closely related to
12 urothelial cancer of the bladder than it is to renal
13 cancer.

14 Q. They're not the same thing, true?

15 A. They're not exactly the same thing, but
16 they're closely related.

17 Q. All right. So let me see if I understand
18 what you're saying. What you're saying is, even
19 though you know that upper tract urothelial carcinomas
20 are, for purposes of the epidemiology, grouped in the
21 category of kidney cancer, you don't think it's
22 appropriate to use the epidemiology results from
23 kidney cancer as it applies to upper tract urothelial
24 carcinoma, is that right?

1 A. That's correct.

2 Q. All right. Does that strike you as odd?

3 A. Not at all because epidemiologic studies
4 by their very nature need to group diseases in -- you
5 know, need to group multiple diseases into one sort of
6 big category. Some of those diseases may be very
7 different and may have very different etiologies. And
8 if a cancer, in this case, is -- is very different and
9 makes up only a small minority of an epidemiologic
10 cohort, then that -- the -- the results from that
11 study may not apply.

12 Q. But if you wanted to try to figure out
13 where those people, the -- all of the people who had
14 upper tract urothelial carcinoma, right, where they
15 fit into the epidemiology, you would look to where the
16 kidney cancer results are, right?

17 A. I would look for studies -- if I really
18 wanted to know that, I would look for studies with
19 upper tract urothelial cancer specifically, because
20 there's simply not enough cases of upper tract
21 urothelial cancer in the general kidney cancer
22 epidemiology to make any firm conclusions.

23 Q. So the studies that you cited in your
24 report all have upper tract urothelial carcinoma with

1 the kidney cancer cases, true?

2 A. So the -- the -- what -- what I describe
3 is the data that is -- as it is best understood for
4 upper tract urothelial cancers. The upper tract
5 urothelial cancer epidemiology and -- and etiologic
6 factors are much more closely related to bladder
7 cancer than they are to renal cancer.

8 Q. My question was just, the studies that you
9 cite in your report group renal pelvis or upper tract
10 urothelial carcinoma with kidney cancer, true?

11 A. I don't believe that's completely true. I
12 would have to look at every single reference here.

13 MR. MANDELL: Can I have 59, please.

14 (WHEREUPON, a certain document was
15 marked Dr. Stadler Deposition Exhibit
16 No. 17, for identification, as of
17 07/16/2025.)

18 BY MR. MANDELL:

19 Q. Exhibit 17 --

20 A. Yep.

21 Q. -- is the Siegel, Giaquinto, and Jemal
22 study?

23 A. Correct.

24 Q. And if you look at Page 14, at the very

1 bottom left of the table, it's a -- I think it's maybe
2 two --

3 A. Yep.

4 Q. -- or three in?

5 A. Yep.

6 Q. At the bottom left of the table --

7 A. Correct.

8 Q. -- there is a category for urinary
9 bladder. Under Urinary System --

10 A. Correct.

11 Q. -- there's a category for urinary bladder,
12 true?

13 A. Correct.

14 Q. And then one for kidney and renal pelvis?

15 A. Correct.

16 Q. So the renal pelvis would be upper tract
17 urothelial carcinoma, true?

18 A. Correct.

19 Q. And if you look at Page 18?

20 A. Yes.

21 Q. 26?

22 A. Yes.

23 Q. 37 and 38, all the same, true?

24 A. Correct, and this is exactly what I said,

1 is that in these epidemiologic studies, these cancers
2 tend to be grouped together in terms of describing
3 incidence and outcomes, but they are very different
4 cancers when it comes to etiology.

5 Q. But I -- I was just asking you the -- the
6 report, in your report, the studies that you cite,
7 they group them together?

8 A. In some of the studies that we -- yeah,
9 in -- in terms -- if I talk -- when I talk about
10 incidence, they are -- some of the studies group them
11 together.

12 Q. Okay. And are you aware as to how they
13 are grouped in the Camp Lejeune epidemiology?

14 A. To my understanding, and I'd have to go
15 back to the original studies, the upper tract
16 urothelial cancers were grouped with the kidney
17 cancers, but there were very few of them diagnosed.

18 Q. On Page 12, we've talked about smoking and
19 chronic inflammation and infection, true?

20 A. Correct.

21 Q. The remainder of the items on your
22 differential diagnosis risk factor list, is it fair to
23 say you are not giving any opinions that any of those
24 are in any way causally related to Mr. Mousser's

1 cancer?

2 A. That is correct.

3 Q. So industrial exposure to polycyclic
4 hydrocarbons, you're not giving opinions that that's
5 in any way causally related, true?

6 A. True.

7 Q. Genomic predisposition, true?

8 A. True.

9 Q. Obesity, true?

10 A. True.

11 Q. Drinking water chlorination, true?

12 A. True.

13 Q. Phenacetin use, true?

14 A. True.

15 Q. And exposure to phytotoxin aristolo- --
16 aristolochic acid, true?

17 A. True.

18 Q. And there are no other ones that you are
19 aware of that are in any way causally related, true?

20 A. True.

21 Q. Could you pull up your report on
22 Mrs. Tukes, please, Exhibit No. 5.

23 Would you agree with me on Page 12, I'm
24 going to take the genetic stuff aside just for a

1 second, but taking the genetic stuff aside, would you
2 agree that in your differential list here, there is no
3 risk factor that you associate in any causal way for
4 Mrs. Tukes with her renal cell carcinoma?

5 A. Correct.

6 Q. Obesity, you do not associate it in any
7 causal way, true?

8 A. Correct.

9 Q. Smoking, you do not associate in any
10 causal way, true?

11 A. True.

12 Q. Hypertension, you don't associate in any
13 causal way, true?

14 A. True.

15 Q. Acquired cystic disease of the kidney,
16 true?

17 A. True.

18 Q. Occupational exposure to cadmium,
19 asbestos, and petroleum byproducts, true?

20 A. True.

21 Q. Heavy use of non-steroidal
22 anti-inflammatory drugs, acetaminophen, or phenacetin,
23 true?

24 A. True.

1 Q. And chronic infection and inflammation,
2 true?

3 A. True.

4 Q. All right. Let me just jump back for one
5 second. For Mr. Mousser, you did not have
6 Camp Lejeune water exposure on Mr. Mousser's -- as
7 being causally related to his cancer, true?

8 A. Correct.

9 Q. We've gone through that at length with the
10 three previous plaintiffs, Mr. Downs, Mr. Fancher, and
11 Mr. Howard?

12 A. Correct.

13 Q. Is it the same applicable analysis for
14 Mr. Mousser?

15 A. It is a similar analysis except for the
16 fact that as a urothelial cancer, there is even less
17 epidemiologic evidence that TCE is a -- that TCE
18 exposure is related to urothelial cancer.

19 Q. Did you do any analysis of that yourself,
20 or are you relying on the experts for that?

21 A. I'm relying both on experts as well as
22 liter- -- general literature on -- on causation of
23 urothelial cancer.

24 Q. You can't cite any literature, true?

1 A. Just -- just the general literature that I
2 reference in regards to some of the chapters on
3 urothelial cancer and on upper tract urothelial
4 cancer.

5 Q. And you don't know as you sit here today
6 whether they have any mentioning at all of any of the
7 chemicals that were in the water at Camp Lejeune,
8 true?

9 A. To -- to my knowledge, it did not have any
10 specific mention of water in Camp Lejeune.

11 Q. Okay. You do not have Camp Lejeune water
12 on your risk factor differential diagnosis list for
13 Mrs. Tukes, true?

14 A. Correct.

15 Q. Is it the same analysis as Mr. Howard,
16 Downs, and Fancher?

17 A. Correct.

18 Q. Now, on page -- if you could turn to
19 Page 13 of Mrs. Tukes.

20 Under this heading Number 7, it says,
21 "Although Mrs. Tukes underwent formal genetic
22 counseling and testing and no defined genetic
23 abnormality was found, the family history of renal
24 carcin- -- of renal cancer in her mother and cousin

1 and the multiple independent tumors strongly suggest
2 the presence of an unrecog- -- -recognized genetic
3 predisposition," and you cite Dr. Vance, true?

4 A. Correct.

5 Q. Did you do any independent analysis of
6 Mrs. Tukes' genetic or hereditary predisposition, or
7 are you re- -- relying on Dr. Vance?

8 A. I reviewed the genetic counselor's reports
9 and the genetic -- and the genetic testing that she
10 had.

11 Q. So did you do your own independent
12 analysis of whether the genetic predisposition
13 syndrome that is undiagnosed or unrecognized, as you
14 say here, was causally related to Mrs. Tukes' kidney
15 cancer; or are you saying that's what Dr. Vance is
16 saying, as you understand it, so that's what you are
17 saying?

18 A. I would -- I would say that Ms. Tukes had
19 a very rare cancer that is different from your typical
20 renal cancer. I would state that this rare cancer has
21 been reported to be more common in African American
22 women and to be multifocal, in other words, occur in
23 multiple -- in multiple tumors. And I know
24 independently, based on my work in kidney cancer, that

1 multifocal, multi-tumors is common in hereditary
2 kidney cancers.

3 Q. So did you do your own independent
4 analysis to come to the conclusion that you believe
5 that Mrs. Tukes' kidney cancer was hereditary and
6 undiagnosed pre- -- undiagnosed genetic
7 predisposition, or are you relying on Dr. Vance?

8 A. I -- I am -- I have come to my -- I came
9 to my own conclusion, and it's consistent with what --
10 Dr. Vance's.

11 Q. Could you pull out Exhibit 16 for me,
12 please. Page 19.

13 Do you see how in the report of
14 Dr. Shahnasarian, the second paragraph, it says,
15 "Dr. Stadler and Dr. Johnstone concur that Mr. Tukes
16 has a genetic predisposition underlying her kidney
17 cancer disease, but they ultimately defer to the
18 United States' retained genetics expert."

19 A. I see that.

20 Q. Is that true?

21 A. As I've testified, I did -- I -- I
22 analyzed these in the sense that the disease patterns,
23 which I'm familiar with, is most consistent with a
24 genetic syndrome, and that's the analysis I did. I

1 also -- my understanding from the Vance report was
2 that Dr. Vance came to sort of the same conclusion.

3 Q. So all -- I guess all I'm trying to figure
4 out here is, do you believe that you independently
5 came to the opinion that Mrs. Tukes had a hereditary
6 cancer, or are you relying on Dr. Vance for that?

7 A. I --

8 MR. BU: Objection; form.

9 You can answer.

10 BY THE WITNESS:

11 A. I came to that conclusion independently.

12 BY MR. MANDELL:

13 Q. Okay. And so in Paragraph Number 7, it
14 says, "The family history" --

15 MR. BU: I'm sorry, are we back to --

16 MR. MANDELL: Yeah, sorry.

17 MR. BU: -- the Tukes report?

18 MR. MANDELL: Sorry.

19 MR. BU: Okay.

20 MR. MANDELL: I'm on exhibit --

21 THE WITNESS: 5.

22 MR. MANDELL: -- 5.

23 BY MR. MANDELL:

24 Q. In Paragraph No. 7, it says, "The family

1 history of renal cancer in her mother and cousin,"
2 true?

3 A. Correct.

4 Q. Do you have any understanding as to
5 whether or not Mrs. Tukes' mother was formally
6 diagnosed with kidney cancer?

7 A. I would have to go back to the exact
8 medical record. This was, if I recall correctly, part
9 of the analysis from the genetic counselor that she
10 saw.

11 Q. Okay. So in terms of your analysis of
12 that issue, the record that you would use to be able
13 to make that determination is from the genetic
14 counselor?

15 A. It is from the genetic counselor and the
16 medical record as I had available.

17 Q. Okay.

18 MR. MANDELL: Can I have No. 71, please.

19 (WHEREUPON, a certain document was
20 marked Dr. Stadler Deposition Exhibit
21 No. 18, for identification, as of
22 07/16/2025.)

23 MR. BU: Thank you.

24 MR. MANDELL: Sure.

1 BY MR. MANDELL:

2 Q. Exhibit 18 we marked, is this the genetic
3 record that you're talking about?

4 A. I believe so.

5 Q. Okay. If you look on page -- the second
6 page of the document, 479?

7 A. Correct.

8 Q. What does it say under "Mother"?

9 A. "Was diagnosed with an unknown cancer
10 which was metastatic, remembers that her cancer [sic]
11 had a renal mass, but it is unclear if it was truly a
12 renal primary tumor."

13 Q. So is it -- is this what you would have
14 used to form the basis of your opinion?

15 A. In part, yes.

16 Q. All right. Is there anything else you're
17 aware of?

18 A. Not that I'm aware of.

19 Q. Okay. The cousin, what relevance does
20 that have?

21 A. It just -- it -- it's also a -- a family
22 member, genetically related.

23 Q. Do you know if according to Dr. Vance
24 having somebody that is of that degree of familiarity,

1 if -- if that is relevant or not to whether or not a
2 cancer is hereditary or not?

3 A. I would have to read Dr. Vance's report,
4 but to understand the -- the details of the relevance,
5 you would have to see sort of the en- -- entire family
6 history.

7 Q. Do you mean, like, I'm not being -- I'm
8 meaning this very seriously. On Page 479 and 480, are
9 you talking about that type of thing?

10 A. It -- it would be similar, but it would
11 have to be a more formal of familial analysis with a
12 family tree, which I don't see here.

13 Q. Do you know if there was a family tree
14 literally like that done at UNC Health?

15 A. I -- I don't know that.

16 Q. Would that be relevant to your opinions?

17 A. It -- it could be relevant to the
18 opinions, but the other component of my opinion really
19 is the -- the clinical presentation of the disease.

20 Q. So let me see if I understand what you're
21 saying.

22 The most important factor to you in terms
23 of whether or not this was hereditary or not is the
24 clinical presentation of the disease?

1 A. The clinical presentation of the disease
2 and the histologic subtype, yes.

3 Q. Did you -- so you said you read the
4 reports from the genetics, true?

5 A. Correct.

6 Q. What did they conclude, do you have an
7 understanding?

8 A. The conclusion was, if I re- -- I mean,
9 the genetics is as -- oh, well, this -- this
10 exhibit that you provided, Exhibit 18, doesn't have
11 those genetic results. If I recall correctly, the
12 genetic results did not demonstrate any known genetic
13 cause. They had offered a more experimental whole
14 genome analysis, but the patient declined to follow up
15 with that.

16 Q. Well, the whole genome analysis doesn't
17 have any genes that are known to be associated with
18 kidney cancer that weren't in the panel that she had,
19 true?

20 A. That is correct.

21 Q. So you're not attributing some fault to
22 Mrs. Tukes about that, right?

23 A. I am not attributing any fault.

24 Q. All right. And is your memory of the

1 testing and the results that were done at UNC that the
2 genetics counselor and experts at UNC believed that
3 Mrs. Tukes likely did not have hereditary cancer?

4 A. I don't remember sort of the details. I
5 think that there has been enough concern about
6 genetic -- there was certainly enough concern about a
7 potential genetic cause that they were interested in
8 doing some further experimental testing to assess
9 that.

10 Q. Sure. Well, I mean, you're familiar with
11 the NCCN guidelines, right?

12 A. Yes.

13 Q. And would you agree that that's part of
14 the reason why Mrs. Tukes had the testing done in the
15 first place?

16 A. Correct.

17 Q. And the reason you do the testing is to
18 figure out if there is a known hereditary gene that's
19 associated with this type of cancer, true?

20 A. Correct, but as I state, there are likely
21 unknown genetic causes as well beyond what's -- we --
22 we test for.

23 Q. Right, but you have no evidence of that,
24 true?

1 A. My evidence for that is that the clinical
2 presentation is most consistent with cancers of
3 hereditary origin.

4 Q. But you have no evidence that there is any
5 other gene out there that is related to hereditary
6 renal cell carcinoma, true?

7 A. The -- the lack of a definitive known gene
8 doesn't mean that it's not genetically related.

9 Q. My question is a little different, which
10 is you have no evidence that there is any gene
11 anywhere in this universe that is causally related to
12 kidney cancer as being hereditary outside of the test
13 that Mrs. Tukes got, true?

14 A. There -- outside of the test that
15 Mrs. Tukes got, there are no other standard genetic
16 tests for -- for hereditary kidney cancer.

17 Q. Can you cite me a gene that is linked to
18 hereditary renal cell carcinoma that was not tested
19 for Ms. Tukes, under the current state of the
20 literature?

21 A. Under the current state of the literature,
22 under the current state, I'm not aware of any kind of
23 genes that Ms. -- Ms. Tukes was not tested for. I'd
24 have to review the full report again to take a look at

1 that.

2 Q. All right. Is there anything other than
3 what we -- strike that.

4 You did cite one study in your report on
5 Page 5. Do you see in the second paragraph, it starts
6 with "Finally"?

7 A. Correct.

8 Q. You say, There are -- There are
9 therefore -- "Therefore, there are almost certainly
10 undiscovered and undescribed genetic predisposition
11 mutations or syndromes and discovery of new cancer
12 predisposing genes is an active area of scientific
13 research (see for example Roberts...)," true?

14 A. Correct.

15 Q. Roberts was a study involving pancreatic
16 cancer, true?

17 A. Correct.

18 Q. So you're not saying that there's anything
19 about Roberts that gives any specific information
20 about kidney cancer, true?

21 A. It's not giving information about kidney
22 cancer. It was just as an example to say that there's
23 lots of research ongoing looking for genetic causes of
24 cancer.

1 Q. So, again, though, what you're saying is
2 that there's a general concept out there that there
3 may be some unknown gene at some unknown time that has
4 some unknown affiliation with some cancer that we just
5 don't know about, true?

6 A. What I'm saying is there's likely lots of
7 genes like that.

8 Q. But you can't cite one of them, true?

9 A. Well, if they're unknown, I wouldn't be
10 able to -- I won't be able to cite them, correct.

11 Q. So how do you know that it's likely?

12 A. Because I know it's being looked at, and I
13 know there's clinical syndromes like Ms. Tukes' that
14 are -- the clinical picture is most consistent with a
15 genetic cause.

16 Q. Well, isn't it true that multifocal
17 cancers also are consistent with carcinogenic
18 exposure?

19 A. So in the sense that the most common
20 carcinogenic exposure leading to kidney cancer is
21 smoking, and smoking-related cancers are very rarely
22 multifocal, I would say no.

23 Q. Well, how about not smoking, how about
24 other carcinogens?

1 A. I'm not aware of any carcinogens causing
2 kidney cancer that cause mul- -- multifocal cancer.

3 Q. You're just not aware of that?

4 A. I'm not aware of any.

5 Q. If that was true and if that's in the
6 literature, would that change your opinion?

7 A. It could, although when we say multifocal,
8 we mean -- we talk about multiple tumors in humans,
9 not necessarily in animals.

10 Q. Are you aware as to whether or not
11 Mrs. Tukes' treating physicians believed that she has
12 an hereditary cancer?

13 A. I -- I don't know for sure what they all
14 believe. I know that they had enough concern that
15 they sent her for genetic counseling.

16 MR. MANDELL: Can you give me Tab 84, please.
17 Thank you.

18 (WHEREUPON, a certain document was
19 marked Dr. Stadler Deposition Exhibit
20 No. 19, for identification, as of
21 07/16/2025.)

22 BY MR. MANDELL:

23 Q. Dr. Stadler, Exhibit 19 is a record from
24 UNC Health, Bates 1553_TUKES_441.

1 Do you see how on the bottom -- towards
2 the bottom of the page it says, "Cancer Screening"?

3 A. Correct.

4 Q. It says, "This normal result is reassuring
5 and indicates that you do not likely have well
6 understood hereditary predisposition to renal cell --
7 to renal cancer," true?

8 A. Correct.

9 Q. So would you agree that at least the
10 providers at UNC at the time believed that Mrs. Tukes'
11 cancer was not likely hereditary?

12 A. It says "not likely a well understood
13 hereditary predisposition to kidney cancer."

14 Q. Do you take that as anything other than
15 they think that -- that the likelihood is not likely?
16 Does that make sense?

17 A. Not necessarily.

18 Q. Okay. Have you seen Mary Garbarini's
19 deposition?

20 A. I believe I have, yes.

21 Q. Do you know what she says about the
22 likelihood of it being hereditary?

23 A. I don't recall off the top of my head.

24 Q. Would it sound consistent with your memory

1 if I were to tell you that she said that that chance
2 was small?

3 A. I -- I don't know that.

4 Q. Okay.

5 MR. MANDELL: Can I have 68, please.

6 (WHEREUPON, a certain document was
7 marked Dr. Stadler Deposition Exhibit
8 No. 20, for identification, as of
9 07/16/2025.)

10 BY MR. MANDELL:

11 Q. This is an excerpted copy of the
12 deposition of Mary Catherine Garbarini, and if you can
13 turn to the last page, Page 88. Do you see how it
14 says, starting at line -- oh, I'm sorry, 87?

15 A. What line?

16 Q. The page before.

17 A. Oh, 87.

18 Q. Yeah, I'm going to go on to 88.

19 A. Okay.

20 Q. The -- Line 16, it says, "Near the -- I
21 guess the second-to-last line, it says the current --
22 'since the current test is not perfect, it is possible
23 there may be a mutation that current testing cannot
24 detect, but that chance is small,' is that right?"

1 Answer: "Yeah. I would say that that's
2 accurate.

3 "Why is the chance that there's a mutation
4 that current testing cannot detect small?"

5 Answer: "I would say I think just the
6 standards of the testing that they have -- that they
7 had then were pretty comprehensive, as they are now.
8 I believe they can detect greater than 99 percent of
9 variants that are detectable in that region."

10 And then she says, "But the testing has
11 improved since then. They're able to get deeper
12 coverage than they were before. There are newer
13 testing technologies. We are just acknowledging the
14 limitation of the test."

15 Do you see that?

16 A. I do.

17 Q. So is it fair to say she believes that
18 it's small?

19 A. It's fair to say that this genetic
20 counselor believes that it's small, but this genetic
21 counselor also states that there are newer testing
22 technologies.

23 Q. Right.

24 A. And different approaches.

1 Q. And as of -- as of the last -- last date
2 of her treatment with UNC, are you aware of any
3 difference in that opinion?

4 A. I'm not aware of any differences in that
5 opinion.

6 Q. All right. Do you know what Mrs. Tukes'
7 treating oncologist testified to in terms of any
8 belief that there was any genetic cancer?

9 A. I'm not sure.

10 Q. I'm going to read you a question and
11 answer, and we can pull the deposition transcript too,
12 I -- I have it, but I just want to know if this jogs
13 your memory.

14 Question: "Right, and we discussed
15 earlier that a genetic test cannot definitively rule
16 out a predisposition to cancer, correct?"

17 There was an objection.

18 The Witness: "I think we kind of say when
19 the genetic test is negative, we rule out the
20 predisposition."

21 Does that sound like it jogs your memory
22 in terms of --

23 A. It --

24 Q. -- what the oncologist --

1 A. It -- it jogs my memory. It rules out a
2 genetic predisposition for known causes.

3 Q. But that's all you can go off of, right?
4 I mean, how -- true?

5 A. Yes and no. I mean, we -- there's lots of
6 things in medicine we don't know, first of all.
7 Secondly, the way we've discovered the known genetic
8 causes is by recognizing certain clinical syndromes
9 and clinical presentations.

10 And what I would say is that Ms. Tukes'
11 presentation is con -- very consistent with other
12 genetic causes of kidney cancer, and -- and that's
13 what a lot of my conclusion is based on.

14 Q. And it sounds like the treating oncologist
15 disagrees with that, true?

16 A. Could be.

17 Q. Okay. How about the treating urologic
18 surgeon, do you remember what Dr. McCarthy said?

19 A. I do not know what Dr. McCarthy said.

20 Q. Let me read something and see if it jogs
21 your memory.

22 Question: "To the extent that there is a
23 genetic" -- strike that.

24 Question: "To the extent that there is

1 genetic testing and that genetic testing comes back, I
2 think you had said negative, or with no mutations,
3 that type of thing, does that -- what does that tell
4 you in terms of an inherited or genetic type cancer?"

5 Answer: "I would say that that would --
6 that that would lead me to believe that this is
7 probably not related to her mother's cancer."

8 Question: "Okay."

9 Answer: "She did not inherit anything
10 from her mother predisposing her to kidney cancer."

11 Does that jog your memory at all?

12 A. It jogs my memory.

13 Q. All right. So you disagree with that?

14 A. I -- I disagree -- A, I disagree with the
15 fact that -- that there's any testimony that there's
16 no way that this could be genetic in origin, or that
17 the probability is low, more accurately.

18 Q. Well, did I -- did I read anything now
19 that -- that said that -- that the proba- -- that
20 there's no way that this could be genetic in origin?

21 A. You did not.

22 Q. Okay. That's not what they said, true?

23 A. Correct.

24 Q. They're just saying -- they are saying,

1 the likelihood is it's not genetic, right?

2 A. That's fair.

3 Q. And so you disagree with all of the -- the
4 treating physicians that I just mentioned, true?

5 A. I disagree with that.

6 Q. Are you aware of any treating physician
7 for Mrs. Tukes that says what you are saying, that --
8 that, no, despite all of the genetic testing that was
9 done -- and you understand it was multiple, true?

10 A. Correct.

11 Q. -- despite all of that genetic testing,
12 this was still hereditary, just based off of clinical
13 findings?

14 A. I don't know what all her physicians say,
15 but if -- if that's -- I -- I would -- I would
16 disagree with any physician that says that this is
17 unlikely to be genetically related.

18 Q. Are you aware of any literature,
19 scientific article, journal, textbook, anything, that
20 says that if you have a negative genetic test that
21 that means -- or strike that -- that you can diagnose
22 somebody with hereditary renal cell carcinoma despite
23 that negative genetic test?

24 A. So my -- my opinion is that Ms. Tukes'

1 cancer is genetic in origin. Whether that's
2 hereditary or not, there's a subtle difference there,
3 but what I would say is, once again, that the only --
4 the only clinical scenarios that I'm aware of in which
5 there are multiple tumors and multifocal cancer in --
6 for -- for kidney cancer are those in which there's a
7 genetic cause.

8 Q. So do you associate those symptoms
9 automatically with a hereditary renal cell carcinoma,
10 meaning every time anybody has those, you have to
11 diagnose it as hereditary?

12 A. My assumption is that if I would see a
13 patient with multiple tumors like this, not just one
14 or two or three, but multiple tumors as in this case,
15 I would very much believe that this is more likely
16 than not to be genetic in origin.

17 Q. So why do you do the genetic testing then?

18 A. You do the genetic testing to assess for
19 known genetic causes, and -- and if hopefully you'll
20 find a known genetic cause, but just because you don't
21 find a genetic cause doesn't mean it's not genetic in
22 origin.

23 Q. Why do you hope to find a genetic cause?

24 A. Because if you find a genetic cause, that

1 would allow you then to diagnose whether other family
2 members carry that diagnosis -- carry that mutation
3 and are also at risk.

4 Q. Do you know what the NCCN guidelines say
5 about what to do when you have multifocal or -- or
6 multi kidney tumors?

7 A. The NCN -- the NCCN guidelines suggest the
8 patients undergoing genetic testing.

9 Q. Right. Is there anywhere in the NCA --
10 NCCN guidelines that you're aware of where it says
11 that that type of patient should be diagnosed with
12 hereditary renal cell carcinoma despite whatever the
13 genetic testing says?

14 A. That's not what the NCCN guidelines are
15 for.

16 Q. Okay. Did you make any accounting in your
17 opinions for the fact that Mrs. Tukes is more
18 susceptible to carcinogenic exposure at lower levels?

19 A. So I know that the plaintiff experts made
20 some of those conclusions. I was unsure about that
21 biologic rationale, and to that extent I depended
22 on -- on Dr. Vance's analysis.

23 Q. So you didn't make any -- you did not
24 account for that in your opinions?

1 A. I -- I did not account for Ms. Tukes being
2 more susceptible to toxic exposures, but I was -- but
3 I did not -- I did not account for any -- I did not
4 account for that.

5 MR. MANDELL: Okay. Let's take a five-minute
6 break.

7 THE VIDEOGRAPHER: We are now off the record at
8 3:05 p.m.

9 (WHEREUPON, a recess was had
10 from 3:05 to 3:16 p.m.)

11 THE VIDEOGRAPHER: We are back on the record at
12 3:16 p.m.

13 BY MR. MANDELL:

14 Q. Dr. Stadler, a couple more questions for
15 you.

16 You had mentioned just a couple of minutes
17 ago that Mrs. Tukes, you believe, declined further
18 genetic testing?

19 A. I believe that was the case.

20 Q. Where did you get that from?

21 A. I -- I -- even in your -- some of these
22 other records from the genetic counselors, I believe
23 they stated that they offered whole genome testing
24 that she -- she declined.

1 Q. Okay. Do you have a cite or source for
2 that?

3 A. I would have to go through all of the
4 records to take a look at that.

5 Q. Okay. Are you aware of what Dr. Vance
6 testified when she was deposed just about a week or so
7 ago?

8 A. I recall seeing Dr. Vance's report. If
9 there was a deposition only a week ago, then I have
10 not seen that.

11 Q. And if Dr. Vance were to have said at her
12 deposition that she cannot say to any degree of
13 certainty that Mrs. Tukes' cancer was of a hereditary
14 nature, would that influence your opinions at all?

15 A. It might, depending on the context of the
16 question.

17 Q. So you'd need to see what she said?

18 A. Correct.

19 Q. Okay. When -- you had said that when you
20 were drafting your reports or writing your reports
21 that you had the defendant's expert reports with you
22 but not the plaintiffs', true?

23 A. My initial draft was without all of the
24 plaintiffs' expert witness, that would be correct.

1 Q. When did you get the plaintiffs' expert
2 reports --

3 A. I --

4 Q. -- or did you ever get the plaintiffs'
5 expert reports?

6 A. I did get the plaintiffs' expert reports.
7 Exactly when, I would have to go back and take a look.
8 I don't recall.

9 Q. Was it before you -- your reports were
10 disclosed to us or after?

11 A. So these final reports, which include some
12 of my responses to plaintiff experts, obviously were
13 written after I received some of those -- some of
14 those plaintiff reports.

15 Q. But the -- the plaintiff reports that you
16 mention in your -- in your reports are plaintiffs'
17 specific causation experts, true?

18 A. Yes, the plaintiff experts that are
19 referred to are more related to the specific experts,
20 that's correct.

21 Q. All right. Did you -- have you ever
22 reviewed, or did you ever review any of the general
23 causation experts for the plaintiffs?

24 A. I don't recall off the top of my head, to

1 be honest.

2 Q. Okay. Is it fair to say -- or strike
3 that.

4 You -- if you could for me, pull up
5 Exhibit, I think it's 6, the billing records.

6 A. The billing records, yeah.

7 Q. Can you tell me where in your billing
8 records it says -- strike that.

9 Can you tell me where in your billing
10 records it says that you reviewed Dr. Goodman's
11 report?

12 A. I'm not sure if it says specifically.
13 I -- I believe I did read her report. If you are
14 asking me exactly when I read it, I can't tell you.

15 Q. Well, I guess what I'm asking is, is there
16 any documentation in your billing that you read her
17 report?

18 A. I don't believe so.

19 Q. Okay. There is a notation in your report
20 that says -- Bates 803. If you look at the bottom
21 right-hand corner, it's like the page numbers.

22 A. Okay.

23 Q. It says, "Goodman discussion"?

24 A. Correct.

1 Q. What is that? Was that a discussion?

2 MR. MANDELL: Oh, sorry.

3 MR. BU: So the substance of your communications
4 with other DOJ experts are protected. You should not
5 disclose the substance of those communications.

6 BY MR. MANDELL:

7 Q. My question I guess is, is that -- where
8 it says, "Goodman discussion," was that a discussion
9 with the -- your counsel?

10 A. There was a discussion with counsel and --
11 and a phone call with counsel and Dr. Goodman.

12 Q. Okay. So is what you're saying that you
13 had a conversation with Dr. Goodman?

14 A. I had a conversation at around that --
15 during that timeframe, yes.

16 Q. And it was with Dr. Goodman?

17 A. Dr. Goodman was on the call.

18 Q. Okay. And is that what's referenced on
19 Bates No. 803, the Number 1?

20 A. Correct.

21 Q. Okay. Now, there are two line items in
22 Item No. 1. It says, "Prep Mousser opinion and
23 Goodman discussion" for a total of 1.5 hours.

24 Do you see that?

1 A. Correct.

2 Q. Do you know how much time was spent on
3 each?

4 A. I -- I don't recall. I -- I also don't
5 recall any phone conversation of longer than an hour.

6 Q. So fair to say that any discussion with
7 Dr. Goodman would have been less than an hour?

8 A. That's fair to say.

9 Q. On Bates 808, it says, Number 2,
10 "Discussion with causation expert."

11 Do you know who that is?

12 A. I don't recall. I'm sorry.

13 Q. Was it -- could it have been the
14 discussion with Dr. Shahnasarian?

15 A. It's possible. I don't -- I just don't
16 recall.

17 Q. All right. You had one call with
18 Dr. Goodman?

19 A. There was only one call, to my
20 recollection.

21 Q. So this wouldn't be related to
22 Dr. Goodman?

23 A. This would not be related to Dr. Goodman,
24 as far as I -- as I recall at least.

1 Q. Okay. On Bates 798, it says, Review of --
2 Number 3, "Review of draft reports."

3 What does that mean?

4 A. What that means is that I had put together
5 some initial drafts of my opinions, and we
6 discussed -- the attorneys and I discussed those
7 drafts.

8 Q. So those are reviewing of your draft
9 reports?

10 A. Correct.

11 Q. I see. On Bates 809, it says, Number 2,
12 line item Number 2, "Plaintiff expert report review."
13 Do you see that?

14 A. Correct.

15 Q. And then it says, line item Number 4,
16 "Plaintiff expert report discussion"?

17 A. Correct.

18 Q. Do you know if there is any billing other
19 than these two references that would in any way
20 reflect your review of the plaintiffs' expert reports?

21 A. I don't believe there is anything beyond
22 those, but I'd have to go through all of the billing
23 records in detail.

24 Q. Okay. The expert report discussion would

1 have been with counsel?

2 A. Correct.

3 Q. So if this is the only expert report
4 review, it would have been -- all of the plaintiffs'
5 experts would have been reviewed in one hour, true?

6 A. I believe so, but I believe this reflects
7 the -- you know, mostly the specific causation
8 experts.

9 Q. Okay. Do you know how many there are for
10 the plaintiffs that you've mentioned in your reports?

11 A. Not off the top of my head.

12 Q. Okay. I just want to make sure I
13 under- -- understand your opinions as to Mrs. Tukes.
14 Is -- let me see if I can summarize this accurately.

15 Your belief that Mrs. Tukes may have
16 hereditary renal cell carcinoma is based off of the
17 fact that there might be some unknown gene that exists
18 that might be determined at some unknown time that is
19 unknown in how the gene would be applicable to renal
20 cell carcinoma, true?

21 A. That is correct, but it's based on her
22 clinical presentation.

23 Q. Okay. I have no more questions. Thanks.

24 MR. BU: Can we go off record?

1 THE VIDEOGRAPHER: We are now off the record at
2 3:27 p.m.

3 (WHEREUPON, a recess was had
4 from 3:27 to 3:40 p.m.)

5 THE VIDEOGRAPHER: We are back on the record at
6 3:40 p.m.

7 EXAMINATION

8 BY MR. BU:

9 Q. Dr. Stadler, so we've been working
10 together for some time. I'm Nathan Bu. I'm a trial
11 attorney with the Department of Justice.

12 Mr. Mandell asked you some questions about
13 risk factors and about causes in your reports and in
14 this litigation. Can you describe briefly the
15 difference, if any, between a risk and a cause?

16 A. So from my perspective, a risk factor is
17 something that increases the odds of a particular
18 cancer. Those increase in odds can be dramatic or
19 they can be modest or they can be low. In general
20 when I look at causation, I look at the -- that a
21 particular etiologic factor is for the most part more
22 likely than not to be the cause of that particular
23 patient's cancer.

24 Q. Okay. And do you also recall some

1 questions about a proportional attributable share for
2 smoking and obesity?

3 A. I did. We talked about a population risk
4 attribution for obesity, and smoking in renal cancer.

5 Q. So if the attributable share for smoking
6 is 18 percent, does that mean that for 18 percent of
7 renal cancers smoking is a cause or smoking is a risk
8 factor?

9 MR. MANDELL: Objection.

10 BY THE WITNESS:

11 A. I would say that the -- in -- in a
12 population, I would consider that smoking would be the
13 cause in about 18 percent of patients.

14 BY MR. BU:

15 Q. Okay. And can you explain briefly the
16 difficulty, if any, in identifying a cause even when
17 risk factors are identified?

18 MR. MANDELL: Objection.

19 BY THE WITNESS:

20 A. So when risk factors are identified, as I
21 stated, the risk factors may be -- have a high, medium
22 or low associated hazard ratio, so to speak, and in
23 those scen- -- scenarios in which the hazard ratio was
24 relatively low or modest, it may be impossible to

1 determine in an individual patient, even one who has
2 those risk factors, whether that's the cause.

3 BY MR. BU:

4 Q. Okay. When you were discussing idiopathic
5 and idiopathy with regards to the plaintiffs' experts,
6 you testified something along the lines of, they
7 jumped to their conclusion too quickly or they ruled
8 out unknown causes without justification.

9 Can you explain what you meant by that, if
10 you remember?

11 A. So similar to your prior question, if
12 the -- if a patient has a known risk factor, just
13 because that's the only risk factor that the patient
14 may have does not mean that that is the likely cause
15 in that patient and one still has to consider that the
16 cause in that particular patient may be idiopathic.

17 Q. Okay. For each of the cases Mr. Mandell
18 walked through you -- through your analysis of the
19 different risk factors for each of the plaintiffs, and
20 you explained that you're not offering causal opinions
21 for many of those risk factors, do you recall that?

22 A. Correct.

23 Q. So, for example, you're not going to opine
24 in this litigation that Camp Lejeune water was the

1 cause of Mr. Downs's cancer, correct?

2 A. Correct.

3 Q. And you're not going to opine that his
4 smoking history was the cause of his cancer, right?

5 A. Correct.

6 Q. Do you have an opinion about whether the
7 smoking history is a risk factor?

8 A. I --

9 MR. MANDELL: Objection.

10 BY THE WITNESS:

11 A. I believe that the smoking is a risk
12 factor.

13 BY MR. BU:

14 Q. You had mentioned that you read two of
15 Dr. Goodman's reports, her bladder cancer report and
16 her kidney cancer report.

17 Do you recall that?

18 A. I did.

19 Q. Why did you review her bladder cancer
20 report?

21 A. I reviewed her bladder cancer report
22 because I believe that upper tract urothelial cancer
23 and its etiology is much more closely related to
24 bladder cancer than to renal cancer.

1 Q. Did you also review reports by Dr. Lisa
2 Bailey?

3 A. I did.

4 Q. Okay. And did Dr. Lisa Bailey calculate
5 the risks attributable to Camp Lejeune water?

6 A. Per my recollection, she did. She did do
7 that.

8 Q. And do you rely on those risk calculations
9 in coming to your conclusions for your report?

10 A. I relied on those at least in part.

11 Q. Okay. Earlier you testified that you
12 don't think there -- and I'm paraphrasing here,
13 there's not like an outer bound of latency, that a
14 cancer does not occur so late that it can't be
15 attributable back to a prior exposure.

16 Do you recall that?

17 A. I did.

18 Q. Okay. Are you expressing any opinions
19 about a lower bound for latency, whether a cancer must
20 arise close in time enough to an exposure to be ruled
21 in?

22 A. No, I don't have any opinions on that.

23 Q. Okay. Is there any reason to think that
24 your financial compensation from the United States has

1 affected your analysis in this litigation?

2 A. I do not believe so.

3 MR. BU: No other questions.

4 FURTHER EXAMINATION

5 BY MR. MANDELL:

6 Q. One -- one question. Do you have as an
7 understanding that any risk calculations done by
8 Dr. Bailey applied specifically to kidney cancer?

9 A. I would have to read the report exactly
10 again. I don't recall off the top of my head.

11 Q. You don't know that?

12 A. I -- like, I reviewed the report, but I
13 don't recall the details exactly of how -- how she
14 applied her analyses to -- to what exact disease and
15 in what exact context.

16 MR. MANDELL: Okay.

17 MR. BU: Thank you, Dr. Stadler.

18 MR. MANDELL: Thanks, Doctor.

19 THE VIDEOGRAPHER: We are now off record at
20 3:46 p.m. This concludes today's deposition.

21 ---

22 Thereupon, at 3:46 p.m., on Wednesday,
23 July 16, 2025, the deposition was concluded.

24 ---

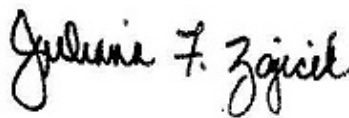
REPORTER'S CERTIFICATE

I, JULIANA F. ZAJICEK, a Registered Professional Reporter and Certified Shorthand Reporter, do hereby certify that prior to the commencement of the examination of the witness herein, the witness was duly sworn by me to testify to the truth, the whole truth and nothing but the truth.

I DO FURTHER CERTIFY that the foregoing is a verbatim transcript of the testimony as taken stenographically by me at the time, place and on the date hereinbefore set forth, to the best of my availability.

I DO FURTHER CERTIFY that I am neither a relative nor employee nor attorney nor counsel of any of the parties to this action, and that I am neither a relative nor employee of such attorney or counsel, and that I am not interested directly or indirectly in the outcome of this action.

IN WITNESS WHEREOF, I do hereunto set my hand on this 18th day of July, 2025.



JULIANA F. ZAJICEK, Certified Reporter

DEPOSITION ERRATA SHEET

Assignment No. 7415291

Case Caption: In Re: Camp Lejeune Water Litigation

DECLARATION UNDER PENALTY OF PERJURY

I declare under penalty of perjury that I have read the entire transcript of my Deposition taken in the captioned matter or the same has been read to me, and the same is true and accurate, save and except for changes and/or corrections, if any, as indicated by me on the DEPOSITION ERRATA SHEET hereof, with the understanding that I offer these changes as if still under oath.

WALTER STADLER, M.D., FACP

SUBSCRIBED AND SWORN TO
before me this day
of , A.D. 20__.

Notary Public

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

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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