

IN THE UNITED STATES DISTRICT COURT  
FOR THE SOUTHERN DISTRICT OF OHIO  
EASTERN DIVISION

- - - - -

Cynthia Madej,  
et al.,

:

:

Plaintiffs,

:

vs.

Case No. 2:16-cv-658

:

Judge Sargus

Athens County

Magistrate Vascura

Engineer Jeff Maiden,

:

Defendant.

:

- - - - -

DEPOSITION OF DR. JOHN M. MOLOT  
VIA SKYPE

- - - - -

Taken at Professional Court Reporters Inc.  
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## A P P E A R A N C E S

ON BEHALF OF PLAINTIFFS:

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ON BEHALF OF DEFENDANT:

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By Molly R. Gwin, Esq. (Via Skype)

1 JOHN MARK MOLOT, sworn,

2 CROSS-EXAMINATION BY MS. GWIN:

3 Q. Good morning.

4 A. Good morning.

5 Q. Thank you very much ---

6 A. Are those blinds behind you?

7 Q. They are. It's like a screen separating the  
8 other room. Thank you very much for making yourself  
9 available and I just want to extend my sympathies regarding  
10 your recent tragedy and appreciate you working around our  
11 schedule in this case?

12 A. Thank you.

13 Q. You're welcome. My name is Molly Quinn. I'm  
14 one of the attorneys representing the Athens County  
15 Engineer in this case and you've been called for a  
16 deposition today based on some opinions that you've  
17 rendered as an expert physician. Do you understand that?

18 A. Yes.

19 Q. Okay and have you ever had your deposition  
20 taken before?

21 A. No. In Canada, depositions are quite rare.

22 Q. Okay, okay. Well, I appreciate that. Thank  
23 you. And I'll go ahead and just tell you a couple of  
24 things before we start and the first is that you're already

1       doing a nice job of giving sort of audible answers and  
2       that's just helpful so that the court reporter can take  
3       them down, so if you can continue to do that and say yes or  
4       no rather than "m'hmm" or "uh-uh".

5               A.   H'mm.

6               Q.   The second thing is if you, right, caught  
7       yourself right there. The second thing is if you can go  
8       ahead and let me finish my question before you answer it.  
9       Particularly with videoconferencing, that's helpful. There  
10      is a natural tendency to sort of anticipate my question,  
11      but if you can go ahead and let me finish the question  
12      before you provide the answer, that's helpful as well.  
13      Okay?

14              A.   Is it possible for you to change the way the  
15      blinds are? Because it's physically very difficult to look  
16      at you. Not you personally, obviously, but the way the  
17      blinds are, there's just these lines that -- I don't know,  
18      maybe you can close them more?

19              Q.   I don't think so, because I think it's a  
20      screen.

21              A.   Okay. Well, if I'm not looking at you,  
22      please don't take that as being rude, but it's a big screen  
23      of these lines. It's very hard to look at.

24              Q.   Sure. Well, just -- if you take a break at

1 any point in time, you get eye strain, that's fine, you're  
2 free to take a break. I'll just ask that you answer any  
3 questions pending before you do so?

4 A. Okay.

5 Q. Okay and if I ask you a question I'm going to  
6 go ahead and assume you understood the question. If you  
7 don't understand the question, let me know that, too. I'll  
8 do my best to rephrase the question, okay?

9 A. M'hmm, yes.

10 Q. Can you please state your name and spell your  
11 last name for the record?

12 A. John Molot, M-O-L-O-T, J-O-H-N is the first  
13 name.

14 Q. And what is your present work address?

15 A. I work part-time at Women's College Hospital  
16 in Toronto. It's 77 Grenville, G-R-E-N-V-I-L-L-E. I can't  
17 think of the postal code offhand, Toronto.

18 Q. And do you receive mail at that address?

19 A. No. I usually receive mail, because most of  
20 the time I work at home. I spend a lot of my time working  
21 on a task force and I do medical legal reports as well. So  
22 my mail is a post office box which I believe is -- it just  
23 got changed from Ottawa to Toronto. I'd have to look up  
24 the address if you want it. Do you want the address?

1                   Q. No, that's fine. I believe that the post  
2                   office box is included in your questionnaire  
3 with Ms.

4           Madej. It's P.O. Box 83004, Bank Street, Ottawa, Ontario,  
5           K1V 8A3; is that correct?

6                   A. If you send something there, it will get sent  
7 to my P.O. Box in Toronto which I just moved. I'm from  
8 Ottawa.

9                   Q. Okay.

10                  A. And the woman who does my admin work is in  
11 Ottawa, so she was collecting the mail there. I changed  
12 the post office box to close to my home. I just don't know  
13 the number off by heart, but if you send it there, it will  
14 be forwarded. Complicated.

15                  Q. So Doctor, you mentioned that you work part-  
16 time at the Women's College Hospital?

17                  A. Yes.

18                  Q. Okay and what do you do at the Women's  
19 College Hospital?

20                  A. I work in Environmental Health Clinic. Do  
21 you want me to tell you about the clinic?

22                  Q. Do you see patients at the clinic?

23                  A. Yes.

24                  Q. Okay. How many patients do you see?

1           A. Depends on the day. Recently, I also  
2           required back surgery, so I was working half-days. New  
3           patients are booked for three-hour appointments. Follow-up  
4           patients are booked for an hour to an hour and a half each.  
5           So given what I was doing recently, I was seeing three  
6           patients, four patients a week, because I was only working  
7           half-time.

8           Q. And were you treating all of these patients  
9           or were any of these patients seen in your capacity as an  
10          expert witness?

11          A. The former. I did not do any of my medical  
12          legal work. I am called the medical legal liaison at that  
13          clinic. If lawyers phone that clinic to ask for a medical  
14          legal assessment, it would be referred to me, but I would  
15          see them outside the clinic. In order to do the  
16          examination in person, I was using one of my colleagues'  
17          offices when required which was maybe once or twice a month  
18          max.

19          Q. And what do you do in your role as medical  
20          legal liaison for the Women's College Hospital?

21          A. As I said if a lawyer phones the clinic  
22          looking for a medical expert, often it will be forwarded to  
23          me.

24          Q. Are you the only medical legal liaison at the

1 clinic?

2 A. Well, I'm the only one with that official  
3 title. The other physicians there, there are three other  
4 physicians. They frequently do medical legal reports as  
5 well. Most of them are about (ringing sound) -- should I  
6 keep going? I don't know what that is.

7 Q. Yes, most of them are what? You can finish  
8 your thought.

9 A. Most of the requests have to do with  
10 accommodation in the workplace.

11 Q. And what percentage of your time would you  
12 say is done providing medical legal liaison work versus  
13 actual treating work?

14 A. Good question. In the last year or so, I  
15 have been quite disabled physically from being able to work  
16 until I had surgery, so I'm kind of working this out in my  
17 head. I would think that medical legal -- the question was  
18 what percentage would be medical legal?

19 Q. Yes, sir.

20 A. Of my time, 20 percent maybe.

21 Q. And the other 80 percent is spent treating  
22 patients?

23 A. No. A lot of it is working -- I'm on a task  
24 force for the Ministry of Health and Long Term Care, so a



1 lot of it has to do with that.

2 Q. Okay and we'll get to that and I appreciate  
3 that. But in comparison, what percentage of your time is  
4 spent providing medical legal reports versus actual  
5 treatment to patients in the capacity of a treating  
6 physician?

7 A. If you add up the two to be a hundred  
8 percent?

9 Q. Yes.

10 A. I'm guessing 33 percent.

11 Q. And you indicated that in this role people  
12 call requesting accommodations for the workplace; is that  
13 correct?

14 A. Yes.

15 Q. Are these calls only from residents of  
16 Toronto?

17 A. No. The clinic itself is a provincial  
18 clinic. It's the only one of its kind in the province and  
19 given that I spent most of my life and my career living in  
20 Ottawa, which is on the border of the province of Quebec,  
21 it's probably an hour and a half from Montreal, I get  
22 requests from people from Quebec as well. Not through the  
23 hospital. The hospital is only mandated to see people from  
24 Ontario. It's the politics.

1 Q. Do you ever get calls from people requesting  
2 accommodations in other countries?

3 A. No.

4 Q. Have you ever provided legal or a medical  
5 opinion regarding an accommodation to a person in another  
6 country?

7 A. No.

8 Q. And you mentioned that you were on a task  
9 force. What is the task force?

10 A. The task force was formed by the Ministry of  
11 Health and Long Term Care. Let's refer to it as Ministry  
12 of Health because it's faster. But it was formed after  
13 receiving a proposal which they funded for a Centre of  
14 Excellence for Environmental Health.

15 Q. Who was they?

16 A. Pardon?

17 Q. Who was they? Who funded a Centre for  
18 Excellence?

19 A. The Ministry of Health.

20 Q. And when was that established? When was the  
21 Centre for Excellence in Environmental Health established?

22 A. Oh, we don't have a Centre of Excellence.

23 Q. Okay.

24 A. There was a consideration for a Centre of

1 Excellence. The Ministry funded a business case proposal.  
2 I actually wrote the medical model for it. It's called  
3 Academic and Clinical Perspectives as to what that would  
4 look like.

5 As a result the Ministry formed a task force to  
6 consider the possibilities of creating a Centre of  
7 Excellence. It was basically what drove all this was the  
8 recognized need that the patients with chronic fatigue  
9 syndrome, fibromyalgia and chemical sensitivity, their  
10 medical needs were not being met, that they were an expense  
11 to the healthcare system and their care and management  
12 needed improvement.

13 Q. And is multiple chemical sensitivity a  
14 recognized disease under the ICD-10?

15 A. It doesn't have its own -- we don't use the  
16 ICD-10 here. So I'm telling you is what I think I know,  
17 which is that it doesn't have its own spot for lack of  
18 another word. But the ICD-10 billing system -- or not  
19 billing system -- coding system, there are apparently a  
20 couple of codes that can be used to document it. And those  
21 numbers I can't tell you offhand. I would have to look  
22 them up, because we don't use it.

23 Q. What else does the task force do?

24 A. The task force has three working groups and I

1 am a member of all three. So there's a working group  
2 looking at education. It's education for the public,  
3 education for medical people, education for paramedical  
4 people, social workers, etc., a support system for medical  
5 people. So there's education. There's research, what  
6 research would be recommended, what would need to be done.  
7 And the third group is, give me a second here. Care, care  
8 working group, how to improve care.

9 Q. And this is care for MCS, fibro and CFS  
10 patients; is that correct?

11 A. Yes.

12 Q. So is it fair to say that the center  
13 advocates for people with these disabilities?

14 A. There is no center. Sorry, are you talking  
15 about the task force?

16 Q. Yes, I'm sorry, the task force.

17 A. I think advocate is not the right word. I  
18 think what the task force is doing is looking at the issues  
19 because the -- more research is required, better care is  
20 required, and a better understanding within the community  
21 as to what these conditions entail, how to diagnose and how  
22 to manage these patients that needs to be done. So the  
23 task force is looking at how to improve the situation.  
24 It's not an efficacy. The information is going to the

1 government as government's request and the government has  
2 representation on the task force.

3 Q. And when was the task force established?

4 A. Twenty-sixteen, I think.

5 Q. And when did you start working for them?

6 A. Twenty-sixteen.

7 Q. And do you have a title with the task force?

8 A. Clinician representative, I guess, if there's  
9 a title. When they had spots open for different types of  
10 representation and there are two spots on the task force  
11 for clinicians.

12 Q. You mentioned that the task force also  
13 performs research into these ---

14 A. No. What I said was it's making  
15 recommendations for research.

16 Q. Okay and what recommendations is it making  
17 for research into ---

18 A. Well -- sorry, I ---

19 Q. We'll start with MCS.

20 A. I interrupted you. Give me the question  
21 again.

22 Q. What recommendations is the task force making  
23 for research into MCS?

24 A. Well, before the recommendations are made,

1 the task force has a three-year mandate and so we're just  
2 completing the second year and so before there's any  
3 suggestions for recommendations, the task force has been  
4 trying to identify gaps. What's missing? Before you can  
5 make recommendations, you need to know what needs to be  
6 done.

7 Q. So gaps in the science surrounding MCS?

8 A. Yes.

9 Q. Okay and same question, gaps in the science  
10 surrounding fibromyalgia?

11 A. And chronic fatigue syndrome, yes.

12 Q. Could a recommendation of the task force be  
13 that peer-reviewed studies are done on MCS?

14 A. Well, any, you know, peer review is not --  
15 you don't do a peer-review study. You do a study and if  
16 you want to get it published, it needs to be peer-reviewed.

17 Q. Okay.

18 A. So the task force will not do research. The  
19 task force will recommend what research should be done.  
20 I'm not sure how specific it will be. It may be more in  
21 general terms. The research that needs to be done, the  
22 task force will be trying to help the government, motivate  
23 the research to be done to encourage it. The government  
24 itself does not actually do research.

1 Q. Was the task force created because more  
2 research is needed on these diseases?

3 A. I think what started -- what generated the  
4 movement was the patients with these conditions reaching  
5 out to the government to provide better care.

6 Q. Okay and how do you know that? How do you  
7 know that's what started it?

8 A. How do I know that? I just know it. I have  
9 no idea how I know that. It's just kind of common  
10 knowledge within the task force.

11 Q. Do you see patients with MCS?

12 A. Yes.

13 Q. How many do you presently see?

14 A. I mean, it's hard to give you a number given  
15 the changes in the hours that I have practiced over the  
16 last couple of years. Up until 2014, I had a practice in  
17 Ottawa. I relocated to Toronto actually in 2007 and  
18 started to work part-time at Women's College Hospital and I  
19 would go back to Ottawa for at least a week every month to  
20 maintain that practice. So when the practice -- so over  
21 the years I have seen thousands of patients with MCS. When  
22 I would --

23 Q. Do you still have your ---

24 A. Sorry?

1 Q. Go ahead. You can finish.

2 A. Now I forgot what I was going to say. You're  
3 probably aware and if you're not, I wrote a book. The book  
4 has 2,200 citations. It's called "12,000 Canaries Can't Be  
5 Wrong." These patients refer to themselves as the  
6 proverbial canaries in the coal mine. And we did a  
7 calculation of the number of patients that I have seen with  
8 likely one or more of these three conditions since I began  
9 my practice in this area. Given that my practice was by  
10 referral only and the calculation came to about 12,000  
11 patients that I had assessed by the time I wrote the book  
12 which was in 2013. It's a long convoluted way of saying  
13 I've seen thousands of these patients.

14 Q. Do you still have your practice in Ottawa?

15 A. No. I closed it at the end of 2014.

16 Q. And why was that?

17 A. Because it became physically too hard. I  
18 mean, if you want my story of my back, I should have had my  
19 surgery two years ago. I live in a different country than  
20 you. It's a little harder to get things done. There are  
21 waiting lists. But I have had nerve damage in my legs that  
22 was identified at least two years ago. So I just could not  
23 sit. Happily I can sit in these chairs right now. The  
24 surgery was successful.



1           Q. Great, thank you. I'm glad to hear that and  
2 I appreciate that. If you need a break, stretch your legs,  
3 feel free to ---

4           A. I'm good.

5           Q. --- let me know.

6           A. I will. Thank you.

7           Q. Okay. Did you see other kinds of patients at  
8 your clinic besides MCS patients?

9           A. Yes. Chronic fatigue syndrome, fibromyalgia,  
10 people claiming or -- claiming would not be a right word,  
11 but thinking that they may have had sensitivities to things  
12 in the environment whether it was foods or scented  
13 products, chemical products. Multiple chemical sensitivity  
14 implies multiple.

15           Q. Anything else besides working at the Women's  
16 College Hospital and on the task force and serving as a  
17 medical liaison? Any other job duties presently?

18           A. Given that I have done many of these, I guess  
19 I have a reputation in the legal community that -- I'm sure  
20 you're quite aware of how this works -- that there are some  
21 firms that will tend to reach out to me, not through the  
22 hospital, to provide opinion.

23           Q. And is that mostly for patients in the  
24 capacity of being asked to provide an opinion, is that

1 mostly in the capacity of plaintiffs in these cases of  
2 patients who are claiming need for accommodation?

3 A. Mostly. On occasion, a small percentage will  
4 come from the insurance company.

5 Q. And how many times have you testified? When  
6 it comes from an insurance company, is that in a defendant  
7 posture?

8 A. Yes.

9 Q. How many times have you testified as a  
10 defence medical expert?

11 A. Testified in court?

12 Q. Yes, start with ---

13 A. Or giving an opinion?

14 Q. Why don't we start with testifying in court?

15 A. None.

16 Q. Okay and how about giving an opinion?

17 A. I can remember a couple of cases. In the  
18 last 10 years, I've probably had a hundred, provided a  
19 hundred reports.

20 Q. Same question with respect to serving as a  
21 plaintiff's medical expert?

22 A. Sorry?

23 Q. How many times have you testified? Okay.  
24 How many times have you testified in court as a plaintiff's

1 medical expert?

2 A. Maybe a dozen, maybe a bit more. I'm not  
3 sure.

4 Q. And how many times have you testified as a  
5 treating physician for an MCS patient?

6 A. So help me out here. As a treating  
7 physician, I understand that as a treating physician is  
8 you're a different level of witness that you're not  
9 providing your expert opinion as to cause and effect and so  
10 on? Do I have that right?

11 Q. Yes, sure, so my question is, you've  
12 indicated that in certain instances you've been retained  
13 specifically for medical opinion surrounding litigation,  
14 correct?

15 A. M'hmm.

16 Q. You've not seen the patient before that time;  
17 is that correct?

18 A. Yes.

19 Q. Yes. For patients that you treat  
20 consistently for their MCS, CFS or fibro, where you see  
21 them regularly and administer treatment to them, have you  
22 ever testified in a court proceeding in that capacity?

23 A. A couple of times, yes.

24 Q. And do you recall when that was?

1 A. When?

2 Q. Yes. Just approximate is fine.

3 A. Can't really recall exactly when. Sometimes  
4 these cases are maybe worker's compensation cases and so  
5 on, but I can't tell you when approximately.

6 Q. Do you remember where the cases were pending?

7 A. Probably Ottawa.

8 Q. And when you testified on behalf of these  
9 patients, how long had you been treating them for?

10 A. You're asking tough questions, because I'm  
11 trying to remember who the patients were. Probably not  
12 long, because I was attempting to, or I had seen them  
13 because they had been referred by their family doctor or  
14 whoever the managing physician was about the particular  
15 problem. So I was not their ongoing treating physician  
16 with respect to these particular conditions. I was helping  
17 them manage. I was not their primary treating physician  
18 often.

19 Q. And what you mean by helping them manage?

20 A. Well, you look at something like chronic  
21 fatigue syndrome and there is no treatment except for  
22 managing their energy so it's trying to teach them how to  
23 do that. They go home and live their lives with a limited  
24 amount of energy. So you try and teach them how to manage

1       it, try and teach them, give them ideas to problem solve.

2               When you have something like that fibromyalgia,  
3       there are treatments that can be suggested that they can go  
4       and get on their own or they can try medications. So I  
5       prescribe medications for them and have them come back, so  
6       -- but those patients, we're treating them.

7               People with chemical sensitivities, the treatment  
8       is environmental control and avoiding. So unless they're  
9       complicated by some other condition, that's the treatment.  
10      So if it's complicated by one of the other conditions,  
11      there's a bit more involvement in managing and suggesting.  
12      Now that I am at Women's College Hospital, we makes  
13      suggestions to the referring physician with respect to  
14      management and treatment rather than do it on our own,  
15      because we're limited to two follow-up appointments per  
16      year.

17              Q. Why are you limited to two follow-up  
18      appointments per year?

19              A. The clinic is funded for eight-tenths of a  
20      doctor, which how you get eight-tenths of a doctor is there  
21      is one doctor there four days out of five. So that's why  
22      there are four of us and we're all working part-time within  
23      that clinic.

24              The waiting time presently is a year just to get

1 in. And we try and triage the referrals in order to try  
2 and keep some kind of control on that. So clearly it is an  
3 undermanned, underfunded clinic which is one of the things  
4 that drove the government to say, well, we have to do  
5 something about this. What are we going to create in its  
6 place?

7 Q. So if you had, say, cancer, would you be  
8 limited to follow-up appointments or is that just  
9 characteristic of patients with MCS, CFS and fibro?

10 A. It's characteristic of this clinic. This  
11 clinic is a -- it's mandated as a provincial clinic which  
12 means that patients who can be referred from anywhere in  
13 the province for an assessment or an opinion.

14 Canada tries to -- tries to, for example, we have  
15 a cancer hospital. I'm sure you have cancer hospitals in  
16 Ohio as well. But it draws from a much larger area. So we  
17 have a much greater, I guess, control with respect to  
18 administration of healthcare through government than you do  
19 in the States. As I'm sure you've heard. We have a  
20 different model. So with respect to these three  
21 conditions, there are a few doctors scattered around  
22 Ontario with a skill set that they have learned to try and  
23 manage these patients. But it's lacking. Education in  
24 this area is lacking. How to manage these patients as part

1 of an education process is lacking. And so the government  
2 is looking to step in to try and motivate that change. For  
3 example, they are now funding a third year family practice  
4 residence training program at our clinic. Family practice  
5 is usually two years post-graduate to get your  
6 certification. Some family physicians choose to do a third  
7 year. Often it gives them a specialized training for  
8 emergency care or palliative care and we have a program now  
9 that's funded by the Ministry to try and train doctors in  
10 environmental health.

11 Q. You mentioned something about MCS, the only  
12 treatments are, what you indicated are environmental  
13 control and avoidance; is that correct?

14 A. With respect to the actual problem of being  
15 sensitive to chemicals, the only treatment we have is to  
16 try and avoid contact. We don't have a treatment to  
17 desensitize, we don't have a treatment to turn the  
18 condition off. Like most chronic medical conditions, they  
19 are frequently co-morbid with other conditions more often  
20 than not, so part of the treatment then or management of  
21 these patients would be to try and manage these other  
22 conditions if they're influencing the severity and  
23 disability of chemical sensitivities.

24 Q. How is MCS diagnosed?

1 A. Pardon? I didn't hear you.

2 Q. How is MCS, how is multiple chemical  
3 sensitivity diagnosed?

4 A. It's diagnosed by the history and the history  
5 is somewhat complex. Simply put, you start with trying to  
6 meet the criteria for the diagnosis which is that symptoms  
7 are multisystem, most often involving the brain that are  
8 provoked or aggravated by exposures to chemicals that used  
9 to be tolerated in the environment that are tolerated by  
10 other people and symptoms are reduced when they're avoided.  
11 Multiple system organs I think I've mentioned that already.  
12 So you see that as the criteria for the diagnosis, but ---

13 Q. So when you say that history, Doctor, the  
14 history is the subjective criteria as relayed by the  
15 patient; is that correct?

16 A. That's right.

17 Q. Okay.

18 A. So part of that, of course, is to -- there's  
19 a pattern to these patients that is common. Usually  
20 middle- aged women. They have multiple system complaints.  
21 The brain is the most common system involved. We usually  
22 see complaints of pain, fatigue, poor cognition, mood  
23 change. Tied for second place are probably respiratory  
24 and/or gastrointestinal complaints. To start to see a



1 pattern. And respiratory complaints may -- will include  
2 both upper and lower respiratory system. Upper  
3 respiratory, possibly, probably partially explained by  
4 allergy. Allergies are more common. I'm talking about  
5 classical allergy. These patients will also complain of  
6 lower respiratory symptoms. So asthma is more common. So  
7 you start to identify patterns.

8 Q. Is there an objective analysis that can be  
9 performed for multiple chemical sensitivity? Does blood  
10 work show multiple chemical sensitivity?

11 A. No. There are no blood tests that will  
12 demonstrate chemical sensitivity. There are no clinical  
13 tests. So it's one of those conditions which is made by  
14 making sure there is no other biological phenomena that  
15 could explain these symptoms and -- but like I said, there  
16 are no biological markers.

17 Q. Okay. Doctor, we've talked a lot about your  
18 experience as an expert. When giving expert testimony, is  
19 it primarily for MCS patients or is it more for fibro or  
20 CFS patients?

21 A. I think the least of the three is fibro. I  
22 would say MCS and chronic fatigue syndrome are probably  
23 equal.

24 Q. And have you ever been disqualified as an

1 expert?

2 A. Not yet. That was -- thank you for smiling.  
3 It was meant to be humorous.

4 Q. Have you ever had your testimony excluded as  
5 an expert?

6 A. No.

7 Q. Any like a portion of it excluded?

8 A. No.

9 Q. And have you ever given expert testimony in a  
10 case in the United States?

11 A. No.

12 Q. Ever given expert testimony anywhere other  
13 than Canada?

14 A. No.

15 Q. Are you being compensated for your time  
16 today?

17 A. Am I being compensated for my time?

18 Q. Yes?

19 A. Yes.

20 Q. And what is the rate you're being compensated  
21 at?

22 A. Four hundred dollars Canadian per hour.

23 Q. Total or per ---

24 A. Per hour.

1 Q. --- per hour?

2 A. Yes.

3 Q. And is that the amount that you were  
4 compensated in the rendering of your report regarding Ms.  
5 Madej?

6 A. Yes.

7 Q. And is that the amount that you were  
8 compensated regarding the medical evaluation of Ms. Madej?

9 A. Yes.

10 Q. Doctor, how did you come to meet Cynthia  
11 Madej?

12 A. I was approached by her attorney, Sky Pettey.  
13 I -- by e-mail, I think. I have a website that has an e-  
14 mail address on it. I think that's, the first contact was  
15 by e-mail. In fact, I'm pretty sure.

16 Q. Did Mr. Pettey tell you how he came to meet  
17 you? How he came to reach out to you, know about you?

18 MR. KHAN: Objection to the extent the  
19 information is protected by attorney-client  
20 privilege. You can answer, Dr. Molot.

21 A. And the question was do I know how he found  
22 me?

23 Q. Yes.

24 A. No. I recall because I was surprised that I

1 got asked from outside the country. And what I recall is  
2 he made some kind of comment like, well, we did our  
3 homework and looked around.

4 Q. Do you recall when approximately that was?

5 A. Before I did the assessment, obviously.  
6 Exactly when, no, I don't recall.

7 Q. Have you ever talked with a Dr. Lieberman  
8 regarding Ms. Madej?

9 A. No.

10 Q. Do you know who Dr. Lieberman is?

11 A. Yes. He is a member of the American Academy  
12 in Environmental Medicine. I have attended annual  
13 scientific seminars. He has given lectures at these  
14 conferences and I think I sat at the same table having  
15 dinner with some other physicians, so met him personally.  
16 I don't remember when that was. It could have been 12  
17 years ago, 15 years ago that I met him that one time on a  
18 personal level.

19 Q. And have you ever talked with a Dr. Barbara  
20 Singer regarding Ms. Madej?

21 A. No.

22 Q. Have you ever met or talked with Dr. Singer?

23 A. No.

24 Q. Have you ever talked with any other

1 physicians regarding Ms. Madej?

2 A. No.

3 Q. Presently, how many patients do you have that  
4 you are treating for MCS?

5 A. Presently, I have not worked since the end of  
6 November.

7 Q. And I'm sorry, Doctor, I apologize. I know  
8 you had some ill health.

9 A. Well, the reason I said that is that from a  
10 clinical practice point of view, I was part-time at the  
11 clinic and most of what is done with chemical sensitivities  
12 is if the diagnosis is made, the reports that we send back  
13 are usually quite lengthy, back to the referring physician,  
14 so they're three to five or six pages. So part of that,  
15 the process there is to try and educate the referring  
16 physician as to how to manage the patient. So when we talk  
17 about ongoing patients, I don't know, but it would be a  
18 very small number right now.

19 Q. Do you treat when them in person? Do you  
20 treat them in person?

21 A. Yes. Occasionally -- you know, our country  
22 is bigger than yours as far as landmass is concerned, but  
23 we're only ten provinces, so we're, you know, Ontario is  
24 huge, goes all the way up to Hudson Bay. So occasionally

1 we will do a follow-up through Tele-Network, like you and I  
2 are doing, close circuit.

3 Q. Did you ever treat with them via e-mail?

4 A. Do I ever treat? Sorry, I didn't hear you.

5 Q. Via e-mail, electronic mail?

6 A. No.

7 Q. Ever treat via snail mail, mailing?

8 A. No. I think treatment of patients, for me  
9 anyway, that way is too difficult. I know there are  
10 doctors that do that. I think I would be inundated with  
11 attempts to message. I find e-mail ---

12 Q. So when someone -- sure ---

13 A. I find it annoying enough now without having  
14 to do it professionally as well.

15 Q. Sure. In your role as a medical legal  
16 liaison, you testified that you'll give recommendations  
17 regarding accommodations; is that correct?

18 A. Yes.

19 Q. Okay and how is that administered? Do you  
20 evaluate the patient in person and then provide that  
21 accommodation?

22 A. Yes. Well, we provide recommendations for  
23 accommodation and unfortunately with these patients, it's  
24 less black-and-white than, for example, with the physical

1       disability that I had, I could only walk five minutes. I  
2       could only sit for a very short period of time in a certain  
3       chair. So the accommodation for me was get the right  
4       chair. I brought my own chair in. You know, sometimes  
5       it's very obvious.

6               When it comes to the patients that we see  
7       primarily with chronic fatigue syndrome and chemical  
8       sensitivity, it's working with the patient to what we think  
9       will work, working with the employer to see if the  
10      recommendations will work and then trying it out. And  
11      almost every time when I give a written proposal for  
12      accommodation, I write that this is at least, in part,  
13      trial and error and it is hoped that the two sides can work  
14      with respect towards trying to find the solution to the  
15      problem so ---

16             Q. And we can agree that the patient is only  
17      entitled to an accommodation insofar as it will alleviate  
18      their symptoms, correct?

19             A. No. I think my perception is that so that  
20      they're able to do their job properly. You know, if you  
21      have a headache, I'm sure you've had them, I'm not sure.  
22      You probably had a headache at work, me too, and sometimes  
23      you take a Tylenol and it makes the pain go away and you  
24      continue to work.

1           An example in this case would be, if you have  
2           chemical sensitivities, one of the possibilities to protect  
3           you is to wear a mask, an appropriate mask that would  
4           filter out the chemicals enough that there would be no  
5           symptoms. Do we recommend that for the workplace? No,  
6           because it's to be wearing it eight hours a day, five days  
7           a week, is extremely uncomfortable and fraught with all  
8           kinds of difficulties.

9           So it's again making an assessment of what would  
10          likely work, especially given the job description, the  
11          location of the job, the ability to provide a clean enough  
12          environment for patients, for example, with chemical  
13          sensitivities. There has been -- there's been occasional  
14          attempts to accommodate people with fibromyalgia by making  
15          recommendations that they're able to get up and move more.  
16          That they're given extended time, that they're given more  
17          time in the morning to prepare for work, so that their  
18          hours change, that maybe they won't start till 10 in the  
19          morning, rather than at 8. So it's all about trying to  
20          make it work, but there's no cookie-cutter advice.

21                 Can you see me if I stand up?

22                 Q. Yes. We can take a break now. That's fine.  
23                 I'd like to take a short break right now.

24                 A. Okay.



1 Q. So we're off the record for five minutes.

2 (A short recess is taken.)

3 Q. I'll go ask the court reporter to mark as  
4 Exhibit 1, the document that says at the top, Dr. John  
5 Molot, MD, CCFPD, SCFP, CV dated February of 2017.

6 Dr. Molot, the court reporter has just handed  
7 what I'll represent as your CV. Do you recognize this  
8 document?

9 A. Yes.

10 Q. Okay and are there any updates to this  
11 document? It's dated a little over a year ago at this  
12 point.

13 A. Are there any updates? I don't think there's  
14 anything of significance.

15 Q. Okay and you are a medical doctor, correct,  
16 Dr. Molot?

17 A. Yes.

18 Q. And are you board-certified in anything?

19 A. No.

20 Q. Environmental medicine is not a recognized  
21 board certification, correct?

22 A. Correct.

23 Q. And Doctor, you mentioned this already, but  
24 have you authored any other publications regarding MCS that

1       you told me about, the "12,000 Canaries" one. Are there  
2       any others that you've authored?

3               A. The one I told -- the other one I told you  
4       about is called the Academic and Clinical Perspectives  
5       which was the paper prepared for the Ministry of Health  
6       which led to the formation of the task force.

7               Q. Okay and tell me, that paper, was that about  
8       advocating for a task force to study these various  
9       illnesses?

10              A. No. I was asked to put together a model for  
11      a Centre of Excellence for Environmental Health from an  
12      academic and clinical perspective, obviously, as to if we  
13      had one, what would it look like and why would it be  
14      necessary, why is it necessary.

15              Q. And did that involve any clinical testing?  
16      Is there any clinical testing mentioned in that paper?

17              A. I think it was more if you have a Centre of  
18      Excellence, it provides the best known care together with  
19      being involved in research. And so there were  
20      recommendations for how to provide more care.

21              And so we kind of broke it down into three  
22      levels. There is the care for these three conditions that  
23      is presently recommended. There is care for patients where  
24      there is some level of evidence that this could be

1       beneficial, that we would be able to do it under case-  
2       control situations, and then there was suggestions for  
3       recommendations that would require it be under the research  
4       auspices purely which means getting it passed through  
5       medical effects, etc., etc., so kind of three levels to be  
6       able to then gather the statistics for the different things  
7       that we're doing, come up with ideas of how to measure  
8       responses and so part of it is to be able to provide more  
9       care and to examine the care that we are providing under  
10      those different levels to see what's beneficial and what's  
11      not.

12               Q.   So again there's no clinical testing that's  
13      been submitted with this paper, there's no studies or  
14      objective data?

15               A.   Well, there was 1,100 citations in that  
16      paper.

17               Q.   I fully appreciate that.

18               A.   So what was the question or statement you  
19      made? There was?

20               Q.   Is there any clinical testing reported in  
21      this paper regarding MCS?

22               A.   There were a couple recommendations -- I was  
23      going to go like this -- but you can't write that, with  
24      quotes around it. For example, it would be useful to see

1       whether or not challenge testing with capsaicin could be  
2       used as a clinical marker for the diagnosis would be --  
3       would we be able establish cutoff points that would be  
4       useful enough to establish as a diagnosis. That's an  
5       example of a recommendation for looking for clinical  
6       markers.

7               Q. Okay. That was a recommendation. There  
8       aren't any reported studies looking for clinical markers in  
9       the paper, correct?

10              A. Well, there's -- again, just looking at  
11       capsaicin inhalation, there are numerous papers showing  
12       that it separates patients from controls and that there may  
13       be a cutoff line that has been suggested by the people who  
14       have done the research in that area.

15              Q. Are you aware of any clinical studies done  
16       using capsaicin?

17              A. No, just research. I mean, I'm not sure what  
18       you mean by clinical studies is looking at -- how would you  
19       define what it is that you're calling a clinical study?

20              Q. Sure. Any testing done on a control group  
21       versus on a variable group? How many patients were in that  
22       study? When was the study conducted?

23              A. Well, there are 16 of those published that I  
24       know of just on that particular tool of capsaicin

1 inhalation challenge. That there's a difference in the  
2 identified patients versus controls. I mean, a clinical  
3 study to me implies that you're doing a study in a clinical  
4 setting to measure an outcome. So that's why I was a bit  
5 confused by your question.

6 Q. Was your article regarding Academic and  
7 Clinical Perspectives, was it peer-reviewed?

8 A. The way this worked was there was a steering  
9 committee and there was a medical advisory committee of  
10 five other doctors that I reported to regularly, so that  
11 when it was submitted, it got submitted to the Ministry of  
12 Health and so they reviewed their medical people or their  
13 medical expert people reviewed the paper before making  
14 recommendations to the Minister. You know, that's not your  
15 sort of typical peer review where it's sent out.

16 Q. Right. This was almost like a grant request,  
17 correct? To establish the task force.

18 A. Yes.

19 Q. Okay. It was a grant. All right. And same  
20 question with respect to the "12,000 Canaries Can't Be  
21 Wrong" book, was that peer-reviewed?

22 A. No. That was my book.

23 Q. Who published that book?

24 A. Good question. Now I cannot remember the

1 name of the publishing company. It's a publishing company  
2 here in Toronto and it was actually managed by my wife.

3 Q. Okay. If we can go to page 3 of your CV  
4 here, Doctor? And this is in the category called  
5 Presentations and Special Lectures and I see that you've  
6 indicated as of February 15, 2017, there's a statement  
7 called, "Accommodations for people with chronic complex and  
8 environmentally linked conditions in long-term care homes,  
9 the enhanced long-term care home renewal strategy design  
10 working group, Ministry of Health and Long Term Care."  
11 Where did you -- is this is a presentation?

12 A. Yes.

13 Q. Okay. Where did you present this?

14 A. In one of the Ministry of Health's buildings  
15 in Toronto.

16 Q. Okay. Thank you and who did you present it  
17 to?

18 A. One of the other projects that the Ministry  
19 of Health is doing apparently is looking at providing more  
20 housing and especially long term care for the elderly,  
21 because clearly our demographic is shifting so that the  
22 largest part of the population, the baby boomers is getting  
23 older. And so they're looking at, how are we going to meet  
24 the needs of these people as they continue to require more

1 long term care, special housing, etc.? So with that group  
2 invited, I presume, through the workings of the Ministry to  
3 have our task force present to them that there are people  
4 with special needs primarily chemical sensitivities, but  
5 also people with fibromyalgia and chronic fatigue syndrome  
6 who are also going to be elderly.

7 Presently the most prevalent group in the  
8 population is women in their middle 50s, so obviously over  
9 the next 20 years, they were going to be in their middle  
10 70s with no expectation that they're going to die sooner  
11 more than anybody else. As a result, will there be an  
12 understanding for accommodating these people? Primarily  
13 with respect to chemical sensitivities to be able to  
14 provide an appropriate indoor air quality with guidelines  
15 for accommodation already in place.

16 Q. Do MCS, fibro and CFS always go together?

17 A. Say that again? Do what?

18 Q. Do multiple chemical sensitivity,  
19 fibromyalgia and chronic fatigue syndrome always present  
20 together?

21 A. No. They don't always present together. But  
22 they are -- if you have one of those conditions, you're  
23 statistically more likely to have one or both of the other  
24 two.

1 Q. And where are those statistics?

2 A. In the literature.

3 Q. What literature?

4 A. Published in medical literature.

5 Q. What's it called?

6 A. I can't tell you offhand. You can look at  
7 prevalent studies within, for example in Canada, we have  
8 and in particular, in Ontario, we've looked at prevalent  
9 studies of how many people in the population have been  
10 diagnosed, doctor-diagnosed with one of these three  
11 conditions and the statistics clearly show that they are  
12 statistically more likely to have more than one.

13 Q. Okay and again, you can't name any of those  
14 statistics offhand, correct? Any of those?

15 A. I can't what? I'm sorry, I didn't ---

16 Q. You can't name any of those studies offhand,  
17 correct?

18 A. Well, they're prevalent studies. You know,  
19 I'd have to look them up. I mean, I think one of the  
20 problems is that there's a lot of literature scattered all  
21 over the place and I do not have on the tip of my fingers  
22 the names of all these papers.

23 Q. And Ms. Madej, in her case, she has all  
24 three, correct?



1                   A. Yes.

2                   Q. And is it her CFS that requires the  
3 accommodation of not using chip and seal on the road? Is  
4 it her fibro or is it her MCS?

5                   A. It's primarily her MCS. What you need to  
6 understand with respect to that question is that when you  
7 have more than one medical condition which is statistically  
8 the norm with chronic disease, then there's a good chance  
9 that when one of them flares, it has an influence on the  
10 other, because they're biologically linked, especially  
11 these three conditions.

12                  Q. Okay and how are they -- I think you  
13 previously testified that there are no biological markers  
14 for MCS; is that correct?

15                  A. Yes.

16                  Q. Okay. So how do you know that CFS and fibro  
17 and MCS are biologically linked?

18                  A. A biological marker means that you have a --  
19 something that you can measure that is sensitive and  
20 specific enough that it can help you to make a diagnosis.  
21 So some of them are really obvious. If you have a broken  
22 bone and you take an x-ray and you see that bone split in  
23 two, that's a real obvious biological marker. It's very,  
24 very sensitive and very, very specific. We don't have

1       those for these conditions. There's other conditions that  
2       we don't have them for either. But in research papers, we  
3       try and with respect to these three conditions, try and  
4       understand, well, what's wrong? Once we can see,  
5       understand what's wrong, then we can start searching for a  
6       marker that we can make, even make available clinically.

7               This is all a process over time. So to say  
8       there's no biological markers means that, to me, it means  
9       that we do not have a test that we can do clinically that  
10      identifies these patients statistically, significantly  
11      enough to help us make the diagnosis. But we do know that  
12      there are physiological, pathophysiological mechanisms  
13      involved in these three conditions that are linked. Areas  
14      of the brain that are malfunctioning are linked.

15             Q. Okay. And again.

16             A. Pardon?

17             Q. Just one second. It was loud here.

18             A. Sorry.

19             Q. What evidence do you have that these  
20      pathophysical[sic] conditions are linked?

21             A. What evidence? All three conditions show  
22      dysfunction within the limbic system of the brain.

23             Q. How do you know that? Have you administered  
24      brain scans to these patients?

1           A. You mean the population at large? Because  
2 me, no, I'm a clinician. And if you do -- you do patient  
3 versus controls and you look at things such as brain scans.

4           Q. That's fine. Did you administer a brain scan  
5 to Ms. Madej?

6           A. No. It was not indicated. I think ---

7           Q. So she had no evidence of limbic system  
8 issues within ---

9           A. Here's the problem. It's not a biological  
10 marker. I would do that and it would be normal. It's like  
11 if I stand up right now and you look at me, hopefully you  
12 would think I look normal, but I'm actually only five-foot-  
13 three. So in a room with 99 other men, I would be the  
14 short guy sitting at the front for the pictures.

15           So what the point of that is, is that when you do  
16 things in research, cases versus controls is to see is  
17 there a difference between the two groups? And what the  
18 literature shows is that the limbic system functions  
19 differently in these -- with these people -- in people with  
20 these three conditions compared to control groups.

21           Q. Okay and I understand the research shows  
22 that, but in order to evaluate if the limbic system was  
23 functioning difficulty, would you require a brain scan to  
24 show that or no?

1           A. Clinically? No. It won't show us anything.  
2       Just like ---

3           Q. What would -- how do you demonstrate that the  
4       limbic system is working incorrectly? Is it a subjective  
5       report from the patient?

6           A. No. Nobody has ever come to my office to say  
7       I think my limbic system is not functioning properly. They  
8       probably never even heard of it. But you'd look for things  
9       such as chronic pain, disturbed sleep, cognitive  
10      complaints, sensory hypersensitivity. Pain being an  
11      example, odour being an example, light sensitive, so  
12      sensory sensitivity. The limbic system is a system that  
13      takes information from your internal and your external  
14      environment and gets the body to respond accordingly. If  
15      it's hot outside, you feel the temperature on your skin, it  
16      goes to the limbic system. The limbic system then tells  
17      your skin to sweat. So there's a whole mechanism in there.

18          Q. So is it your testimony that there is no  
19      biological marker for determining that the limbic system is  
20      functioning inappropriately? There's no way to measure  
21      that with a biological marker, other than the subjective  
22      report of chronic pain?

23          A. For function, yeah. If you're looking for  
24      pure pathology, because you're suspicious of a tumour or

1 damage from a stroke, then of course you do a scan to look  
2 for measurable damage. But with respect to these  
3 conditions, that's not a useful marker clinically.

4 Q. Okay. Thank you. How many patients have you  
5 recommended that they not be exposed to asphalt?

6 A. How many have I recommended? I have had the  
7 occasional patient with multiple chemical sensitivity where  
8 we have attempted to accommodate them when the roof of the  
9 building where they're working might be, is being repaired  
10 through tarring, or if there is road work going on outside  
11 their workplace.

12 Q. Okay. When were those cases?

13 A. I don't recall. And no one's ever even asked  
14 me that question before today about how many times have I  
15 recommended it. That's not a very common happening. What  
16 is common, is that patients with chemical sensitivities  
17 will clinically report that the odours that they perceive  
18 coming from asphalt trigger symptoms. That's common.

19 Q. And is there a certain distance that these  
20 patients need to be away from the asphalt?

21 Do you ever  
22 make a recommendation regarding that?

23 A. No. It's based on the patient's experience  
24 and it's not -- the level of sensitivity will vary from

1       whether or not the sensitivity is mild, moderate or severe.  
2       And the level will also vary according to other factors  
3       which can influence level of sensitivity such as repeated  
4       exposure, repeated exposures to other triggering factors  
5       which will -- which seems to stimulate the level of  
6       sensitivity and make it worse. So it's really variable.  
7       It's a clinical -- it's a clinical decision making process.

8               Q. How do you control for -- how do you control  
9       for the other variables and determine that it's asphalt in  
10      patients that are exquisitely sensitive?

11             A. How do you control for that? You know,  
12      patients make their observations based on, I smelled this  
13      and it makes me sick. And that's all we have.

14             Q. That's the only way you control for other  
15      stimuli that might be making them sick, their own  
16      subjective observations can factor ---

17             A. Well, you can ask questions as to what else  
18      is out there and what else are you observing? Observing  
19      through the sense of smell. Not through, gee, I think I  
20      see this and so on. Patients sometimes come in with their  
21      theories. But it's about can you smell it and does it make  
22      you sick?

23             Q. Do you always charge your patients for your  
24      time in rendering legal medical opinions?

1           A. Do I always? There's a bill sent out. I  
2       have done some cases for much lower fees through legal aid.  
3       I don't know if you have and what legal aid is, whether  
4       there's an equivalent in the States. People who are on  
5       minimal incomes can go to legal offices that are funded by  
6       the Ministry. I don't know which Ministry they're funded  
7       by. But they're funded by the government in order to  
8       provide the legal representation for people who cannot  
9       otherwise afford it. And they will sometimes talk to me  
10      about, you know, can you do this for this amount of money?  
11      Because it's all we have budgeted. So I do. And sometimes  
12      I have learned over my years of experience to make a  
13      contract with the lawyers, with the law firm, rather than  
14      the lawyers in order to get paid. Because sometimes people  
15      don't want to pay their bills. You probably have similar  
16      experience if you look at your own track record I guess.  
17      But that's what I do. Sometimes I will, if it's just  
18      writing a letter for recommending accommodation, which is  
19      probably the most common thing that I do, and knowing a  
20      patient's circumstances, I will sometimes just do it.

21           Q. Do you let the patient tell you what  
22               accommodation they want or how does that  
23      process work?

24           A. Well, it's me asking questions as to what

1                   bothers them, what's bothering them with  
2   respect to the  
3       accommodation. The accommodation almost -- it's workplace  
4       accommodation. So what are the issues involved?

5                   The most prevalent issue to deal with by far in  
6       these cases is having to do with scented products in the  
7       workplace. It's the most common pollutant. I believe,  
8       this may be wrong, that we are somewhat ahead of you,  
9       Canada versus US, with respect to recommending scent-free  
10      policies, making it a bit more common. All our hospitals  
11      here in Toronto which is -- Toronto is huge. Toronto has  
12      the fourth-largest area, urban area in North America. So  
13      we have a lot of hospitals here and they all have a scent-  
14      free policy. The difficulty, of course, is to enforce it.  
15      We don't have scent police. When the public is involved,  
16      it's pretty hard to police them.

17                  I had one case of a nurse and this was in Ottawa.  
18      The hospital had a scent-free policy. She was a nurse  
19      working in a particular ward and she had severe asthma  
20      provoked by scented products and her colleagues would, on  
21      our behalf, ask people to leave. There's a sign on the  
22      wall saying, you know, this is a scent-free zone and if  
23      people showed up with wearing scented products that were  
24      very easily detected and unfortunately quite dangerous for



1       this particular woman, all her colleagues would go and get  
2       this person to leave. So got going off I guess on a bit of  
3       a tangent there.

4               Q. All right. Let's go ahead and look at your  
5       CV again. And again, under Presentations and Specialties  
6       the second item in here is September 19, 2016. Is this the  
7       grant that we discussed for the task force? Is that when  
8       it was written?

9               A. No. The task force was put together and the  
10      first thing to do was to make sure that people who were on  
11      the task force were educated with respect to all three  
12      conditions, so I did a presentation on multiple chemical  
13      sensitivity to the task force.

14              Q. Okay. So this was a presentation you made to  
15      the task force, correct?

16              A. Yes.

17              Q. Okay and the next item, does that represent  
18      the grant writing?

19              A. No. That was another paper -- another, not  
20      paper, another lecture presentation given to the task force  
21      on that day just to bring them up to date as to whether  
22      there was anything new in the literature with respect to  
23      what I had written in 2013.

24              Q. Okay and on May 12, 2014, it looks like you

1        authored a paper called Toxic Legacy and Gender Inequality.  
2        Prevention Diagnosis and Management from Preconception to  
3        Old Age. Environmental Sensitivity Association of Quebec,  
4        McGill University. What was this about?

5                A. That was a provincial patient organization  
6        for -- that advocates -- not advocates, but -- yeah, I  
7        guess advocates. It's a patient support system for  
8        chemical sensitivity. They organized a day at McGill  
9        University and that one was through that association to  
10       members.

11               Q. What was the presentation -- what was the  
12       gender inequality aspect regarding?

13               A. It was based on a question which is, why is  
14       it that women are more likely to get these conditions than  
15       men?

16               Q. And who posed that question?

17               A. Who posed the question?

18               Q. Yes. You said it was based on a question of  
19       why women are more than ---

20               A. Let me finish and maybe you'll get your  
21       question answered.

22               Q. Sure.

23               A. It was also based on informing the patient  
24       population that the -- because we see that these conditions

1 are environmentally linked, there are differences in -- on  
2 the exposures generally in the population in a non-  
3 industrial workplace for women compared to men. And so why  
4 is that? There are two reasons. One is sex and the other  
5 is gender, right? So the differences between the two is  
6 that sex is biological and women seem to be not quite as  
7 efficient as men with respect to the enzyme systems for  
8 detoxification. The limbic system also tends to be more  
9 easily sensitized. And secondly, the behaviour of women  
10 which is more gender when they break that down, is that you  
11 use more scented products on a daily basis than we do and  
12 given the social norms, that may not be the right word  
13 anymore, but social behaviours, women tend to do more of  
14 the housecleaning and laundry etc., etc. And therefore have  
15 more exposures. So it was about the differences in  
16 exposures and the differences in handling it, increase  
17 likely of sensitization. That was sort of the theme. So I  
18 don't know if that answered your second question or not.

19 Q. Okay. Well, it answered the second question,  
20 but who posed the question? Who asked you to document the  
21 alleged gender inequalities and the appearance of these  
22 disorders? You said the question was posed. Who posed it?

23 A. I was talking I think more in general terms.  
24 I was asked to give a presentation to this patient group

1 and their goal was to make environmental -- awareness of  
2 environmental pollutants to be increased in a general  
3 population, but they were reaching out to women's groups at  
4 that time to try and increase the awareness of these  
5 conditions as well.

6 Q. Okay and who was the group who asked you to  
7 give the presentation?

8 A. It's listed right here. It's the  
9 Environmental Association of Quebec. I don't know exactly  
10 what their official name is. It's on here. Which date was  
11 it again? May. So the Environmental Hypersensitivity  
12 Association of Quebec. I'm used to the French name (says  
13 French name), ASEQ. That's what they usually call this as  
14 an English version. Quebec pushes the French language way  
15 more than the English. So I had to look it up.

16 Q. So the group that asked you to do it was  
17 Environmental Hypersensitivity Association of Quebec?

18 A. That's right.

19 Q. Okay and who were the women's groups that  
20 were being presented to?

21 A. I don't recall.

22 Q. Okay and what statistical evidence do you  
23 have that women are not as efficient as men with getting  
24 rid of these environmental toxins?

1                   A. You tend to be a little bit slower at phase  
2 two.

3                   Q. Okay and again, I appreciate that that's what  
4 you're saying, but statistical studies you can point to?

5                   A. Off the top of my head, I would have to go  
6 and look it up, because I don't remember the name.

7                   Q. Okay and medical evidence that women are not  
8 as efficient as men with getting rid of these toxins?

9                   A. Same thing. It's in the literature.

10                  Q. Okay and in terms of the limbic system being  
11 more sensitive and developed in women, statistical evidence  
12 of that?

13                  A. Again, it's in the literature. Some of it's  
14 based on pain.

15                  Q. Okay and the literature being what? The  
16 cites in your report or what literature?

17                  A. What did you say before what literature?

18                  Q. Can you identify by name any of the  
19 literature?

20                  A. Off the top of my head, no.

21                  Q. Okay and ---

22                  A. These are things that I had in the citations  
23 in my book which was published in 2013.

24                  Q. Okay.

1           A. There were 2200 citations. I don't recall  
2 the names of most of them anymore.

3           Q. Okay and then in terms of the medical  
4 evidence that limbic systems are more developed in women  
5 than men, what is the medical evidence of that?

6           A. It's based on sensory. Some of it is based  
7 on the fact that you feel pain more in comparison studies,  
8 that you see colours better than we do. So it's based on  
9 the sensory comparisons.

10          Q. Okay and what are those studies?

11          A. I just mentioned. Some of it based on pain.  
12 How long can you keep your hand in a pail of ice water is a  
13 way to measure pain that doesn't do damage. So despite the  
14 TV commercials and so on, apparently we have a higher pain  
15 threshold as a group. You might be better at it than me,  
16 but as a group. They're not strong, but they're there.  
17 And these kinds of things are looked at in order to try and  
18 help us to understand why are women more susceptible to  
19 these conditions which involve limbic system than men. So  
20 we try and understand it. That's where that information  
21 came from.

22          Q. Okay and I just want to turn briefly to page  
23 10 of your CV. This lists your court experience?

24          A. What?

1 Q. This, there's a section ---

2 A. Oh sorry, I was on the wrong page 10.

3 Q. Page 10.

4 A. There's something else attached to this.

5 Q. Okay.

6 A. Page 10 of the CV, sorry, go ahead.

7 Q. So this lists your court experience.

8 A. M'hmm.

9 Q. And go ahead identify for me of these which  
10 ones you were retained by a defendant?

11 A. They're all -- oh, Nesbitt Aggregates versus  
12 Smith. They're all on behalf of the defendant -- I'm  
13 sorry, on behalf of the plaintiff.

14 Q. Okay and do these all involve multiple  
15 chemical sensitivity?

16 A. I cannot tell you for sure. I think that  
17 Canada Pension Board, possibly the life assurance company,  
18 the one from 1995, I think these may have been disability  
19 for chronic fatigue syndrome.

20 Q. Okay, so these were disability proceedings  
21 that you testified in?

22 A. They're all -- yeah, they're almost always  
23 disability.

24 Q. Okay.

1           A. The one, Karen Somerville versus Ashcroft  
2       Homes was a case whereby this woman was blaming Ashcroft  
3       Homes for the faulty building of her new home, because she  
4       developed chemical sensitivities. So that was not  
5       disability.

6           Q. Okay. Let's go ahead and look at your report  
7       dated June 9, 2017. I'll mark it. I'll have the court  
8       reporter hand it to you and I'll mark it -- and have her  
9       mark it as Exhibit 2, please.

10          A. Okay.

11          Q. Okay and this notes that this was in response  
12       to a letter from Mr. Pettey; is that correct?

13          A. Yes.

14          Q. Okay. Is it typical that you would ask  
15       questions -- that you would answer questions as posed by an  
16       attorney?

17          A. Yeah, I expect it. My understanding of  
18       writing a medical expert opinion is that instructions  
19       regarding what points need to be addressed should come from  
20       the attorney in writing, it should be listed at the  
21       beginning of the report in order to make it clear what I  
22       was asked to do.

23          Q. Okay. So you got these before you examined  
24       her; is that correct? These questions?



1 A. Yes, yes.

2 Q. Okay and did you understand when you examined  
3 her that she sought to prohibit the Athens County Engineer  
4 from chip sealing the road in front of her home?

5 A. Did I understand before I got the questions?

6 Q. Before you examined her.

7 A. Yes.

8 Q. Okay. Did you know that before you got these  
9 questions?

10 A. Yes.

11 Q. And what did you understand that her fear  
12 regarding the chip sealing of the road was based on?

13 A. That she had severe chemical sensitivities  
14 and was concerned that being exposed to the fumes would  
15 force her to leave her home and she had nowhere to go,  
16 because of the severity of her condition.

17 Q. Have you ever encountered anybody who is so  
18 exquisitely sensitive that they can smell asphalt product  
19 within a mile radius of their home?

20 A. This particular point with respect to asphalt  
21 in proximity to the home? No. This degree of described  
22 severity of sensitivity is very unusual, but I've seen it  
23 before.

24 Q. All right. So let's go to page 2 of this

1 report, paragraph 2, and you've indicated here, "I have a  
2 special interest and expertise in indoor air quality and  
3 health effects." Is that accurate?

4 A. Yes.

5 Q. Okay. This includes up-to-date knowledge of  
6 the published scientific papers regarding potential adverse  
7 health effects of multiple indoor contaminants such as  
8 volatile organic compounds which off-gas from building  
9 materials; is that correct?

10 A. Yes.

11 Q. What are those indoor contaminants?

12 A. What are they? You want names?

13 Q. Yes, please.

14 A. I can't give you names offhand, because if  
15 you go into -- this is what I know as a clinician. Okay?  
16 I'm not a -- I do not have an expertise on chemical  
17 engineering. What I have an expertise in is knowledge that  
18 indoor air quality has higher levels of volatile organic  
19 compounds compared to the outdoors. They come from a  
20 variety of sources. They contribute to chronic exposures  
21 to chemical pollutants. And often when there are  
22 complaints so that people -- let me rephrase this. Often  
23 when there are complaints so that the owner or employer or  
24 manager of a building looks to do an indoor quality

1       assessment, if the pollutants are measured, they're  
2       measured most commonly as a total amount. It's called  
3       PVOCs. So which chemicals are there? Well, the closer you  
4       are to a major roadway, the more likely you are to also  
5       have contamination from the outdoors. That's ---

6               Q. Did you ever evaluate Ms. Madej's home for  
7       contamination from the outdoors?

8               A. Did I ever evaluate? I don't have the  
9       expertise to do an assessment of air quality. That's an  
10      engineer's job.

11              Q. And what are the scientific papers regarding  
12      potential adverse health effects? What are those papers  
13      called?

14              A. Adverse health effects of what? You're  
15      asking me -- there's a huge amount of literature on indoor  
16      air quality.

17              Q. Yes. I appreciate that, Doctor, but your  
18      report says, "I have special interest and expertise in  
19      indoor air quality and health effects. This includes up to  
20      date knowledge of the published scientific papers regarding  
21      potential adverse health effects of multiple indoor  
22      contaminants."

23              So based on that statement, what are the  
24      published scientific papers regarding potential adverse

1 health effects of multiple indoor contaminants?

2 A. Okay. What I don't have memorized are the  
3 papers and the list, because there's many. So my expertise  
4 as it were is the knowledge.

5 Q. Can you identify the ones that relate to Ms.  
6 Madej's condition that you used in evaluating her?

7 A. Indoor air quality? That question doesn't  
8 even make sense to me. Can I identify papers that have  
9 anything to do with the indoor air quality that would  
10 affect Ms. Madej. Ms. Madej is describing multiple  
11 chemical sensitivities. So right away we know that she is  
12 more likely to have problems with indoor air quality  
13 exposures than the average person. The exposures can come  
14 from building materials, can come from products used in the  
15 house, can come from products worn by other people, can  
16 come from off-gassing from things like computers,  
17 electronic equipment. There's a soup that the average  
18 building has up to 50 volatile organic compounds that are  
19 from indoor sources and they get ---

20 Q. And which ones of those would Ms. -- which  
21 ones of those is Ms. Madej reacting to? Which ones of  
22 those ---

23 A. I have no idea, because there's no way to  
24 test it. We can't test. And I get asked that question,

1 well, which chemicals is it exactly, do you think? Nobody  
2 knows, including me.

3 Q. Thank you. And this document references  
4 building materials for building structures; is that  
5 correct?

6 A. Sorry, say the question again?

7 Q. I'm sorry. Your report references  
8 contaminants from building materials at least in this  
9 paragraph; is that correct?

10 A. My report references building materials?

11 Q. Yes. Your stated expertise per this  
12 paragraph is in building materials; is that correct?

13 A. No. It's in the indoor air quality and  
14 health effects.

15 Q. Okay and Ms. Madej's complaints are not  
16 related solely to the indoor quality of her home, correct?

17 A. Correct.

18 Q. They're related to the use of chip seal and  
19 the outdoor air quality, correct?

20 A. That's what the issue is, but her medical  
21 condition is that she is sensitive to a variety of  
22 different chemicals.

23 Q. Can you identify with any specificity what  
24 those chemicals are?

1           A. Only from the history of what the patient  
2 identifies.

3           Q. Okay. There's no way to test if she's  
4 actually sensitive to those?

5           A. No.

6           Q. And in fact, if she is sensitive, would she  
7 display the same symptoms in response to the same  
8 chemicals? So would she have consistency regarding symptom  
9 with exposure or not necessarily?

10          A. I was watching your hands, because there is a  
11 little bit of this. Generally speaking, the symptoms are  
12 the same. But the -- sometimes the patients can identify  
13 differences. Just as an example, you know, if you have  
14 headaches and lightheadedness and nausea from chemical X.  
15 and chemical Y., that sounds the same. But the quality of  
16 the headache and the severity of the headache may vary.  
17 Patients tend to be able to identify the difference in  
18 chemicals quite commonly and I don't really understand why.

19          I can suggest to you that there is a very strong link  
20 between the sense of smell and memory and that link  
21 somehow, I believe, tends to help these people identify one  
22 exposure versus another. So there's a combination of  
23 things. But generally speaking, they have a group of  
24 symptoms that more or less are stimulated by an exposure

1 maybe more when the exposure is repeated within a short  
2 period of time. Maybe more or less depending on what other  
3 exposures that they've had. So there's fluctuations in the  
4 quality of sensitivity. It's complicated.

5 Q. Can this maybe identify differences in her  
6 symptoms based on what she's exposed to?

7 A. It's my belief that she can, yes. I think  
8 she has said that, yes.

9 Q. And what symptoms does she present with when  
10 exposed -- what symptoms -- let me strike that.

11 What symptoms did you observe her demonstrate  
12 when exposed to chip and seal?

13 A. I've never observed her demonstrate any  
14 symptoms. I had not exposed her to chip seal.

15 Q. Okay. So it's your testimony that diagnosis  
16 for this condition is based strictly on a subjective  
17 criteria of history and reported symptoms; is that correct?

18 A. Yes.

19 Q. And you've never observed her display  
20 sensitivity to chip and seal, correct?

21 A. Correct.

22 Q. And you've never observed her display  
23 sensitivity to asphalt products; is that correct?

24 A. Correct.

1                   Q. Have you ever observed her display  
2 sensitivity to anything?

3                   A. I spent a couple hours with her outside in a  
4 rural environment on a lovely sunny day with a minimal  
5 breeze if there was one at all. I don't remember. It was  
6 just a lovely day. And as a Canadian, I have great  
7 appreciation of those lovely days. So that's my memory of  
8 it. And the purpose of being in that environment was so  
9 that it would be tolerated by her, that I could talk to her  
10 and do the physical exam. So that's my experience in being  
11 with Ms. Madej to make observations clinically.

12                  Q. Okay. Ms. Court Reporter, could you read the  
13 question back, the last question?

14                  THE REPORTER: I have did she display sensitivity  
15 to anything?

16                  A. Sorry? Did she display sensitivity to  
17 anything to me? No.

18                  MS. GWIN: Let's take a break.

19                  (A short recess is taken.)

20                  Q. So we were talking about your report and  
21 we're on page 2 of it still. And I'd like to go ahead and  
22 look at page 2, it's paragraph 3 and there is an indication  
23 in the first sentence that as a member of the Environmental  
24 Health Committee of the Ontario College of Family



1 Physicians from 1994 to May 2016, I developed and provided  
2 workshops for both the Canadian and Ontario Colleges of  
3 Family Medicine regarding sick building syndrome. What is  
4 sick building syndrome?

5 A. As I mentioned that there's differences in  
6 the environment inside a building versus outside and there  
7 are some people who complained about adverse health  
8 effects, again subjective symptoms usually unless it's  
9 something like asthma that they get in a particular  
10 building. And because the symptoms are provoked in a  
11 particular building, it's called a sick building syndrome.  
12 It's not necessarily that the building is sick, but there's  
13 something unique about the, I guess the fingerprint of the  
14 exposures of that building that seems to trigger off  
15 symptoms in susceptible individuals.

16 Q. Okay and this is different than multiple  
17 chemical sensitivity because it's specific to the building  
18 that they're in?

19 A. That's right. I mean, there's an overlap  
20 because there are people who have mild degrees of chemical  
21 sensitivities and are okay in some places and not others  
22 and when it becomes an issue is if they have to be in that  
23 building and obviously or apparently most of the time work  
24 related.

1 Q. And this is a case that you chaired a  
2 committee developing a two day, four module workshop  
3 entitled, "Environmental Linked Illnesses Prevention  
4 Diagnosis and Management from Preconception to Old-Age."  
5 What was that? Tell me about that?

6 A. Well, sitting on that committee for the  
7 College of Family Physicians, it became apparent that there  
8 was not much education with respect to the impact of the  
9 environment on health. So we formed a committee and I got  
10 asked to chair it, so that we could develop workshop  
11 modules for educating family physicians.

12 Q. And who asked you to chair it?

13 A. My fellow members who volunteered to be on  
14 the committee -- on the subcommittee in the first place.  
15 Well, John, you chair it. Okay. I mean that's -- it's  
16 doctors who are ---

17 Q. Is this committee affiliated with the Ontario  
18 Ministry of Health?

19 A. No. This is the ---

20 Q. Okay. This is a separate ---

21 A. --- College of Family Physicians.

22 Q. Okay. This is where you work right now?

23 A. No. The College of Family Physicians is the  
24 -- is mandated to promote education, etc. For family

1 physicians, so as a family physician ---

2 Q. Environmental illness?

3 A. Pardon?

4 Q. It's just in environmental illness or in  
5 other ---

6 A. No, we had a -- there was -- we had a  
7 committee called the Environmental Health Committee that  
8 had been there since the early '90s until 2016 when many of  
9 the committees were disbanded because of attempts to cut  
10 costs. But prior to that, that committee existed for 20  
11 years and I sat on that committee for most of those years.  
12 The College of Family Physicians is responsible for the  
13 education and the maintenance of educating programs for  
14 family physicians.

15 Q. Do you know, is there a counterpart in the  
16 States? Is there a similar kind of thing?

17 A. I would presume so. I presume that each  
18 specialty or even subspecialty has an organization  
19 responsible for maintaining accreditation and study hours  
20 to keep your accreditation or your fellowship. You know,  
21 you can't get a certification or a fellowship and then  
22 never maintain your education. I presume your profession  
23 is the same thing. That you have to maintain certain  
24 amount of study hours in order to maintain your licence.

1 Q. Okay. But environmental illness is not a  
2 recognized board specialty, correct?

3 A. Sorry, environmental illness?

4 Q. Environmental medicine, excuse me.

5 A. No.

6 Q. Okay. What did you teach at the two-day  
7 workshop regarding how to take an environmental exposure  
8 history?

9 A. How to take an environmental exposure  
10 history. Environmental exposure history is based on  
11 community, home, hobbies, occupation, medications and  
12 drugs, personal habits, personal things such as hobbies,  
13 personal care products, diet. You know, all of these  
14 things are sub-grouped into environmental exposures and  
15 then within each area, we ask questions. For example, you  
16 live in Ohio, I live in Toronto, so when we look at  
17 community, a lot of the regional movement of air towards  
18 Toronto actually comes from Ohio, so we have an interest in  
19 how much coal you burn or produce for energy, right?  
20 That's an example of community. So we teach the doctors  
21 how to take that history, how to -- what questions to ask  
22 as we're breaking it down.

23 Q. And how does that history differ from taking  
24 a standard medical history?

1           A. A standard medical history as it's been  
2           taught does not include environmental exposure. They might  
3           ask well, what kind of job you have. But it's more with  
4           respect to the social meaning of that job description.  
5           Certainly if you were working in an industry, the doctor  
6           might take note of that as an exposure. The reason this  
7           committee was formed in the first place is because there is  
8           a lack of awareness within the medical profession,  
9           generally speaking, about the impact of environmental  
10          exposures and the development of disease.

11          Q. Okay and would you say you're an advocate for  
12          awareness of environmental exposures?

13          A. Yes.

14          Q. And would you say that you're an advocate for  
15          MCS to be recognized as a real illness for a lack of a  
16          better word?

17          A. I would say that I'm an advocate for greater  
18          understanding of that condition for more research with  
19          respect to the condition and for educating physicians as to  
20          how to manage the condition in the best way in the  
21          patient's best interests.

22          Q. Okay. Let's go to page 3 and it looks like  
23          on here, and I'm going to jump around a little bit, you've  
24          listed the documents that you reviewed in examining Ms.

1 Madej; is that correct?

2 A. Yes.

3 Q. Is that all of the documents?

4 A. At the time I wrote this report, yes.

5 Q. Okay. So if Dr. Lieberman testified that he  
6 does not recognize MCS as a real diagnosis, would that  
7 change your opinions in this report?

8 A. Sorry, if Dr. Lieberman?

9 Q. Yes.

10 A. Said that it was not recognized?

11 Q. Yes.

12 A. Or he didn't recognize?

13 Q. It is not recognized, if he testified as to  
14 that.

15 A. So if he testified that it is not recognized  
16 as a legitimate illness? Is that how you put it?

17 Q. No. As a real illness.

18 A. Here's what you see in the literature. You  
19 see things such as a statement of consensus of opinion.  
20 Sometimes you'll see in the literature there are patients  
21 who have multiple chemical sensitivity and we are going to  
22 do this research based on the international consensus  
23 definition, etc.

24 So we do not have any kind of formal system in

1 place where we've decided check, it's met the criteria for  
2 recognition. I do not even know what those criteria are.  
3 It appears to be a process. So I don't know how to answer  
4 that question. One of the things that our task -- sorry?

5 Q. One of the questions I had is if Dr.  
6 Lieberman testified that he did not initially diagnose her  
7 with MCS, would that change your medical opinion regarding  
8 her condition?

9 A. Well, my medical opinion is based on my  
10 assessment and the history and the information that I had.  
11 I would not -- I would not change my diagnosis based on  
12 somebody else's opinion unless they could provide reasons  
13 to me that would be acceptable that I would be wrong.

14 Q. Okay; understood. So what documentation from  
15 Dr. Lieberman did you rely on in reaching  
16 your medical  
17 opinions, if any?

18 A. I think basically that the history of  
19 information that he had was consistent with what I was told  
20 by Ms. Madej. He had -- I'm trying to recall -- there were  
21 a series of blood tests done over the last 30 years, urine  
22 tests and so on, and I think that a lot of them came from  
23 perhaps clinical notes and records of the other physicians.

24 Q. If the first time that Dr. Lieberman's

1 records mentioned asphalt was in September of 2015, would  
2 that change your assessment that the history shows a  
3 sensitivity to asphalt?

4 A. I do not recall it being mentioned before  
5 then.

6 Q. Okay and do you recall that Dr. Lieberman  
7 indicated that the main concern was her home for that; it  
8 was the environment, not the outdoors?

9 A. Do I recall that?

10 Q. Yes. In his medical records.

11 A. What I recall from his medical records is his  
12 attempt to try and manage the sensitivities and quite  
13 clearly based on the testing and treatment offered, he was  
14 diagnosing multiple chemical sensitivity.

15 Q. Do you recall whether or not Dr. Lieberman  
16 ever tested Ms. Madej for petroleum products?

17 A. That testing technique uses various mixtures.  
18 I do not recall whether -- what exactly he used, but some  
19 of them represent petroleum products, could be natural gas,  
20 could be something else and again, I'm not sure where he  
21 got his substances for testing from.

22 Q. So could we say that that test would not be a  
23 reliable biological indicator of MCS?

24 A. Yeah, the testing for sensitivity using



1 sublingual challenges has not been documented as reliable  
2 for the diagnosis of chemical sensitivity.

3 Q. And if Dr. Lieberman testified that he had no  
4 medical evidence that Ms. Madej would die if she was  
5 exposed to asphalt or chip seal, would that change your  
6 medical opinions in this report?

7 A. No.

8 Q. Do you believe Ms. Madej will die if the road  
9 is chip and sealed?

10 A. Extremely unlikely, maybe change extremely to  
11 highly. Yeah.

12 Q. Have you ever seen a patient die from  
13 multiple chemical sensitivity strictly?

14 A. Have I seen that? No.

15 Q. Have you ever seen a patient die from chronic  
16 fatigue syndrome?

17 A. No.

18 Q. Have you ever seen a patient die from  
19 fibromyalgia?

20 A. No.

21 Q. So is it fair to say these are not life-  
22 threatening conditions?

23 A. No, they're not. What they do create is a  
24 biological response.

1 Q. I'm sorry, Doctor you cut out. A biological  
2 what?

3 A. I stopped talking. There's a biological  
4 response in these patients. There's a biological response  
5 by everybody to environmental pollutants that is very  
6 subtle, so -- and can contribute to chronic disease. When  
7 people have chemical sensitivity, the response is  
8 significant enough that they feel symptoms that make them  
9 feel unwell.

10 If a patient is frail, has other medical  
11 conditions, then exacerbating anything that would be  
12 biologically stressful could potentially do so. So one of  
13 the things that is in the literature with respect to  
14 chronic fatigue syndrome is that these patients are more  
15 likely to develop cardiovascular disease. They're more  
16 likely to die from cardiovascular disease.

17 Q. To develop what? I'm sorry, I couldn't hear  
18 you. To develop what?

19 A. Cardiovascular disease.

20 Q. Okay.

21 A. Which again then increases mortality rate.

22 Q. Does Ms. Madej have cardiovascular disease?

23 A. Not that I'm aware of, no.

24 Q. And so obviously, do you think she'll suffer

1 cardiac arrest if the road is chip and sealed?

2 A. I don't think that would happen. I would be  
3 very surprised if it did.

4 Q. Okay. Do you think that she'll suffer  
5 paralysis if the road is chip and sealed?

6 A. No.

7 Q. Do you think that she'll suffer respiratory  
8 failure if the road is chip and sealed?

9 A. No.

10 Q. These documents, did you review these  
11 documents before you met with her or after you examined  
12 her?

13 A. Oh, before.

14 Q. Before, okay. And who provided you with  
15 these documents? Was that Ms. Madej herself or?

16 A. I don't recall. I got them by e-mail.

17 Q. Thank you. And do you recall that the  
18 affidavits of Dr. Barbara Singer and the letters of medical  
19 necessity from Dr. Alan Lieberman, do you understand that  
20 those were submitted to a court and subsequently an  
21 injunction was issued, prohibiting the use of chip and seal  
22 on the road in front of Ms. Madej's home? Do you  
23 understand that?

24 A. Yes.

1           Q. Okay. Do you think that there's any medical  
2 basis for the need for an injunction within a mile of her  
3 home?

4           A. The question that I can't answer you exactly  
5 is how far away from that road she would need to be. I  
6 can't answer that.

7           Q. Okay. Why not?

8           A. Because nobody knows. We know, for example,  
9 when we look generally at proximity to major roadways and  
10 impacts on biological function let alone health. So  
11 studies arbitrarily pick a line, 200 meters, kilometer,  
12 which .6 of a mile. And compare people who are on one side  
13 of that line versus people on the other side of the line to  
14 see if there's a difference.

15          Q. And what studies do that?

16          A. Pardon?

17          Q. Just tell me what the names of the studies  
18 are.

19          A. Oh, there are multiple studies looking at the  
20 impact of pollution on health. Multiple. So one of the  
21 problems is you keep asking me for the name of a study and,  
22 you know, I've read thousands of studies, so my expertise  
23 is to understand what the literature says. If you want a  
24 particular paper from me, I have to get on my computer and

1 I'll find it, because I probably stored it, but I have  
2 thousands.

3 So I can't give you the exact names, but I'm  
4 giving you what I know. Same as anybody who would be an  
5 expert board-certified in a particular -- they're not going  
6 to tell you which mentor told them and on what date.  
7 They'll just tell you what they know. So I'm trying to  
8 tell you what I know.

9 And so what I know is that how much exposure  
10 there is from something is dependent on many factors, what  
11 that substance is, how long it lasts, how it travels, is it  
12 travelling attached to particles or is it attaching -- is  
13 it travelling purely as a gas form, what the wind factors  
14 are like, humidity, temperature? These are things that  
15 chemical engineers can answer better than I.

16 Q. Is there any way to control for all those  
17 factors, I guess. There isn't really, right?

18 A. Right.

19 Q. Okay and in terms of, is it possible that Ms.  
20 Madej could react even if the road was chip sealed more  
21 than a mile from her house? Could that happen?

22 A. Yeah, you know, a mile is picked because it's  
23 -- it's a distance that we have a pretty good idea of what  
24 it is, but it's just an approximate guess and it -- why the

1 file was chosen as opposed to half a mile or as opposed to  
2 a mile and a half, I do not know. I think, again, if we  
3 take away the litigious nature of our discussion and we're  
4 just looking at what we're trying to do in the best  
5 interests of a patient, it's based on the patient's  
6 experience because the level of sensitivity has such a wide  
7 grading. So that's what we have.

8 Q. I appreciate that and I'm not trying to be  
9 litigious.

10 A. No, no ---

11 Q. I'm just trying to find out if there are  
12 bases for the opinions that are rendered and what those  
13 are, you know. This is not meant to be adversarial.

14 A. No, I'm not trying to be adversarial to you  
15 either. I was just trying to make a point that there's a  
16 clinical -- I'm a clinician and we make our decisions based  
17 on working with the patient. But in this case, I'm kind of  
18 trying -- you're asking me about, well, what about a mile?  
19 I don't know exactly.

20 Q. Yes. It's kind of arbitrary, right? She  
21 could react further than a mile. She could react less far  
22 than a mile, correct?

23 A. And it could depend on the day.

24 Q. And it could depend on the day. And is there

1 any way to determine based on the fact that we can't  
2 control her other factors that it's the chip and seal  
3 that's causing her to react?

4 A. Well, if there is very little problem and  
5 then some of these symptoms are provoked, then the question  
6 gets asked, well, what's different in the environment that  
7 would be unusual that would give you the symptoms that  
8 you're feeling. This is a clinical approach. Say, well,  
9 they paved the road outside my house. That kind of becomes  
10 an obvious change.

11 Q. Understood, understood and that's fine,  
12 that's fair. You're aware that there's an injunction on  
13 the road presently, correct?

14 A. Yes.

15 Q. Okay and if I represent to you that Ms. Madej  
16 as well as Dr. Lieberman have testified that she's only  
17 been sicker in the last two and a half years, do you have  
18 any reason to dispute that?

19 A. Sorry, ask me the question again?

20 Q. Sure, sorry. There's been testimony in this  
21 case from Ms. Madej as well as from Dr. Lieberman, her  
22 treating physician, that she's still very, very ill. She's  
23 still sick despite the injunction prohibiting the use of  
24 chip and seal. Do you have any reason to dispute that?

1 A. No.

2 Q. Okay. So could it be the chip and seal  
3 that's making her ill if there's been an injunction  
4 prohibiting it, but she's still sick?

5 A. No. She was sick before there was any paving  
6 going on in the road altogether as far as I understand.

7 She's been sick for 30 years. And I know there was a  
8 period of time when she became more ill or lost weight, for  
9 whatever reasons. I was not the clinician at that time.  
10 But she's been generally unwell for a very long time.

11 She's been seeing Dr. Lieberman for, I don't know, 20  
12 years, whatever it's been.

13 This woman is chronically ill. And I don't think  
14 that -- I do not believe and I have not been led to believe  
15 that there's been a correlation with how much more sick she  
16 may or may not be in coordination with the timing of when  
17 the chip and seal was applied on that road in question.

18 Q. Okay. Thank you. Now, this is a case here  
19 that Ms. Madej was examined with her husband outside at her  
20 home. That's the other documents provided. It's the third  
21 paragraph down. Is that correct? Do you recall that?

22 A. It's the backyard of her neighbour's home?

23 Q. I'm sorry, excuse me.

24 A. I use the term backyard, because it was



1 rural. This was a huge backyard and I live in Toronto and  
2 had to measure it in square feet. My recollection of it is  
3 that there was a big garden. We were on one side and the  
4 house and Mr. Madej and a neighbour were on the other side  
5 of that garden and it was maybe, I'm guessing from memory,  
6 75 yards away, so yeah we were in ---

7 Q. General vicinity.

8 A. We were not like as close as you and I are,  
9 technologically speaking.

10 Q. Fair enough. Why was her husband present?  
11 Did she tell you why she wanted him there?

12 A. No. I think he brought her there.

13 Q. Did you have to take any precautions prior to  
14 examining Ms. Madej?

15 A. Well, I personally didn't, because -- well,  
16 let me rephrase that. I -- my wife and I want to live as  
17 long as we can as most of us do. We are both of the belief  
18 that the science is fairly clear that the impact of the  
19 environment has an effect on developing chronic illness, so  
20 we lead very clean lives. We eat organic. We don't use  
21 scented products. Our house is very environmentally clean  
22 and safe. So that's how we live as a chosen lifestyle. We  
23 -- in order to go to Ohio, we had to stay overnight. We  
24 stayed in a place which is maybe found for us which was

1       very clean, did not use scented products, etc., etc. So we  
2       practice those precautions, but it wasn't that I did  
3       anything unusual. My wife is -- has some mild  
4       sensitivities to scented products, so when we go someplace,  
5       we try to stay in places that are scent-free. I spent two  
6       weeks in Ottawa as you probably are aware. My daughter  
7       died. It took two weeks to go through that process and we  
8       -- I didn't want to stay with my kids, because I needed  
9       alone time. So we stayed in a hotel on the outskirts of  
10      Ottawa that used scent-free cleaning products and that you  
11      could open the windows and we were city rural. That's our  
12      lifestyle. So I did not have to do anything unusual to be  
13      able to access Ms. Madej.

14               Q. Do you need a break or anything? Are you  
15      okay?

16               A. Right now?

17               Q. Yes.

18               A. Oh yeah, yeah. I'm fine. And I've been  
19      practicing talking about this.

20               Q. Okay.

21               A. Thank you.

22               Q. Thank you. I appreciate that. Do you  
23      remember the name of the place that you stayed when you  
24      examined her?

1 A. No.

2 Q. Ms. Madej?

3 A. It was, the arrangements were made by my  
4 wife. She takes good care of me.

5 Q. Do you remember where the place was?

6 A. It was outside of whatever the closest town  
7 is. One of my flaws is names as you probably figured out  
8 already. I've always been lousy at that. So -- but it was  
9 -- it was a lovely rural, just fields and gardens outside.

10 Q. Did you have to wash your hands off with  
11 alcohol, rubbing alcohol prior to examining Ms. Madej?

12 A. Don't recall doing that.

13 Q. Did you have to shower with any kind of  
14 special soap or anything prior to examining  
15 her at her  
16 request or her lawyer's?

17 A. No. Because that was already taken care of.  
18 I think there was a discussion about that prior to me going  
19 there and this is not an issue for me, because this is how  
20 we live.

21 Q. Did you have to air out your clothing or  
22 anything prior to examining her?

23 A. No, but we don't use scented products. We  
24 don't use fabric softeners and so on.

1 Q. Did you travel by car?

2 A. Did I travel in a car? The day before.

3 Q. Did you travel in a car to get to the site  
4 where you examined her?

5 A. I think it was five minutes, maybe eight.

6 Q. Did you travel in an airplane to get to Ohio?

7 A. No, drove the car.

8 Q. Drove, okay. So how long did that take you?

9 A. Eleven hours. One of the reasons for that  
10 choice was so -- because I can sit in my car. Could not  
11 sit in an airplane.

12 Q. Sure, sure, understood and you can stretch  
13 and take breaks and stuff in a car, right?

14 A. Exactly, yeah.

15 Q. Did you put gasoline in the car when you  
16 drove there?

17 A. My wife did. Sorry for the smile. I'm  
18 starting to look bad here.

19 Q. And did Ms. Madej ask that her husband be  
20 present or did you -- did he ask to be present?

21 A. Well, he wasn't really present. He was like  
22 on the other side of the yard.

23 Q. Is it typical that you would evaluate a  
24 patient with their spouse or significant other present?

1           A. It's not typical for an IME. But many times,  
2     you know, when you're trying to extract a history over a  
3     lifetime, environmental exposure history as over a  
4     lifetime, there's actually a term that's been developed  
5     called an exposome, everything is an ome now, right? But  
6     there's an exposome which is lifetime exposure histories --  
7     this discussion well, how accurate is it, because it's  
8     based on memory. So often for details of memory, details  
9     of information or being able to take home whatever message  
10    has been given in a very long appointment, because  
11    appointments are long. Their shorter appointments are an  
12    hour. They just bring a partner quite often. Could be a  
13    child, well, an adult child. It could be a parent or it  
14    could be a partner. It could be a very close friend, but  
15    they often do that. And within the clinical setting,  
16    that's totally acceptable and also encouraged because many  
17    of these people have cognitive difficulties and they get  
18    foggy in the brain and they get more tired as the  
19    appointments goes on and they don't assimilate the  
20    information, so I'm very used to having somebody sitting in  
21    the room. Rare is it that the second person provides any  
22    kind of support or care except for providing information  
23    according to memory.

24           Q. Did Mr. Madej provide any information during

1 the IME, during your evaluation?

2 A. No. He was 75 yards away.

3 Q. Okay and why was the examination conducted  
4 out of doors?

5 A. Ms. Madej did not want me to come in her  
6 home. Her reason was in case I was contaminated. Clearly  
7 the ventilation is superior outdoors than indoors in any  
8 environment. Perhaps, I shouldn't say clearly, but it is.  
9 Buildings have to provide ventilation.

10 Q. How far away from the road were you when you  
11 examined her?

12 A. How far away from what? Sorry, I didn't ---

13 Q. The road. How far away from Dutch Creek Road  
14 were you when you examined her?

15 A. There was a kind of a long driveway maybe. I  
16 don't recall how long it was. It may have gone to more  
17 than one home. And my memory of it is that I got to the  
18 end, turned around, parked the car and maybe 50 meters,  
19 yards maybe away was where Ms. Madej was waiting, sitting  
20 with her husband, so I met them, chatted briefly. There  
21 was a table set up for examination. There was a fence.  
22 There was a couple of chairs. I brought a clipboard. I  
23 brought everything that I needed for the examination. I  
24 actually have a little doctor's bag. I used to make house

1 calls back in the day. So I had all the equipment I needed  
2 to do the examination.

3 Q. Was the home that was located nearby made out  
4 of wood?

5 A. I don't recall. I don't recall looking at  
6 it.

7 Q. Are you aware that Dr. Singer and Dr.  
8 Lieberman opined that exposure to herbicides, pesticides  
9 will kill Ms. Madej. Are you aware of that testimony?

10 A. I saw the letters that you referred to  
11 earlier. So I'm aware of their opinion that this could be  
12 life-threatening.

13 Q. That's not your opinion though, correct?

14 A. You know, if life-threatening is defined as  
15 the person is going to die from that, then no. If life-  
16 threatening is you're going to change the quality of life  
17 for a specified period of time, perhaps a very long time,  
18 that's a threat, that's a threat.

19 Q. But there's a change in a quality of life  
20 that is not synonymous with dying, right? That is a change  
21 in a quality of life, but there are degrees that are less  
22 than dying, correct?

23 A. It's very easy -- it's very easy in most  
24 cases to measure death. The reason I say the most cases is

1           because I flashed back to last month.

2                   Q.   Are you okay?   Do you need a break?

3                   A.   I'm okay.

4                   Q.   Okay.   You tell me if you need a break.

5                   A.   I'll let you know -- yes, I will let you know  
6           if I...

7                   Q.   Okay.   So this opinion regarding herbicides  
8           and pesticides, herbicides and pesticides are primarily  
9           used out of doors, correct?

10                  A.   Primarily, yeah, especially herbicides.  
11           They're only used outdoors.   The pesticide also includes  
12           insecticides, so they're sometimes used indoors.

13                  Q.   All right and then moving on to the next  
14           paragraph, you've opined here that Ms. Madej was last  
15           consistently well in 1985.   What did you base that opinion  
16           on?

17                  A.   Her story.

18                  Q.   Her -- her ---

19                  A.   Her story.   Now, how long, you know, when  
20           were you last consistently well is a question and there's  
21           an answer.

22                  Q.   Okay.   If Dr. Lieberman's records indicated  
23           that Ms. Madej's developments began in 1995, approximately  
24           10 years later, would that be inconsistent with the medical



1 history she gave you?

2 A. No. I mean, if you look at the next  
3 sentence, in '86-'87, she started getting sinus infections.  
4 She kind of get increased, more fatigue, more  
5 gastrointestinal complaints, she started to get other kinds  
6 of -- of problems, so she was last consistently well in  
7 1985. That's a point in time when things started to change  
8 and that's not unusual to get that kind of history in these  
9 kinds of patients.

10 Q. Okay. I mean, so when you say this kind of  
11 history, you mean a pretty -- what do you mean by that?

12 A. Well, I mean, if you categorize what she had,  
13 sinus and ear infections are sort of considered, especially  
14 sinus, obviously, the two are linked, and upper respiratory  
15 kind of symptoms. A lot of these patients do have problems  
16 with congestion in their ears.

17 So you start to see a pattern developing here.

18 She had gastro -- the other thing is gastrointestinal  
19 complaints. She started to develop these things. And we  
20 see these things quite commonly in patients with these  
21 three conditions that we're talking about and so the story  
22 starts. After 1985, she started to get these symptoms.  
23 There started to be a change in the quality of her health.  
24 That's where the story starts. That's typical.

1           Q. And I mean, none of these symptoms in and of  
2 themselves are strictly characteristic of MCS, fibro or  
3 CFS, correct?

4           A. Exactly. They're just more common. So with  
5 respect to MCS, to help you understand, there's two ways it  
6 can start, acutely or slowly. Acutely usually is, I got  
7 overwhelmed with some kind of chemical exposure according  
8 to the history and I developed chemical sensitivity and  
9 they blame that exposure from a litigation point of view,  
10 we have a complaint against someone who caused harm or  
11 something that caused harm, right? There is that. And the  
12 other is, is there's this gradual insidious onset. And if  
13 you'll forgive me for this metaphor, I -- in trying to  
14 explain this to my patients, I explain it this way. It's  
15 like stress. I can make you crazy two ways. I can  
16 threaten to kill you with my gun. That will take 30  
17 seconds of your life and you may need a psychiatrist for  
18 two years to overcome such a horrible experience, very  
19 rapid, or I can marry you and do it more slowly. It's a  
20 joke. But it's used to try and explain how this can  
21 happen, how the limbic system can become sensitized from  
22 something major or gradually more slowly.

23           Q. Thank you.

24           A. Apologies for the ---

1 Q. Which one -- which one does Ms. Madej have?

2 Acute exposure or gradual insidious onset?

3 A. It says gradual insidious onset of her  
4 symptoms without a real finite period of time. And so the  
5 story is significant in that after 1985, she started to  
6 develop these changes. They're what we call non-specific.  
7 They're not specific to a particular condition; nausea,  
8 there's hundreds of conditions, fatigue, hundreds of  
9 conditions, right? So we call them non-specific. She  
10 started to develop non-specific symptoms, especially in her  
11 upper -- upper airway and gastrointestinal system. That's  
12 not uncommon at all as I mentioned after central nervous  
13 system complaints, those two systems are tied for second  
14 place with respect to how frequently the symptoms occur.

15 Q. So in looking at just these symptoms during  
16 this period, you really can't rule out anything, because  
17 they're non-specific, correct? These symptoms in and of  
18 themselves are not indicative necessarily of MCS, CFS or  
19 fibro.

20 A. Well, I think, you know, if I was a family  
21 doctor and someone came in and said I have mild nausea,  
22 abdominal bloating and diarrhea. You say well, how long  
23 have you had it? And they say, well, since yesterday.  
24 Say, well, go home and get some sleep. It's probably the

1 flu. I mean, this is -- a lot of family medicine is often  
2 from common sense. If these symptoms persist and gee,  
3 maybe it's not a virus, then you start looking. You're  
4 doing stool tests. You're doing analysis. You're looking  
5 for inflammation. You're looking for growths. You may be  
6 ordering scopes from a referral to a gastroenterologist or  
7 barium enema or all -- done ultrasounds in a variety of  
8 different tests to try and a diagnosis.

9 Q. Are you aware that Ms. Madej, there was  
10 concern that she was having problems with her gall bladder  
11 by Dr. Singer and Dr. Lieberman?

12 A. Right now I can't recall reading that, so I  
13 may have been aware of it but ---

14 Q. Do you recall that she referred for an  
15 ultrasound?

16 A. What I can't recall right now is whether I  
17 read an ultrasound report or not. Whether it was in -- if  
18 it was in there, I read it at the time.

19 Q. Do you recall that Dr. Singer was concerned  
20 that -- and referred Ms. Madej to a gastroenterological  
21 specialist and she did not go? Do you remember her telling  
22 you that or seeing that in Dr. Singer's records?

23 A. I don't recall it, no.

24 Q. Would that change any of the opinions in your

1 report if you knew that she was referred to a G.I.  
2 specialist and refuse to see one?

3 A. Well, I think it would be significant enough  
4 to ask her why she didn't go. I think in retrospect if  
5 somebody's had gastrointestinal symptoms for -- of like  
6 sections of abdominal bloating, if my memory serves me  
7 right and again, I apologize for having a lousy memory  
8 these days, assuming that the stools are normal and she has  
9 abdominal bloating for the last 30 years, I think there  
10 would be very few physicians who would feel that it would  
11 be mandatory that we do all kinds of extravagant tests in  
12 order to rule out diseases that are extremely unlikely  
13 given that there's been no progression of illness over 30  
14 years, with respect to those symptoms, progression of  
15 illness and timeline.

16 Q. Okay. There is a statement here that Ms.  
17 Madej -- this is the last, second to last sentence, whole  
18 sentence. Ms. Madej recalls that the allergist determined  
19 that, quote, "Her lung capacity was reduced," end-quote.  
20 What did Ms. Madej tell you about that?

21 A. From my collection, I mean I put that quote  
22 in there because she -- that was her -- those were her  
23 words -- from my recollection, there's been no pulmonary  
24 function tests showing any abnormalities.

1 Q. Did you do any pulmonary function test?

2 A. No. I do not have the tools or the expertise  
3 to do that.

4 Q. Did you refer her for any tests like that?

5 A. No.

6 Q. Why?

7 A. Because it was my understanding that she had  
8 been complaining about these things for a very long time  
9 and if there was nothing progressive and nobody else had  
10 found anything of significance there to explain the  
11 symptoms.

12 Q. How do you know that allergy shots were tried  
13 for Ms. Madej?

14 A. She told me.

15 Q. And do you know who the internist was that  
16 she treated with that's referenced herein? Or, I'm sorry,  
17 the allergist, not the internist, the allergist who she  
18 treated with?

19 A. I do not recall if the allergist's notes were  
20 actually part of the clinical notes and records.

21 One other thing to say about with respect to the  
22 question about referral is my understanding, at least here  
23 in Canada, that as when you provide a -- an IME, it's a  
24 one-off, so to speak that we are not responsible and should

1 not be responsible for -- for care. So we can make  
2 recommendations to the lawyer if we think that something  
3 should be addressed. I recall -- I don't recall whether I  
4 put it in my report, actually, but -- no, I didn't -- I  
5 recall when Dr. Baratz found a low arginine vasopressin  
6 that I suggested that she get a brain scan, but I ---

7 Q. You were feeling ---

8 A. --- it's not my responsibility ---

9 Q. --- right now ---

10 A. Pardon?

11 Q. It's your -- you believe she needs a brain  
12 scan right now?

13 A. Well, the initial response was she may have  
14 neurogenic diabetes insipidus based on the initial opinion  
15 from Dr. Baratz. And he said, well, why is that? You  
16 know, maybe you should get a brain scan. That's -- and  
17 there's been more information since then which raises the  
18 question as to why those tests were reported as abnormal in  
19 the first place, but that was just an initial response.

20 So I tell you this in order to explain to you  
21 that it is my understanding doing an IME that I'm not  
22 responsible, should not take any responsibility for care.  
23 Once they order a test, then I'm responsible for providing  
24 information for that test and making recommendations.

1           That's care. That's not supposed to be my role.

2                   Q. Okay. Did you ever refer Ms. Madej to have  
3 any blood work performed?

4                   A. No.

5                   Q. Did you ever refer her for a urine sample to  
6 be performed?

7                   A. No.

8                   Q. Did you examine her with her clothing on  
9 outside?

10                  A. I pushed her shirt up. She was wearing a  
11 loose T-shirt. I pushed pants legs up. I did not examine  
12 her breasts or pelvic area, didn't see them.

13                  Q. Okay and then the next page there is a  
14 statement that Ms. Madej was prescribed Pamelor. What is  
15 Pamelor? It has the technical name, but what is that?

16                  A. Sorry, where are you looking? Next page?

17                  Q. At the top of page 4 in the first paragraph,  
18 it says she was prescribed Pamelor, Nortriptylene.

19                  A. Oh, Nortriptyline is an antidepressant  
20 medication. It's a tricyclic antidepressant.

21                  Q. And did you -- you believe Ms. Madej  
22 potentially has -- is depressed?

23                  A. Clinically with respect to requiring  
24 medication, no. I'm not sure why she was prescribed it.



1 The previous sentence says she was diagnosed with chronic  
2 fatigue. So in the differential diagnosis of chronic  
3 fatigue is depression. So someone told her to take this  
4 antidepressant. That medication is also used for chronic  
5 pain. Not because the patients are depressed, but because  
6 antidepressants also have an effect on certain types of  
7 chronic pain such as fibromyalgia, have an impact on ---

8 Q. Do you know why she was prescribed this?

9 A. From what I understand, she was prescribed it  
10 because of the chronic fatigue and I do not know what the  
11 thinking was of the prescribing physician.

12 Q. Page 4, the second paragraph has a statement  
13 of during this time. When was that?

14 A. You mean, during this period of time? Well,  
15 see previous ---

16 Q. Yeah. Are we still in ---

17 A. Previous paragraph.

18 Q. Are we still in the '90s? When are we?

19 A. Yeah, yeah, I would think so.

20 Q. Is provocation neutralization testing  
21 appropriate testing for allergies?

22 A. Is provocation and neutralization an  
23 appropriate test for allergies. Provocation and  
24 neutralization testing can also be done intradermally.

1 Allergists almost always use the skin prick test. So the  
2 difference is they put a drop of whatever it is, ragweed or  
3 peanut or whatever on the skin and they prick the skin. An  
4 intradermal test is to take that drop in a diluted form and  
5 inject it entirely into the skin and the technique used is  
6 such that it makes a bump in the skin. What should happen  
7 to that bump is that it should just slowly over five or ten  
8 minutes recede as it gets absorbed into the skin but an  
9 intradermal test, the bump will grow instead of recede. So  
10 that's -- that's an intradermal test.

11 So provocation and neutralization testing has  
12 been used to test for classical allergies, because  
13 intradermal testing is sometimes used when it is felt that  
14 the regular allergy testing is not giving reliable answers.  
15 The downside of provocation -- of an intradermal test is it  
16 could be a false positive. So you would not use the test  
17 with the strong dilution if somebody already had a positive  
18 test from the skin prick test. It's trying to find things  
19 that you think show up.

20 I'll give you an example, because skin prick  
21 tests is not a hundred percent accurate either. You come  
22 to me and you say, gee, every mid August to the end of  
23 September, beginning of October, I have itchy eyes and a  
24 runny nose, especially when I'm outside. I go (sneeze

1 sound). Sounds like ragweed allergy. Let's do some  
2 allergy testing. And to do that, we'll do a skin prick  
3 test. And skin prick test this thing. They say, well,  
4 that's weird. I wonder if it's a false negative. You do  
5 an intradermal test.

6 Q. Okay. So the first test, the first line is  
7 the skin prick test, correct?

8 A. For classical allergy, correct.

9 Q. Okay, but Ms. Madej, it's not your position  
10 she has classical allergy, correct?

11 A. It's not my position that she has classical  
12 allergy?

13 Q. It's not your opinion that she has classical  
14 allergy.

15 A. Certainly with respect to the conditions that  
16 we're addressing here, that's -- no, she just ---

17 Q. She's not allergic to chip seal.

18 A. No.

19 Q. Okay. Are you aware that Dr. Lieberman  
20 tested Ms. Madej with what you call intradermal testing for  
21 alleged sensitivities?

22 A. Am I aware that he did that?

23 Q. Yes.

24 A. Yes.

1 Q. Okay. Did you review those test results?

2 A. I had a hard time looking at the way the  
3 results were recorded. Sorry. I had a hard time  
4 understanding what was written when the results were  
5 recorded.

6 Q. So those tests are -- you did not rely on  
7 them in forming your medical opinions. Is that fair to  
8 say?

9 A. Yes.

10 Q. Okay. In terms of -- are you aware that Dr.  
11 Lieberman, for a brief period of time, prescribed Ms. Madej  
12 with injections of certain substances in order to allegedly  
13 build up her tolerance to those substances and she could  
14 not tolerate them. Are you -- did you see that in the  
15 medical records?

16 A. Yeah, but I'm having trouble remembering  
17 exactly what it was that he was injecting her with or for.

18 Q. Is it your opinion that that's an appropriate  
19 form of treatment for sensitivities?

20 A. I think it's an appropriate form of treatment  
21 for classical inhalant allergy, because what the  
22 provocation and neutralization technique can provide is a  
23 dosage that is tolerated. I used to do that for classical  
24 allergies in these patients to try and see if I could help

1       them with respect to managing their classical allergies.  
2       The immune system also has an effect on them, an existent  
3       function. When the patients are as severely sensitive and  
4       complicated as Ms. Madej, even trying to find out exact  
5       dose that was tolerated for more than a few shots was  
6       difficult. They're just unstable.

7               Q. So you did try to explore that with Ms.  
8       Madej?

9               A. No. I don't do that. I don't do that  
10       anymore.

11              Q. Okay.

12              A. So -- and they certainly -- that was in my  
13       office in Ottawa anyway. I was not trying to treat her.

14              Q. Is there any treatment that would be  
15       effective for Ms. Madej?

16              A. Simply put, she's got three conditions.

17              Q. Okay. It's just yes or no. Is there any  
18       treatment that would alleviate these symptoms other than  
19       avoidance of them?

20              A. You're talking about chemical sensitivities?

21              Q. Yes.

22              A. With respect to chemical sensitivities, there  
23       is no treatment known except avoidance. And avoidance is a  
24       management, not a treatment. It does not ---

1           Q. So is there any environment that would be  
2 totally safe for her?

3           A. Yes. The difficulty is that her condition is  
4 complicated by the chronic fatigue syndrome. So safe with  
5 respect to chemical exposures, yes, she has tried as hard  
6 as she can to try and create that in the home that she  
7 apparently spent a long time looking for in order to find a  
8 place that was safe enough for her. There is, you know, if  
9 we imagine the patients with chemical sensitivity is kind  
10 of like an iceberg or a triangle -- a pyramid. She's at  
11 the tip of the pyramid with respect to the level of  
12 sensitivity. It's relatively quite uncommon to what is  
13 much more normal ---

14          Q. Is there anything she's not sensitive to that  
15 you're aware of?

16          A. With respect to what we ask about, about  
17 scented products, about dry-cleaning, about new clothing,  
18 about things where the scents are fairly apparent, no. If  
19 you ask me which chemicals in particular she's reacting to  
20 in a scented product or chip seal, for example, nobody  
21 knows.

22          Q. Nobody knows.

23          A. Nobody knows exactly which chemical it is.  
24 Are there chemicals that she would tolerate? Probably, but

1 I don't know what they are and neither can anybody else  
2 figure it out.

3 Q. She doesn't know what they are, right?

4 A. No.

5 Q. So these alternatives that she's proposed for  
6 the road, there's no evidence that they would be any safer  
7 for her, correct?

8 A. There's a probability that the ones that she  
9 was recommending would not be off-gassing volatile organic  
10 compounds which is the understanding of that group of  
11 chemicals, which is huge. Okay? Which is huge. Are  
12 probably the main culprits for this condition. The meaning  
13 of volatile ---

14 Q. Okay, but ---

15 A. Do you understand the meaning of volatile  
16 organic compounds?

17 Q. I do.

18 A. Okay.

19 Q. Are volatile organic compounds present in  
20 some of the substances that she's proposed, the  
21 alternatives?

22 A. From what I have read, there is limited to no  
23 off-gassing of volatile organic compounds from these types  
24 of chemicals. One of the things that the Canadian ---

1 Q. Where -- wait -- which type specifically?

2 A. Which types of -- I'm sorry?

3 Q. Which products, which alternative products  
4 that she's proposing ---

5 A. She gave a list, she gave a list of products  
6 which again, not being an engineer and knowing what these  
7 products are, I have to look up, well, what are they and so  
8 on. So what I was going to tell you is that the -- in  
9 looking at trying to minimize air pollution, the Canadian  
10 Ministry of the Environment has looked at the production  
11 and application of different kinds of asphalt type products  
12 or road products, sorry, including chip seal. And they  
13 looked at what the contents are and which ones give off the  
14 most volatile organic compounds and in the list of the  
15 alternatives, it was apparent to me that these would off-  
16 gas minimal or none.

17 Q. Okay. Is that included in your report?

18 A. I don't recall if I made that statement in  
19 particular.

20 Q. Okay.

21 A. I certainly did not talk about the Ministry  
22 of the Environment's examination of these products,  
23 something they'd have come across.

24 Q. And we touched on this, but there is a



1 notation that Ms. Madej never had any pulmonary function  
2 tests including a methacholine challenge; is that correct?

3 A. There's a notation that she -- oh here --  
4 yeah.

5 Q. That's not -- okay.

6 A. Yeah.

7 Q. And are pulmonary function tests, would those  
8 be key to diagnosing why a patient has shortness of breath?

9 A. Are they key to why? They should be part of  
10 an evaluation by the clinical physician. Sometimes you go  
11 to an allergist and the allergist will do a firm what they  
12 call spirometry. Spirometry is looking at how well you can  
13 blow air out. So it looks at obstruction of airflow out  
14 which is what you see in asthma.

15 Q. Could the results of a pulmonary function  
16 test have changed for Ms. Madej since 1990?

17 A. Could there be -- say that again?

18 Q. Could the results of a pulmonary function  
19 test either a methacholine challenge or otherwise, could  
20 those be different from today to 1990?

21 A. If there's a progression of disease.

22 Q. Page 5. The first -- the third full  
23 paragraph, it says it has been recommended by her  
24 healthcare provider that she move to a rural clean

1 environment and a home that can be tolerated. What  
2 healthcare provider recommended that to her?

3 A. I'm presuming, based on memory, that it would  
4 have been -- it would have been Dr. Lieberman, I presume,  
5 because he ---

6 Q. Okay, if that is not reflected in Dr.  
7 Lieberman's records, is it possible that Ms. Madej came up  
8 with that?

9 A. That sentence or that recommendation?

10 Q. That recommendation.

11 A. Possible. But from the notes that I have  
12 here, someone recommended it to her. You need to find a  
13 place, safe place to live and it may not have been in Dr.  
14 Lieberman's notes, but when you've got someone who's  
15 chemically sick all the time and even in their own home,  
16 you say, well, someday you have to go somewhere else.

17 Q. Did you examine Ms. Madej's house?

18 A. No.

19 Q. Do you know on what she bases her belief that  
20 her house is still not safe enough for her?

21 A. She bases it on the belief that she gets  
22 symptoms provoked in the home.

23 Q. What do you think is provoking the symptoms  
24 in the home?

1           A. I don't know. That's one possibility.

2           Another possibility is that she has two other chronic  
3 conditions which can fluctuate sometimes for reasons that  
4 we don't understand. One of the characteristics when we  
5 describe chronic fatigue syndrome, is that the patients  
6 with respect to being able to work are unreliable and what  
7 that basically means is that we cannot predict when these  
8 things will flare. We don't understand everything about  
9 the condition to understand why the symptoms would flare.  
10 And the symptoms of chronic fatigue syndrome clearly  
11 overlap with the symptoms provoked by an exposure.

12           Q. Do you have any medical evidence that her  
13 chronic fatigue or her fibro are exacerbated by any actions  
14 of the Athens County Engineer?

15           A. By the actions? I'm sorry, is that what you  
16 said?

17           Q. Yes.

18           A. There is no question and I'm sure you'd be  
19 comfortable with this statement that being in a legal  
20 adversary process is stressful.

21           Q. Yeah. Do you have any reason though to  
22 dispute that she's the one who sued the county. She  
23 dragged the county into the legal adversarial process,  
24 right? That wasn't the county.

1           A. Well, fair enough, but why did she do that?  
2           Because she asked for accommodation, was refused. And with  
3           that, what the literature also shows is that patients with  
4           these kinds of conditions which are invisible are often  
5           treated with disrespect. Are led to believe that they are  
6           not being believed. So literature shows and this comes out  
7           in conversation with the task force that because these  
8           disabilities are invisible, people are made worse by social  
9           situations when they are being confronted, not believed and  
10          not being granted the requirements to minimize the  
11          symptoms. And in this case ---

12          Q. Well, everybody here, I can assure you, takes  
13          her condition very seriously and her allegations very  
14          seriously, including the allegation that by using chip and  
15          seal on the road, she will die. And that's what we're here  
16          to explore, because those are serious allegations and  
17          they're serious allegations against my client and the  
18          county takes them seriously and I take them seriously. So  
19          I'm entitled to ask these questions.

20          A. Oh, I'm not saying you shouldn't ask me  
21          questions.

22          Q. Let's go to page 6.

23          A. But the question that you asked me is whether  
24          or not this situation could be contributing to symptoms and

1 my answer in one word is yes.

2 Q. My question to you is, other than this  
3 litigation, have any actions of the county engineer  
4 exacerbated Ms. Madej's fibromyalgia or her chronic fatigue  
5 syndrome? And what medical evidence do you have of that?

6 A. The only medical evidence that I would have  
7 and the answer which would be yes was prior to those -- was  
8 prior to the litigation, there was actions by the engineer  
9 which prompted the litigation which is basically from my  
10 understanding -- from my understanding of what happened and  
11 I clearly was not there, she said I have a problem, can you  
12 use this product instead of that product and he said no.  
13 And in that case, that would contribute to the -- to the  
14 stress perceived, the lack of control over whether or not  
15 she would lose her home. This led to the litigation in  
16 which case, then the answer is yes. Whether or not the  
17 explanation is death or not, that's irrelevant. She has a  
18 condition. She asked for accommodation. He said no which  
19 led to the litigation. I think that contributed quite  
20 likely in some level to the severity of her condition.

21 Q. But again, we don't have any evidence that  
22 the alternative products would be any safer for her,  
23 correct? We can't say that with any medical certainty.

24 A. Well, define medical certainty. If you're

1 looking at probability which is a lot of what  
2 we do in

3 medicine, the probability is that that would  
4 be a safer

5 product for her to use -- for -- for -- not for her to use.

6 That would be a safer product to be applied, because it's  
7 much less likely, if at all, to give significant exposures  
8 that would provoke symptoms over a long period of time for  
9 her. The answer to the question ---

10 Q. Okay. What do you base that opinion on  
11 though, Doctor? What is -- what evidence do you have of  
12 that? This is very important ---

13 A. My opinion is that she has multiple chemical  
14 sensitivity complicated by the two other conditions. And  
15 as a result, exposures to chemicals would provoke symptoms  
16 perhaps for a long period of time. Therefore if something  
17 has to be used and I understand why the engineer wants to  
18 put something or this, that's not for discussion. I  
19 understand why he wants to do that. Makes perfect sense to  
20 me. But it's like, so what product are you going to use?

21 And say, well, the probability is if you're trying to  
22 accommodate the patient, as I said way back at the  
23 beginning of our conversation, you try and work with the  
24 people to see what would work the best. The best bet for

1 her ---

2 Q. Doctor, that is not the question.

3 A. What was the question?

4 Q. The question is, what medical evidence do you  
5 have that these products will be safer for her? I  
6 understand ---

7 A. If medical evidence ---

8 Q. --- your opinion regarding the legal duties  
9 of the County Engineer. That's respectfully not ---

10 A. My medical evidence is based on my opinion  
11 that it is my understanding that the products that she  
12 would like to be used are much less likely to provide --  
13 sorry, exposures to significant volatile organic compound  
14 levels that would set her off and that if there's an option  
15 here, that's what should be used. That's my medical  
16 evidence.

17 Q. Have you ever tested her for exposure to any  
18 of these alternative products?

19 A. There's no test available.

20 Q. Okay. Have you ever seen her become  
21 symptomatic around any of these alternative products?

22 A. I only spent two hours with her.

23 Q. How do you -- do you even know what's in  
24 these alternative products?

1           A. I looked at them at the time. I do not know  
2 exactly what's in them, but I am not -- my expertise is not  
3 chemical engineering. I look at what was in them. I do  
4 understand that even in the classical products that we used  
5 before we started to try make changes in reducing these  
6 chemical exposures, there were products made from bitamin,  
7 etc., etc., so that there was a lot of volatile organic  
8 compounds, a lot of petrochemical derivatives contributing  
9 to significant pollution and we are attempting to reduce  
10 that generally by changing the products.

11           Q. All right. Let's go to page 6.

12           A. Sorry?

13           Q. Page 6 of your report.

14           A. M'hmm.

15           Q. I think we were on that. Okay. So there is  
16 an allegation regarding recent lab data and this is --  
17 indicates that a chest x-ray and an EKG at Dr. Lieberman's  
18 request outside of her home were apparently normal. Did  
19 you review that x-ray or that EKG?

20           A. No. The statement is that she states this.

21           Q. Okay. Is it standard protocol that an EKG  
22 would be done outside?

23           A. No, nor a chest x-ray. It's not standard  
24 protocol to do things outside.



1 Q. Okay. And then page 6 also has a  
2 description. She describes exquisite sensitivity at  
3 chemicals and again that's a subjective description; is  
4 that correct?

5 A. Yes.

6 Q. Okay and then there is an opinion that she is  
7 able to physically detect odours which seem infinitesimally  
8 small. What medical evidence is that based on?

9 A. Her history.

10 Q. As relayed to you by her?

11 A. Yeah.

12 Q. Did she ever tell you the exact quantity of  
13 the infinitesimally small proportion?

14 A. It's impossible; exact quantity.

15 Q. Do you remember anything ---

16 A. It's exact quantity. You can't, you know,  
17 things are in the air that you can't see. So then that's  
18 impossible to do. But she describes experiences. Off the  
19 top of my head, I don't remember what they are, but she  
20 will describe, example, when she would be walking in an  
21 environment, an urban environment that she could detect the  
22 odour of pesticides that have been used. I can't do that.  
23 I don't know whether you can.

24 Q. How do you know it was pesticides that she

1 was detecting?

2 A. Because she told me she could smell them.

3 Q. How do you know it wasn't something else she  
4 was smelling?

5 A. I don't. But she was smelling something that  
6 was foreign to her that was provoking symptoms.

7 Q. Okay and then this environmental exposure  
8 history, that was given to you by Ms. Madej, correct?

9 A. Yep.

10 Q. Okay and did you review Dr. Lieberman's  
11 records regarding her exposure history?

12 A. I reviewed the records that were given to me  
13 and again, off the top of my head, I don't recall what  
14 exactly was written in his records.

15 Q. Okay. If Dr. Lieberman's records indicated  
16 once again that her exposure started with Dursban instead  
17 of with the mould in the basement apartment, that would be  
18 different, correct?

19 A. Different than what I have here? Correct. I  
20 got this from her.

21 Q. Okay. I'd like to go to page 7 and I'd like  
22 to look the site of social history here. I'd like to go to  
23 paragraph 2 of that. It indicates she met her husband,  
24 Bob, while attending university. Their relationship is

1 good and he is very supportive; is that correct?

2 A. Yes.

3 Q. Are you aware that there have been numerous  
4 complaints to the Athens County Sheriff's Office of  
5 domestic violence at the Madej property?

6 A. I'm aware that there were episodes where she  
7 was yelling. I'm not aware of any violence.

8 Q. So if Mr. Madej admitted in deposition and  
9 sworn testimony that hitting his wife occasionally, would  
10 that change your opinion regarding her psychosocial  
11 history?

12 A. I think it would, based on the fact that I  
13 think any hitting is abusive.

14 Q. This indicates she also finds support from  
15 her spiritual beliefs, church members, other friends and  
16 family. Do you know when the last time was that Ms. Madej  
17 left her home approximate to when you examined her?

18 A. Sorry, do I know when the last time was she  
19 left her home?

20 Q. Yes. So you examined her on or about May of  
21 2017, correct?

22 A. Yeah.

23 Q. Did she indicate that she stayed at home most  
24 of the time or that she was able to go out in the community

1 and drive or did she say she primarily had to stay home?

2 A. The latter. She primarily had to stay home.

3 Q. Okay. Did you understand that her husband  
4 had to care for her and bring her water from a special  
5 source? Did she relay that to you?

6 A. That her husband gets water from a special  
7 source?

8 Q. M'hmm.

9 A. Yes.

10 Q. Okay. Page 24. All right. So we have here  
11 under paragraph 2, that Ms. Madej takes an inordinate  
12 amount of time to perform physical and mental functions.  
13 It is the third sentence under there.

14 A. Paragraph 2. You mean after question 2?

15 Q. Yes, m'hmm, yes.

16 A. Okay.

17 Q. Okay. Is that your opinion? Is that  
18 correct?

19 A. Yes.

20 Q. Okay. Are there any functions that she  
21 cannot perform at all?

22 A. If you look a little bit down in that  
23 paragraph, there are numerous things mentioned that impact  
24 on her fatigue and these are classical things that we see

1 in chronic fatigue syndrome.

2 Q. Okay. So she's tired and it takes her longer  
3 to do things?

4 A. She's tired. It takes her longer to do  
5 things. And there are things that we normally do that we  
6 take for granted that exacerbate the fatigue.

7 Q. Okay. But is there any medical evidence that  
8 she cannot do any of these things?

9 A. The history.

10 Q. Okay. Any evidence other than the history  
11 that she's substantially limited in any of these things  
12 other than what's in this report?

13 A. That -- evidence that I would have?

14 Q. Yes.

15 A. No.

16 Q. Did the exam take an inordinate amount of  
17 time to perform or did the exam take a standard amount of  
18 time to perform, your examination of her?

19 A. I mean, there were -- there were several  
20 times when I asked whether she was okay to continue and she  
21 said yeah. I mean, I think she was quite aware that --  
22 that I had made a long journey to get there, that she was  
23 therefore going to go out of her way to complete the  
24 process. I think, if I remember correctly in the physical

1 exam, I commented about how she seemed to show some  
2 evidence of more fatigue towards the end of the  
3 examination.

4 Q. But you were with her for two hours, correct?

5 A. Yes.

6 Q. Is that a standard time for an exam or is  
7 that longer? I'm just asking.

8 A. Standard time for me?

9 Q. Yes.

10 A. For me? Gets the standard time. We provide  
11 more time than that when we book our patients at the  
12 Environmental Health Clinic because we also try and give  
13 information back with respect to what the diagnosis is,  
14 what it means and what they can do.

15 Taking the history is complicated. And I think,  
16 you know, given that there's a good chance that I have to  
17 go through a process like this, sorry, if I'm boring you,  
18 if going through a process where you need to be able to defend  
19 what you do and to be able to argue details, etc., that the  
20 process may take a little bit longer with respect to try  
21 and get details of information.

22 Q. Okay. Fair enough. Let's take a short  
23 break, five minutes.

24 A. Okay.

1 (A short recess is taken.)

2 Q. So opinion number three. Okay. So Doctor,  
3 the first sentence under the question is, from the history  
4 obtained, Ms. Madej has demonstrated severe sensitivity to  
5 a variety of petroleum based products which is very common  
6 in patients with MCS. And that is the history you got from  
7 her, correct?

8 A. Yes.

9 Q. Okay and did you review anything from Dr.  
10 Lieberman in coming to that conclusion?

11 A. Well, his opinion, given what he was trying  
12 to do and the letters that he wrote on her behalf would be  
13 that she has MCS, that he would agree with the diagnosis.

14 Q. But that's not -- that doesn't have to do  
15 with petroleum based products, correct? There's no  
16 independent evidence regarding petroleum based products?

17 A. It's probably the most common thing that we  
18 see. When you look at petroleum based products and you  
19 look at things whether they're plastics or other kinds of  
20 products. There's petroleum based products in scented  
21 products, etc., etc. And they fall under that heading of  
22 volatile organic compounds and the majority of them that  
23 we're faced with on a regular basis are petroleum based.

24 Q. Are the products harmful to her only when

1       they're volatile or would they be harmful when they're  
2       stable as well?

3               A. She has to have exposure that's -- that  
4       allows the chemical to get inside her body in some way. So  
5       for example, paint off-gases volatile organic compounds.  
6       So people will say, well, I react to the odour of paint,  
7       say, well, great, but once the paint dries, you know,  
8       there's paint on the walls right here. The paint on the  
9       walls right here are not off-gassing. There's not going to  
10      be a problem. So somehow it has to be sensed by the body  
11      more than simply the sense of touch to stimulate a  
12      response.

13             Q. Okay. So no then, it's potentially?

14             A. Yes, to be succinct, the answer is no.

15             Q. Okay. All right. We're going to go through  
16      the MSDF sheets on the alternative products, but I want to  
17      go through number four?

18             A. Number four, on the question you mean?

19             Q. Yes. Question four on page 25.

20             A. Okay.

21             Q. But before we do that, I'm sorry about this.  
22      The last paragraph under question three on page 25 starting  
23      with, "It is my opinion," and in terms of Ms. Madej being  
24      unable to remain in her present home, again, that is only



1 during the volatile stage of when the chip seal is applied.

2 That's your opinion, correct?

3 A. What I wrote in here is if it's applied. So,  
4 you know, when it's applied implies a very short period of  
5 time. Questions to be asked for me of a chemical engineer  
6 would be how long these -- so for example, there is  
7 something called semi-volatile and obviously they're not as  
8 volatile as the volatile. And those chemicals have the  
9 characteristic of going back and forth between a gas and a  
10 solid phase when they're in contact with solids. So if  
11 particular matter is being given off by the -- from the  
12 asphalt when in use, would that particular matter have  
13 chemicals attached to it that would be potentially inhaled  
14 by Ms. Madej. So these are engineering, chemical engineer  
15 questions. So the way you asked the question of when it's  
16 applied is not -- not a fair question. It should be if she  
17 has exposure.

18 Q. Okay. So -- and it's your opinion that  
19 she'll suffer harm and that harm includes fatigue, pain?

20 A. Shortness of breath.

21 Q. Poor cognitive functioning, sleep disturbance  
22 would all be exacerbated. Are there any other harms that  
23 she'll suffer, in your opinion?

24 A. When you have somebody as sensitive and with

1 the severity of the chronic fatigue syndrome and the two  
2 are linked, the question then becomes what is the recovery  
3 time? And if there is a significant enough impact on those  
4 conditions, will the recovery from those symptoms provoked  
5 be complete or will she be at a new level of sensitivity  
6 and fatigue and pain for a longer period of time, is the  
7 question. With respect to somebody from, in my opinion,  
8 who is as severely disabled as she is by her conditions, I  
9 think the potential for long term change in the severity of  
10 the conditions is there.

11 Q. Okay, but based on if the chip and seal is  
12 applied, will any other conditions manifest that you're  
13 aware of? Any other symptoms?

14 A. Besides one listed here?

15 Q. Yes.

16 A. I put etc., because she has other symptoms.  
17 Those are the prevalent ones with respect to the link with  
18 the chemical sensitivities and chronic fatigue syndrome.  
19 So we've got, you know, the respiratory ---

20 Q. What other symptoms are there?

21 A. --- the respiratory and central nervous  
22 systems complaints would be exacerbated and I don't know  
23 for how long and I don't know whether she would recover  
24 completely or not given the level of instability that she

1 already has.

2 Q. Have you ever observed her become  
3 symptomatic?

4 A. No. I was only there for those two hours. I  
5 saw -- well and, you know, as I mentioned, I saw her become  
6 more fatigued.

7 Q. And is it possible that these symptoms could  
8 be exacerbated regardless if the chip and seal is applied?

9 A. Sure, for unpredictable reasons. Some of the  
10 more -- there's a recent article that came out in Italy on  
11 chemical sensitivity where they were talking about the  
12 potential for people to -- for their health, it deteriorate  
13 in the long run. So what we don't have are long term  
14 studies of people diagnosed with chemical sensitivity to  
15 see whether or not they go on to develop other conditions  
16 whether there's a shortening of lifespan and increased  
17 mortality rate, we don't know that. We know that for  
18 chronic fatigue syndrome, there is increase in probability  
19 of cancer and heart disease, mortality rate.

20 Q. But we don't know that for chemical  
21 sensitivity, correct?

22 A. No, no.

23 Q. Any other symptoms that you believe she will  
24 display if the road is chip and sealed?

1           A. I think -- well, I mentioned pain, so within  
2           that, you know, there's the fibromyalgia pain and there's  
3           also the probability that she would have more headache.  
4           She does get migraine headaches.

5           Q. Okay and then let's go through the  
6           alternative products.

7           A. Where is that? In this as well?

8           Q. This is number four. Okay and what did Ms.  
9           Madej tell you regarding the efforts that she and her  
10          husband took to obtain this information from the other  
11          suppliers?

12          A. Oh, in question four, sorry.

13          Q. Yes, sorry. First sentence. "Ms. Madej  
14          reports that she and her husband studied the MSDF and  
15          toxicology information, asked many questions of the  
16          manufacturers and requested samples," correct?

17          A. Yeah.

18          Q. What did she tell you they did?

19          A. I think memory tells me that one of the  
20          things that she did was, with the samples, was to put a  
21          small amount of the sample in a container outside her home.

22          Q. What kind of container?

23          A. I don't recall.

24          Q. How far away from her home was it?

1           A. I don't recall. My memory is trying to, you  
2 know, get a picture of what she was describing was maybe on  
3 her balcony or porch or walkway, driveway, somewhere. I  
4 remember her saying that she had done that to expose  
5 herself.

6           Q. Did you ever observe ---

7           A. No.

8           Q. Did you ever observe the, I'll call it the  
9 box? Yes or no.

10          A. Did I ever observe?

11          Q. The box with the samples?

12          A. No.

13          Q. Did she tell you how much of the sample she  
14 put in there?

15          A. If she did, I don't recall.

16          Q. Okay. Did she tell you which, there's a  
17 statement in here that she reacted to some of the products,  
18 but mildly compared to her experience with asphalt. She  
19 was never really completely free of reaction. Is that  
20 accurate? Is that what she told you?

21          A. That's what I wrote, so I presume that that's  
22 what she told me and that it's accurate.

23          Q. Okay. I'll presume that, too, then. Did she  
24 tell you which product she reacted to mildly?

1 A. No.

2 Q. Do you believe that that level of  
3 experimentation is efficient to establish that the enzymes,  
4 that those products are safe for her?

5 A. It's all we have is -- is an exposure on some  
6 level with a -- with the patient's observation. So, you  
7 know, how long do you do this? How repeatedly is it done  
8 before you can make an assessment or not? And I think that  
9 that question is unknown. So it's like the patient's  
10 experience is basically what it boils down to.

11 Q. Okay. Just the patient's experience?

12 A. That's all we have.

13 Q. Yes. There's no scientific method employed  
14 here in making this determination, correct?

15 A. Correct.

16 Q. Okay, correct, and the fifth paragraph down  
17 under number four, it says, "In my experience other  
18 extremely sensitive patients have found material that they  
19 could tolerate by scalp testing." And what are those other  
20 patients? You don't have to give names, but if you could  
21 give general descriptions?

22 A. Well, let me give you this example. When I  
23 first started doing this, I had a patient who had extreme  
24 chemical sensitivity and I had not met her. Her husband

1       came to the appointments. So I lived in Ottawa, the town  
2       of maybe a million people less and right outside the city  
3       is a national park with camping grounds and so on. It's  
4       like 20 minutes from the center of town. And this woman  
5       was living in a tent there. And the first time I ever saw  
6       what she looked like was when she was -- when her picture  
7       and her story was published in a magazine called Maclean's  
8       magazine, sort of Canada's version of Time or Newsweek,  
9       that kind of national magazine. That's my first time I  
10      ever saw her. This waif looking woman living in a tent.  
11      But her husband came from a family with a lot of money and  
12      so they decided they were going to build a safe home and  
13      I'm talking about this is the '80s then, late '80s, right?  
14      So they were going to try and build a safe home and so what  
15      they did was they -- whatever materials they wanted to use  
16      in there to build their home, they brought out to her tent  
17      to see if tolerated it and if she tolerated it, she kind of  
18      hung around it in her tent to make sure that she would  
19      tolerate it for more than five minutes. And they built  
20      this home. And after they built the home, they -- there  
21      was a patient support group in Ottawa at that time and so  
22      they had an open house to show people what could be done.  
23      Now, obviously, you'd need money, but what could be done to  
24      provide safe housing. And the experience was that a lot of

1 the people loved her home and were fine in it and some  
2 people still weren't fine in it, that they had their own  
3 problems. But there have been other attempts to try and  
4 build safe housing. There's a federal agency called the  
5 Canadian Mortgage and Housing Corporation, I allude to that  
6 in my introduction to my expertise, CMHC. And way back,  
7 they were mortgage company back in the '40s and '50s, but  
8 they became more involved in safe housing and indoor air  
9 quality. And they built a prototype home for people with  
10 chemical sensitivities. In the '90s, they had a display on  
11 there as an exhibition to canvass. A lot of people found  
12 it quite safe. A few people still found that it was a  
13 problem. So there's those two experiences.

14 Q. Okay. I appreciate that. So I mean, what  
15 I'm taking from that is some people are sensitive to  
16 something and other people are not sensitive to it, based  
17 on their symptoms that they display, correct?

18 A. Correct.

19 Q. Okay and I am just wondering in terms of --  
20 okay, so this does not -- this sentence doesn't  
21 specifically reference materials that are the specific ones  
22 she's proposing for the yard. It's just saying that self  
23 testing might show results for a safe product; is that  
24 correct?



1           A. Yes.

2           Q. Okay. All right and -- all right. You've  
3 also noted in the fourth paragraph, we're going to jump up.  
4 "Exposure to products does not appear to be reliable as a  
5 testing procedure for a variety of reasons. However, in  
6 this case, the fact that Ms. Madej attributes minimal  
7 reactions to these alternative products and is willing to  
8 allow the use of these products close to her home should be  
9 given some credibility." There was -- and then it says,  
10 "It is my opinion that the way she conducted her exposures  
11 and observations is reliable. There was extended  
12 observation albeit subjective in an appropriate washout  
13 period." How long was the washout period?

14          A. Could have been several days between  
15 exposures.

16          Q. Do you recall exactly?

17          A. No.

18          Q. Okay.

19          A. I think in the first sentence there as a  
20 testing procedure, I was talking about an objective test to  
21 be performed for sensitivity to chemicals that can be  
22 reliable under controlled conditions. So we're ---

23          Q. But there are no controlled conditions here,  
24 correct? The box is outside. It could be exposed to any

1       number of factors, right?

2               A. True, but I think if you feel good with that  
3       exposure despite the fact that there could be other things  
4       possibly outside, then you've got to assume that you're  
5       going to feel good with that exposure. Unfortunately,  
6       sometimes we make our -- our -- get our impressions based  
7       on logic. But if you want to use science, it has to be  
8       more than logic. It has to be immeasurable.

9               Q. Science has to be measurable, correct?

10              A. Yeah, that's what I just said.

11              Q. Okay and this is a subjective measurement  
12       only, correct?

13              A. Yeah, correct. You can't measure her  
14       symptoms either.

15              Q. Well, you could with a methacholine test or a  
16       pulmonary test to evaluate her shortness of breath,  
17       correct?

18              A. No. You can use that to find -- a  
19       methacholine test is able to exacerbate obstruction of  
20       airflow in someone who has obstruction of airflow. Okay?  
21       So ---

22              Q. Well, her shortness of breath could be  
23       attributed to obstruction of airflow, correct?

24              A. Could be or you could rule it out, but it

1 doesn't mean that you can measure shortness of breath based  
2 on that. If you have shortness of breath because you have  
3 a bad heart, for example, your methacholine challenge test  
4 would be normal. Your shortness of breath because you're  
5 out of shape. Methacholine challenge test says normal.

6 Q. Would the EKG show if you have a bad heart?

7 A. It's one of the tools that we use to try and  
8 figure it out. It's more complex than simply an EKG. An  
9 EKG is looking at electrical activity.

10 Q. Okay. The last sentence on this report is  
11 that I trust that this report is satisfactory. Is that a  
12 standard way that you sign your reports?

13 A. Yeah, I hope I answered your questions is  
14 really what it means.

15 Q. You just put that on all of them?

16 A. Yes and I, you know, I notice that other  
17 people may sometimes sign it off differently and I realize  
18 this is a legal document, but I don't know how to sign off  
19 any -- sincerely yours is probably completely  
20 inappropriate. So that was to end it.

21 Q. Are all of your opinions regarding Ms. Madej  
22 set forth in this report?

23 A. As far as I know, yes. I mean, I think  
24 they're subject to change if new information is provided.

1 I notice, for example ---

2 Q. Did you order Ms. Madej to have blood work  
3 done recently in April?

4 A. Sorry, ask me the question again? I didn't  
5 hear you.

6 Q. Did you order Ms. Madej to have blood work  
7 done in April or March of this year?

8 A. Did I order her to have blood work done?  
9 Meaning I told her to go someplace to get tests done?

10 Q. Yes.

11 A. If I recall correctly, you know, that was not  
12 a great period in my life and so if I recall correctly, I  
13 may have said you should get these things repeated. And  
14 perhaps more tests should be done to establish or rule out  
15 the diagnosis of diabetes insipidus from an  
16 endocrinologist. That's my recollection.

17 Q. Do you recall -- is it your opinion that she  
18 does not have diabetes insipidus?

19 A. She has a low base oppression. She does not  
20 have symptoms of diabetes insipidus which are excessive  
21 urine production. The lab results that were obtained by  
22 Dr. Baratz showed that -- that for 24 hours she produced  
23 2600 cc's of urine and it is my understanding that diabetes  
24 insipidus is more than 3000. So I'm looking at that and

1       saying that's not my area of expertise, but I question  
2       that, so told her to go and ---

3               Q.   It's not your area then.

4               A.   --- get it checked out.  Because obviously if  
5       she has diabetes insipidus, this situation aside, it should  
6       be addressed.  That's what you would advise any patient.  
7       I'm not supposed to be doing that, but that's what I've  
8       been doing for 40 years, so I told her to go and get it  
9       checked.

10              Q.   Any evidence that her diabetic condition is  
11       related to the use of chip and seal on the road?

12              A.   No.

13              Q.   Okay.  Any -- none of her medical conditions  
14       are related to the use of chip and seal on the road,  
15       correct?

16              A.   No.  You're smiling and I was smiling.  I was  
17       going to say not yet, but that would not be fair.  So, you  
18       know, obviously I have the position that the chip and seal  
19       could exacerbate a condition, but from what I understand,  
20       she has not had prolonged exposure to that before.

21              Q.   I'd like to look at what will be marked as  
22       Exhibit 3 and this is -- these are your records that ---

23              A.   Okay.

24              Q.   --- is a question it looks like?

1                   A.  Yep.  I have it.

2                   Q.  It says Dr. John Molot, MD, CCFP, FCFP.

3                   Doctor, what does CCFP stand for?

4                   A.  Certified by the College of Family Physicians  
5                   and FCFP is a Fellowship College of Family Physicians,  
6                   Fellow with the College of Family Physicians.

7                   Q.  Okay.  What is this document, Doctor?

8                   A.  What's the question?  What is this document?

9                   Q.  Yes.

10                  A.  Most people who practice environmental  
11                  medicine, certainly at the clinic, use a questionnaire to  
12                  try and expedite the gathering of information by getting to  
13                  fill a questionnaire.  It's a work in progress.  We're  
14                  working on this also within the clinic and to do this as  
15                  well in a Centre of Excellence to try and figure out how to  
16                  gather this data to make it also chronological, so it's  
17                  huge.

18                  Q.  So this is a form you just -- you use this in  
19                  your practice, correct?

20                  A.  Yes.

21                  Q.  And is this your handwriting on it or is this  
22                  Ms. Madej's or ---

23                  A.  No.  It's hers, it's Cindi's.

24                  Q.  Okay and when do you give the people the

1 questionnaire, the patients?

2 A. Before they're seen.

3 Q. Okay. So she fill this out before you came  
4 to see her?

5 A. Yes.

6 Q. Did she fill this out before you reviewed her  
7 medical records?

8 A. This is a standard questionnaire that I used  
9 in ---

10 Q. Okay, but did ---

11 A. So I do not recall which came first. If you  
12 go to the last page on page 54, she signed it that she had  
13 filled it out and the date completed is April 19, 2017.

14 Q. Okay. So that's about a month before the  
15 IME, correct?

16 A. Yes.

17 Q. Okay. Tell me about what you do after you  
18 receive this document. Do you use it in your evaluation of  
19 the patient?

20 A. Well, yeah, you can see the little, what  
21 would you call these things, bullets? They're not bullets  
22 where I comment that -- I guess they don't come out on this  
23 printed form, but they're comments that I made for  
24 questions to address when I actually do the assessment. So

1        what I do is I look at this, I look at all the other  
2        information given to me and I formulate for my own  
3        information what questions need to be addressed and  
4        answered in order to try and formulate an opinion. So  
5        apologies, when I sent this, for my ignorance in not  
6        realizing that those notes that I have in here do not  
7        appear on the printed copy.

8                Q. Not a problem. I have seen those. They  
9        appear on the PDF.

10              A. Okay.

11              Q. Okay. Why does it say referring lawyer on  
12        the front? Because patients are typically referred you by  
13        a lawyer; is that correct?

14              A. Yeah. It used to say referring physician  
15        when I had my own personal practice, but I changed it to  
16        that, because then I got all the information that I need.

17              Q. Okay. All right. I'd like to show you this,  
18        there's a lean test that is one page and it's from the date  
19        that you examined her?

20              A. The one with the blood pressures marked in --

21        -

22              Q. Yes.

23              A. --- May 13, 2017? Yeah, okay, I have it.

24              Q. And Ms. Court Reporter, could you please mark



1           that document as Exhibit 4?

2                   And if you didn't, these notes or the  
3           questionnaire form should marked as Exhibit 3.

4                   Doctor, what is this document?

5                   A.   It's the results of blood pressure -- the  
6           document that you're talking about, the lean test?

7                   Q.   Yes.

8                   A.   It's just a piece of paper really where we  
9           can mark the blood pressure and the pulse, so the lean test  
10          where you have the patient lying down until the blood  
11          pressure and pulse are reasonably stable and then you get  
12          them to stand up leaning against a wall which in this case  
13          was a fence and you record the blood pressure and pulse  
14          every minute for ten minutes.

15                  Q.   Okay and her blood pressure is normal?

16                  A.   Normal and stable.   There's nothing abnormal  
17          in any of these to interpret the results of lean test is  
18          normal.

19                  Q.   Okay.   I'd like you to look at and I'm having  
20          trouble reading it, so we're going to have to do that.  
21          It's Exhibit 5, what will be marked Exhibit 5.

22                  A.   Is that my physical exam with the scribbles  
23          on it?

24                  Q.   Yes.

1                   A. Okay.

2                   Q. Okay, so these are your handwritten notes?

3                   A. This is 5. Sorry?

4                   Q. These are your handwritten notes?

5                   A. Yeah.

6                   Q. Okay. So let's go through what they say.

7                   They start by saying Cindi Madej at the top, correct?

8                   A. I don't know what you've got there. My copy,  
9                   the first thing I see is "dressed simple" and  
10                  there's

11                  something above it, because there's a little squiggly line,  
12                  but perhaps it wasn't -- I don't think it was photocopied,  
13                  so there's a big blank space of two inches at the bottom of  
14                  mine, so it probably was not -- what do you have on the top  
15                  of yours?

16                  Q. Well, I have a date that says May 13, 2017,  
17                  and then a notation that says Cindi Madej in the left-hand  
18                  corner?

19                  A. But you're talking about the physical exam.  
20                  Yeah, on my exam what's quote -- what's photocopied on here  
21                  I'm sure this is my handwriting, but it wasn't perfectly  
22                  centered on the photocopy machine, so I do not have the  
23                  name and the date on here. But I recognize this and would  
24                  attest to that -- I'm sure that's what it is.

1 Q. Okay. So this says dressed simple with  
2 top/pants.

3 A. Light top. So this is, you're talking to a  
4 guy. I was trying to -- I knew you might be questioning me  
5 on this. I was talking to my wife and saying my memory of  
6 it is, it was just this very loose material. It's probably  
7 cotton.

8 Q. Right.

9 A. That's what that meant by light top/pants.

10 Q. So just read these to me if you can.

11 A. No something and jewelry -- makeup -- no  
12 makeup and jewelry. That's important so when you're  
13 looking at colour of skin, etc., etc. Skin colour normal.  
14 Looks stated age. Affect appropriate. Respectful.  
15 Engaged in conversation easily. Cooperative. Gait normal.  
16 Colour normal. No visible rash. Pupils are equal and  
17 reactive to light and accommodation. Ears, nose and throat  
18 normal. No lymphadenopathy. That's no swelling of lymph  
19 glands. No thyromegaly. Chest is clear. Heart sounds are  
20 normal. Abdomen is flat. Bowel sounds are normal. The  
21 abdomen was soft. LKKS with little zeros is liver, kidneys  
22 and spleen were not really palpable, they were normal, they  
23 were not tender, there was no tenderness. Deep tendon  
24 reflexes. I had difficulty eliciting the deep tendon

1 reflexes. Musculoskeletal system is grossly normal. In  
2 watching her move, there was no evidence for hypermobility.

3 Basically that's one of the things that we may see in  
4 patients with fibromyalgia is they can do things like move  
5 their thumb here much further if there's a -- I didn't see  
6 any evidence of that. Those funny pictures with the Xs all  
7 over it is my attempt at drawing a human figure marking the  
8 tender points for fibromyalgia that were positive and you  
9 can see there I have "FM" for fibromyalgia tender points,  
10 16 out of 18 were positive.

11 Q. And how do you test for that? You just poke  
12 her or how does that work?

13 A. The theory is that if you push down on your  
14 thumb or your finger and you start to blanch the skin of  
15 the nail, that's about four kilograms of pressure and  
16 that's what's recommended as how hard you should push on  
17 these tender points to see if there's a response.

18 Q. There are some documents that were sent over  
19 that start with the phrase EnviroSAFE Chemicals Canada  
20 Material Safety Data Sheet that came in a big packet. I  
21 don't know if -- I sent them this morning late.

22 (A short recess is taken.)

23 Q. I'm going to go ahead. I think I can ask you  
24 about these just generally and go from there. Did you

1 review the material safety data sheets for all of the  
2 alternative products that Ms. Madej proposed?

3 A. My memory is that I saw information regarding  
4 what those products may contain. I don't remember whether  
5 they were MSDS sheets or not.

6 Q. If I represented to you that some of those  
7 products contain butoxyethanol, would you have any reason  
8 to dispute that?

9 A. I have no reason to dispute what's on an MSDS  
10 sheet.

11 Q. Can we agree that that would be a petroleum-  
12 based product that she is likely sensitive to?

13 A. What's the name of the product again?

14 Q. Butoxyethanol, has ethanol in the title.

15 A. You'd have to ask a chemical engineer or a  
16 chemist, because that's an alcohol. We drink alcohol and  
17 it's not petroleum-based, too, usually.

18 Q. If Ms. Madej's medical records reflect that  
19 she doesn't tolerate alcohol any longer, can we agree that  
20 she'd be sensitive to it?

21 A. No. Patients who -- one of the things that  
22 we see in patients with chemical sensitivity is they do not  
23 tolerate drinking alcohol. So what it means is that  
24 they're more likely to feel the effects at a smaller level

1       than you and I would find social to have a glass of wine  
2       with a meal, you and I would not feel that we would be  
3       hung-over, perhaps I speak on your behalf when I shouldn't,  
4       but one would not expect to feel fatigued, hung-over, feel  
5       the effects of alcohol from a glass of wine sipped over  
6       dinner, but these patients will. And that's what alcohol  
7       intolerance is -- it's commonly seen in these kinds of  
8       patients. So drinking the alcohol is not the same as  
9       perhaps being exposed to a small amount of man-made alcohol  
10      a mile away.

11               Q. And when you rendered your medical opinions  
12      about Ms. Madej, did you review any blood work that was  
13      performed?

14               A. Well, there's several blood tests, results  
15      and urinalysis results that were in the clinical notes and  
16      records over the years, so I looked at those.

17               Q. But you did not order new blood work or  
18      urinalysis, correct?

19               A. Correct.

20               Q. Have you told me everything about your  
21      opinions in this case, Doctor?

22               A. Have I told you everything about my opinions?

23               Q. Have you told me all of your opinions in this  
24      case?

1           A. I presume you have a lot more questions and  
2 then I would have more answers, but I think that my opinion  
3 on this case as far as I have at present is well  
4 represented in the things that I've written.

5           Q. Okay. I don't have anything.

6           A. Sorry, you don't have any further questions?  
7 Is that what you said?

8           Q. Yes. We're done.

9           A. Thank you very much.

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## 1 CERTIFICATE OF REPORTER

2 CANADA

3 PROVINCE OF ONTARIO

4 I, Jo Lynn Dickinson, CCR, certify:

5 That the foregoing proceedings were taken before me  
6 at the time and place therein set forth, at which time the  
7 witness was put under oath;

8 That the testimony of the witness, the questions  
9 propounded and all objections and statements made at the time  
10 of the examination were recorded digitally by me and  
11 were therefore transcribed;

12 That the foregoing is a true and correct transcript  
13 of my recorded notes so taken.

14 I further certify that I am not a relative or  
15 employee of any attorney of the parties, nor financially  
16 interested in the action.

17 I declare under penalty of perjury under the laws of  
18 Ohio that the foregoing is true and correct.

19 Dated this 24th day of April, 2018.

20   
21 \_\_\_\_\_

22 Jo Lynn Dickinson, CCR  
23  
24



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