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1 IN THE COURT OF COMMON PLEAS
2 OF CUYAHOGA COUNTY, OHIO
3 -----
4 WILLIAM J. GILL, III,
5 Executor of the Estate of
6 DANIEL P. GILL, deceased,
7 Plaintiff,
8 vs. Case No. 457634
9 ROGER A. MANSNERUS, M.D.,
10 et al.,
11 Defendants.
12 -----
13 DEPOSITION OF MARK J. BOTHAM, M.D.
14 TUESDAY, FEBRUARY 3, 2004
15 -----
16 Deposition of MARK J. BOTHAM, M.D.,
17 a Witness herein, called by the Plaintiff for
18 examination under the statute, taken before me,
19 Cynthia A. Sullivan, a Registered Professional
20 Reporter and Notary Public in and for the State
21 of Ohio, pursuant to notice and stipulations of
22 counsel, at the offices of Hillcrest Hospital,
23 6780 Mayfield Road, Mayfield Heights, Ohio, on
24 the day and date set forth above, at 5:15 p.m.
25 -----

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1 APPEARANCES:
2 On behalf of the Plaintiff:
3 Becker & Mishkind Co., LPA, by
4 HOWARD D. MISHKIND, ESQ.
5 Skylight Office Tower
6 1660 West Second Street
7 Suite 660
8 Cleveland, Ohio 44113
9 (216) 241-2600
10
11 On behalf of the Defendant:
12 Reminger & Reminger, by
13 ROBERT D. WARNER, ESQ.
14 1400 Midland Building
15 101 West Prospect Avenue
16 Cleveland, Ohio 44115
17 (216) 687-1311
18
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1 -----
2 (Thereupon, Plaintiff's Deposition
3 Exhibits 1 through 4 were marked for purposes
4 of identification.)
5 -----
6 MARK J. BOTHAM, M.D., of lawful age,
7 called for examination, as provided by the Ohio
8 Rules of Civil Procedure, being by me first duly
9 sworn, as hereinafter certified, deposed and
10 said as follows:
11 EXAMINATION OF MARK J. BOTHAM, M.D.
12 BY MR. MISHKIND:
13 Q. Could you state your name for the
14 record?
15 A. Mark Judson Botham.
16 Q. You are a physician; is that
17 correct?
18 A. That is correct.
19 Q. Dr. Botham, you and I have never met
20 before, have we?
21 A. No, we have not.
22 Q. My name is Howard Mishkind, and I
23 represent the estate of Mr. Gill. I'm going to
24 be asking you some questions concerning the
25 opinions that you have expressed in your report

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1 of November 29, 2002, that you sent to
2 Mr. Warner and also some questions about your
3 background, and hopefully, we won't be terribly
4 long. Famous last words.
5 You have had your deposition taken
6 before, I know, so you know the routine in terms
7 of waiting and making sure that you understand
8 my question before you answer it; right?
9 A. Yes.
10 Q. If you don't understand a question
11 or if for some reason I ask a question that
12 somehow isn't intelligible, you'll tell me it
13 isn't, and I'll rephrase it; okay?
14 A. That sounds fair.
15 Q. If you do answer the question, I
16 have every reason to accept that you understood
17 the question; is that fair?
18 A. That is fair.
19 Q. Exhibit 1 is a copy of your report
20 that you wrote to Mr. Warner; is that correct?
21 A. That is correct.
22 Q. It appears that you were contacted
23 sometime in September of 2002 to review the
24 case. Exhibit 3 which I've just handed to you,
25 does that --

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1 A. It was either September or late
2 August, I believe, that I received a phone call
3 asking if I'd be willing to review that and then
4 subsequently received the materials stipulated
5 on Plaintiff's Exhibit 3.
6 Q. Now, attached to Plaintiff's
7 Exhibit 3 is it looks like a draft of your
8 report?
9 A. Yes. I believe so.
10 Q. Did you review the draft of the
11 report with Mr. Warner before you signed what is
12 Exhibit 1, the report on the Cleveland Clinic
13 stationery?
14 A. I don't know whether I actually
15 would have spoken to him by phone regarding
16 this. This is probably something that my
17 secretary printed up for me to look at, and then
18 usually what I'll do is just check that I'm okay
19 with it, and they'll print that up on my
20 letterhead. Sometimes the attorneys do wish to
21 have me speak to them about the report prior to
22 actually sending it down; sometimes not. I
23 don't recall whether I did or not.
24 Q. Do you recall whether there were any
25 changes made to the draft report which is

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1 attached to Exhibit 3 and the report that you
2 signed that is Exhibit 1 without going through
3 it line and verse?
4 A. I don't believe so, no.
5 Q. Exhibit 2 is a copy of your CV; is
6 that correct?
7 A. That is correct.
8 Q. If I could see Exhibit 3 for a
9 moment?
10 A. (Indicating.)
11 Q. Your report, Exhibit 1, identifies
12 certain information that you apparently had at
13 the time that you reviewed the case and
14 considered for purposes of that report; is that
15 correct?
16 A. That is correct.
17 Q. Does that list of items that's
18 contained in Exhibit 1 constitute all of the
19 information at that time that you had reviewed
20 for purposes of your opinions?
21 A. I believe so, yes.
22 Q. You are a cardiothoracic surgeon; is
23 that correct?
24 A. That's correct.
25 Q. The overwhelming percentage of your

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1 cardiothoracic surgeries that you do are
2 coronary artery bypass surgeries; is that
3 correct?
4 A. Well, things have changed in the
5 last five years. I would suspect that probably
6 60 to 70 percent of my present surgery involves
7 cardiac surgery and 30 percent noncardiac
8 thoracic surgery. Of the cardiac surgery that I
9 do, probably 70 to 80 percent of that is bypass,
10 coronary bypass surgery.
11 Q. When did the percentages of your
12 surgical experience change?
13 A. When the cardiologists became more
14 adept at doing balloon interventions,
15 percutaneous interventions, the number of
16 coronary bypass surgeries that we do as
17 cardiothoracic surgeons decreased.
18 Q. If a patient such as Mr. Gill came
19 to you at a point in time where he was Stage I
20 nonsmall cell carcinoma and a patient that was
21 an appropriate surgical candidate, would you be
22 the type of surgeon that would perform surgery
23 on a Stage I nonsmall cell carcinoma lung
24 cancer?
25 A. If it was a clinical Stage I

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1 carcinoma of the lung and we had done the
2 appropriate preoperative evaluation to ascertain
3 that it was indeed a clinical Stage I disease
4 and that he was a candidate for surgical
5 resection based upon his medical condition and
6 his pulmonary function test, yes, I would then
7 be the surgeon who would perform that surgery.
8 Q. What type of surgery would be
9 performed?
10 A. It can vary anywhere between a
11 preoperative nodal sampling, be it a scalene
12 node biopsy or a mediastinoscopy to ascertain
13 the absence or presence of microscopic nodal
14 disease that might preclude formal thoracotomy
15 and surgical resection of the primary tumor to
16 actual resection of that primary tumor along
17 with the mediastinal lymph node dissection.
18 The surgical resections that can be
19 encompassed in that type of resection can vary
20 anywhere between a wedge resection, a lobectomy,
21 or a pneumonectomy.
22 Q. In terms of the initial
23 intervention, surgical intervention, that you
24 mentioned, if there has been expansion of the
25 tumor into the mediastinum, that would by

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1 definition no longer be a Stage I tumor;
2 correct?
3 A. That is correct.
4 Q. If it had progressed into the
5 mediastinum, would you abort the surgical
6 procedure at that point or not go on to do a
7 lobectomy or other further resective surgery?
8 A. That is correct. If they have
9 positive mediastinoscopic biopsies, in general
10 we do not recommend that they go on and have
11 resection of the primary tumor.
12 There are rare instances where under
13 protocol therapy we would identify positive
14 nodal stations and then perhaps enter them in a
15 chemotherapy/radiation therapy protocol and
16 subsequently re-mediastinoscope them. There are
17 some surgeons who are doing that. I am not one
18 of those. There are very specific institutions
19 in the country that are carrying out those
20 studies now to ascertain the benefit of that
21 type of therapy.
22 Q. In looking at your surgical
23 practice, currently what percentage of your
24 surgical cases involve resections of early lung
25 cancer patients as opposed to coronary artery or

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1 cardiac patients? It may not be terribly
2 artfully worded, but hopefully you understand.
3 A. I understand the question. I
4 probably do 500 operative procedures per year.
5 Roughly 200 of those or 250 of those will be
6 open heart surgery, so the remainder of those
7 are general thoracic surgical cases. I would
8 venture to say that of those 200 or 250
9 operative procedures, probably 60 percent of
10 those relate to carcinoma of the lung. Of that
11 number of procedures, probably 25 or 30 percent
12 of those cases are patients with Stage I-A or
13 Stage I-B bronchogenic carcinoma.
14 Q. If you are fortunate enough to
15 diagnose a patient in Stage I bronchogenic
16 carcinoma nonsmall cell and a patient is
17 referred to you or someone that does this type
18 of surgery, what is your experience in terms of
19 the prognosis for those patients without any
20 other significant comorbidities?
21 A. It depends a little bit upon the
22 pathologic stage. There are different aspects
23 of Stage I, pathologic Stage I bronchogenic
24 carcinoma, and those include the absence or
25 presence of angiolymphatic invasion on the

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1 histologic study and whether the tumor is well
2 differentiated or poorly differentiated and the
3 degree of anaplasia.
4 In general the survivability of the
5 five-year survival will vary between 60 and 80
6 percent based upon those tumor subgroups, and
7 then we take Stage I disease and classify it
8 into Stage I-A and Stage I-B which is more
9 dependent upon tumor size. The smaller the
10 tumor size, the better the prognosis.
11 Q. I usually have a tendency of getting
12 ahead of myself in a deposition just because I
13 get all wound up and want to just jump right
14 into it. I'm now going to back up a bit, and
15 we'll move back into matters which are germane
16 to Mr. Gill.
17 Your report, does it contain all of
18 the opinions that you understand that you've
19 been asked to provide and are prepared to
20 provide at the time of the trial in this case?
21 A. Yes, they do.
22 Q. Is there any information that you
23 have asked for of Mr. Warner that he has not
24 provided to you that you feel somehow affects
25 your ability to evaluate this case?

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1 A. No, there is not.
2 Q. I see that you've reviewed expert
3 reports of both sides, reports from Dr. Levitan,
4 Dr. Rozman, as well as expert reports that have
5 been retained by experts that have been retained
6 from the plaintiff's side as well; correct?
7 A. That is correct.
8 Q. Did you review those before you
9 prepared your report?
10 A. No, I did not. I don't believe so
11 with the exception perhaps of Dr. Mansnerus
12 whose deposition I do believe I read prior to
13 issuing this report.
14 Q. Have the opinions that you had
15 arrived at back in November, have they been in
16 any way altered, modified, changed, increased,
17 if you will, any one of those adjectives if
18 that's an adjective, since reading the other
19 expert reports or depositions?
20 A. No, they have not.
21 Q. Your report is silent with regard to
22 the topic of standard of care. May I assume
23 that you will not be providing testimony on
24 behalf of Dr. Mansnerus at the time of trial
25 with regard to whether he met or in fact fell

<p style="text-align: right;">Page 13</p> <p>1 below the standard of care for an internist or 2 family practice doctor in evaluating Mr. Gill in 3 December and early January of the years 4 involved? 5 A. That assumption would be correct. 6 Q. You will be providing testimony as 7 it relates to that legal term called proximate 8 cause; is that correct? 9 A. That is correct. 10 Q. If Mr. Gill had been diagnosed 11 Stage I and knowing the histology that 12 ultimately was appreciated in terms of the 13 poorly differentiated components, but if you 14 back up in time to a snippet in time, whenever 15 that may have been, and he had been diagnosed 16 Stage I-A or Stage I-B and had come to someone 17 like you without any mediastinal involvement, he 18 would have been an appropriate candidate for 19 surgical treatment; correct? 20 A. In order to accurately answer that 21 question, I just want to make sure I understand 22 the question. Are we talking at any point in 23 time prior to and/or including the presentation 24 on 12-9-99? Because it is my belief that on 25 12-9-99 he probably was not a Stage I-A or B.</p>	<p style="text-align: right;">Page 15</p> <p>1 Q. More likely than not, if he had been 2 operated on at a point in time where he was 3 Stage I-A or Stage I-B, would he have had more 4 likely than not a greater than 50 percent 5 probability of a good outcome? 6 A. I think it's safe to say that he 7 would have had a greater than 50 percent 8 probability of surviving more than five years. 9 Q. That's sort of the magic period, is 10 it not, that you use, a five-year survival, or 11 do you go out further than that? 12 A. Five-year survival is how we 13 delineate percentages of survival. In 14 bronchogenic carcinoma, most patients who reach 15 five years without evidence of a clinical 16 recurrence are more than likely going to stay 17 that way throughout the duration as it pertains 18 to bronchogenic carcinoma. So that's the reason 19 why we use those numbers as a percentage of 20 survival. 21 Q. They're sort of out of harm's way, 22 if you will, if they make the five-year period 23 of time without any recurrence or distal 24 metastasis? 25 A. The likelihood is extremely high</p>
<p style="text-align: right;">Page 14</p> <p>1 So if you're asking the question could it 2 potentially be prior to that, if he had 3 presented and at that time been clinically Stage 4 I-A or I-B, yes, I do believe that he might have 5 been a candidate for surgical resection. 6 Q. I understand from reading your 7 report -- and we'll talk about certain snippets 8 of it, but we're not going to go through the 9 entire thing because they taught me how to read 10 in law school -- but my question is really, 11 regardless of whether that point in time was 12 December or whether it was months or years 13 before that, if we got to that snippet in time 14 and everyone agreed that he was a Stage I-A or 15 Stage I-B and he fell into your lap and you then 16 had the benefit of knowing, which this would 17 never happen, but at Stage IV what the cancer 18 looked like, but you were fortunate enough to be 19 able to turn the hands of the clock back and 20 treat him at Stage I-A or Stage I-B nonsmall 21 cell carcinoma, in a man of Mr. Gill's age and 22 comorbidity factors, he would have been an 23 appropriate candidate for surgical 24 consideration? 25 A. I believe he would have been, yes.</p>	<p style="text-align: right;">Page 16</p> <p>1 that they are out of harm's way from their 2 original bronchogenic carcinoma. They still are 3 at risk, however, to develop a second primary 4 which is the reason we continue to follow them 5 even after five years' time. 6 Q. You mean they can't say good-bye to 7 the doctor after five years and a good report? 8 A. No, they can't. 9 Q. That's what you call job security; 10 right? 11 A. It's not so much job security but 12 just making sure that our patients continue to 13 do well. 14 Q. I know. I say that obviously in 15 jest. Obviously, if you reach the five-year 16 time period after surgery in a patient without 17 any significant comorbidities, the prognosis 18 would be favorable for long-term survival? 19 A. Ideally, yes. 20 Q. In a patient of Mr. Gill's age, his 21 comorbidity or lack thereof, and obviously he 22 was a smoker -- which in your opinion is the 23 smoking a probable cause of the lung cancer? 24 A. Almost assuredly, yes. 25 Q. Even though his smoking caused the</p>

4 (Pages 13 to 16)

<p style="text-align: right;">Page 17</p> <p>1 lung cancer, there are literally thousands of 2 patients in which smoking causes lung cancer but 3 yet are fortunate enough to be diagnosed at a 4 Stage I-A or Stage I-B and have a good outcome; 5 correct? 6 A. That's correct. 7 Q. So while it's not good to smoke 8 because it creates the risk of cancer, if you're 9 in the right place at the right time and a 10 doctor diagnoses it at an early stage, there can 11 be a happy ending as long as the person doesn't 12 continue to smoke after having the surgery; is 13 that a fair statement? 14 A. That's a fair statement. 15 Q. Again, with the assumption that 16 Mr. Gill was diagnosed Stage I-A or Stage I-B, 17 would he have required adjunctive therapy as 18 well to maximize his long-term survival? 19 A. At the time of his diagnosis, no. I 20 think we are now revisiting that. More recently 21 we've looked at patients who are Stage II and 22 are recommending that they get adjunctive 23 chemotherapy and at times radiation therapy. 24 There were some studies that now suggest a small 25 but definitely significant benefit for those</p>	<p style="text-align: right;">Page 19</p> <p>1 largest portion of the tennis ball. So it's 2 subject to error, and it's subject to 3 interpretation. In general it does not change 4 the clinical presence of the tumor. 5 Q. Could I borrow that? 6 A. (Indicating.) 7 Q. I think you indicated that in your 8 opinion in this case had Mr. Gill's disease been 9 diagnosed at the end of '99 or the early part of 10 2000 that the tumor would have been less bulky 11 in size; correct? In that last paragraph about 12 the fourth line down, do you see that? 13 A. Yes. I see that. The question is? 14 I'm sorry. 15 Q. That the tumor had it been diagnosed 16 at the end of December or January or that time 17 period, and I understand what your opinions are, 18 but you do acknowledge that there is a 19 probability that the tumor would have been less 20 bulky in size at that earlier period of time? 21 A. I believe so, yes. 22 Q. Just so I understand, because 23 sometimes the term bulky may mean one thing to 24 one person, if we use that 4.5 or 4 centimeter 25 tumor and we reduce it in size to say 3.5, is</p>
<p style="text-align: right;">Page 18</p> <p>1 patients. 2 The overwhelming percentage of 3 oncologists now I think probably still do not 4 recommend adjunctive therapy for Stage I 5 disease. 6 Q. Stage II-A would be what, T1-N1? 7 A. T1 or T2 and N1 lesions. 8 Q. There's some discrepancy, as I see 9 it, in the records as to what the size of the 10 tumor was when it was first diagnosed. At one 11 point I see 4 centimeters, and then at one 12 point -- it's been a while since I've looked at 13 this -- but at one point I think it was maybe 14 4.5 centimeters. Is that significant, the 15 difference between 4 and 4.5 centimeters? 16 A. No. I think that really depends on 17 when and how the CAT scans are done and the 18 radiologist's interpretation. It's similar to 19 taking a tennis ball and slicing it into 20 multiple little pieces. It depends upon where 21 in the ball you slice it, whether you slice it 22 in the absolute maximum diameter or you miss 23 that by 2 or 3 or 4 millimeters. 24 It may look smaller on one slice, 25 but in actuality you haven't actually hit the</p>	<p style="text-align: right;">Page 20</p> <p>1 the difference between 3.5 and 4 that 4 is 2 bulkier than 3.5? 3 A. By definition if it's larger in 4 size, it truly is bulkier. In terms of the 5 histopathological classification and stages, it 6 does not change the stage of the lesion at that 7 time. 8 Q. Can you tell me, if you have an 9 opinion, what size the tumor would have been in 10 let's take from December of '99 into the turn of 11 the year, into January and maybe the early part 12 of February, if it was less bulky in size? I'll 13 give you sort of a range. Tell me the smallest 14 you believe it would have been and the largest 15 you believe it may have been as well those 16 months earlier. 17 MR. WARNER: Objection. Go ahead. 18 A. Again, it's pure supposition because 19 I don't have the radiographs to look at and we 20 don't have the benefit of retroactive staging 21 with any other study back in December, but if I 22 were to make that supposition, I would say the 23 smallest the tumor size would have been would 24 have probably been around 3 centimeters, and 25 probably the largest it would have been would</p>

<p style="text-align: right;">Page 21</p> <p>1 have been similar to what it was when it was 2 diagnosed eventually later that year, roughly 4 3 to 4.5 centimeters. 4 Q. If there were no other clinical, 5 pathological, or histological findings other 6 than a tumor of 3 centimeters, then that would 7 by definition be a T1 nonsmall cell carcinoma? 8 A. It would be a T2 lesion. Anything 3 9 centimeters or larger is a T2 tumor. 10 Q. So once it hits 3, it kicks from T1 11 to T2? 12 A. That is correct. 13 Q. Are there studies that indicate 14 anything above 3 centimeters is T2 and anything 15 3 centimeters and below is T1? 16 A. That's the standard classification 17 for bronchogenic carcinoma. A T1 tumor is less 18 than 3 centimeters, and a T2 tumor is greater 19 than 3 centimeters. That's the specific size 20 criteria that delineates a T1 and T2 tumor. 21 Q. Maybe I wasn't clear. If anything 22 greater than 3 centimeters is T2 and anything 23 less than 3 centimeters is T1, what is a tumor 24 that is 3 centimeters right on the button? 25 A. That would be by definition a T2</p>	<p style="text-align: right;">Page 23</p> <p>1 Q. Just to give me an idea, in 2003 -- 2 I won't ask you in 2004 because it's not old 3 enough -- in your surgical practice, how many 4 situations were you called upon to perform 5 resection on a lung cancer patient? 6 A. Without having the specific numbers, 7 I would guesstimate probably somewhere between 8 100 and 150. 9 Q. All of those patients were Stage I-A 10 or Stage I-B? 11 A. No. I suspect probably 20 or 12 30 percent of that group of patients were 13 Stage I. 14 Q. Until you went in and did the 15 initial intervention, diagnostic intervention, 16 you didn't know whether or not they were 17 Stage I-A or Stage I-B? 18 A. That is correct. 19 Q. Have you reviewed any literature on 20 the topic of nonsmall cell lung cancer in terms 21 of staging and prognosis that would be germane 22 and relevant to the topic in this case for 23 purposes of preparing your report? 24 A. No, not specifically for purposes of 25 preparing the report.</p>
<p style="text-align: right;">Page 22</p> <p>1 tumor. 2 Q. Have you seen any studies in this 3 area that describe a 3 centimeter nodule, not 4 more than 3 centimeters but just 3 centimeters 5 exactly, as being T1 as opposed to T2? 6 A. I have not. 7 Q. In your CV, Doctor, you have nine 8 publications? 9 A. Correct. 10 Q. Are there any in the works? 11 A. Presently, no. 12 Q. Are all of the nine publications 13 peer reviewed? 14 A. Yes, they are. 15 Q. Do any of them touch on the topic of 16 the diagnosis and treatment of nonsmall cell 17 lung tumors or lung cancer in general? 18 A. No, they do not. 19 Q. Are all of the articles more in the 20 area of the coronary artery and cardiac end of 21 your surgical interests? 22 A. They are related to both cardiac as 23 well as general thoracic topics. There is 24 nothing specifically there related to 25 bronchogenic carcinoma, though.</p>	<p style="text-align: right;">Page 24</p> <p>1 Q. Since you prepared your report, have 2 you reviewed any literature again on that same 3 topic that you believe to be relevant or germane 4 to the issues in this case? 5 A. Not specifically, no. 6 Q. Are there any articles, journal 7 articles, or studies that you consider to be 8 reasonably reliable or, as the lawyers like to 9 say, authoritative on the topic of prognostic 10 indicators for nonsmall cell lung cancer in 11 terms of the diagnosis and treatment as well as 12 the prognosis for those types of patients? 13 A. I believe that all articles that are 14 written are opinions of their authors, and 15 they're generated in an effort to educate their 16 colleagues. The appropriate nature of education 17 for colleagues is to read those and to formulate 18 their own opinions based upon them. 19 There are numerous historical 20 clinical as well as histopathological staging 21 papers in terms of how they relate to prognosis 22 in lung carcinoma which most cardiothoracic 23 surgeons have read and hopefully encompassed 24 into their practice in terms of how they present 25 information to their patients.</p>

6 (Pages 21 to 24)

<p>Page 25</p> <p>1 Q. Are you able to cite me to any that 2 you, Dr. Botham, consider to be very reliable or 3 reasonably reliable on this very topic? 4 A. Specifically, I don't think I could 5 give you the name of an article. Over the last 6 16 years I've read hundreds and hundreds of 7 articles that pertain to staging in lung 8 carcinoma and how it affects prognosis in an 9 attempt to assimilate all those and generate my 10 opinions at to how we go about managing this 11 type of problem. 12 Q. Did you review the article that 13 Dr. Steele had referenced that was attached to 14 his deposition? 15 A. I don't believe that I did. 16 Q. The reason I ask you not about 17 Dr. Steele but about whether there are any 18 articles that you consider to be reliable is 19 that I want to find out whether or not you are 20 currently in a position to acknowledge a journal 21 article or a section from a journal article on 22 the topic of nonsmall cell lung cancer as being 23 reliable from the standpoint of having any 24 evidentiary value in this case, and if I 25 understand what you're saying, it is that there</p>	<p>Page 27</p> <p>1 charged more than that unless I'm away for two 2 days' worth of work. If I have to fly somewhere 3 and stay for the night, then it may be two days' 4 worth of work. 5 Q. After the diagnosis -- here I go 6 again. I'm jumping off one topic and going on 7 to another, but I'm going to come back to your 8 medical-legal again, so you're not out of the 9 woods yet. 10 After the diagnosis was made of the 11 cancer, it was a Grade IV at that time? 12 A. At the time it was diagnosed, it was 13 a Stage IV. 14 Q. Stage IV, I'm sorry. He was seen at 15 both the Cleveland Clinic and University 16 Hospitals, but I think his treatment was pretty 17 much confined to one institution. Do you 18 remember which one that was? 19 A. I believe it was at University 20 Hospitals. 21 Q. Do you know any of the doctors that 22 were involved in Mr. Gill's care after the 23 diagnosis of cancer was made? 24 A. The only one that I know by 25 reputation is Dr. Dowlati. I have not had</p>
<p>Page 26</p> <p>1 may be articles out there, but as you're sitting 2 here right now there's nothing that you can cite 3 me to? 4 A. Correct. 5 Q. To the extent that that position 6 changes and you are likely to take the stand and 7 acknowledge anything as being reasonably 8 reliable or authoritative, just for the record I 9 would ask that I be notified before you take the 10 stand to that effect. 11 A. I would be happy. 12 Q. Do you still charge \$250 an hour for 13 depositions? 14 A. Yes. 15 Q. Trial testimony is \$4,000 to \$5,000 16 for half a day? 17 A. \$5,000 for a day. 18 Q. So the \$4,000 is no longer current? 19 A. It has never been \$4,000. My fees 20 haven't changed in 14 years. 21 Q. In one deposition you may have 22 slipped to say \$4,000 to \$5,000. 23 A. It has always been \$5,000. 24 Q. \$10,000 for the day? 25 A. No. \$5,000 for a day. I've never</p>	<p>Page 28</p> <p>1 patient interactions with him. 2 Q. Well, you're not an oncologist, so 3 you would not be treating from a nonsurgical 4 standpoint a patient that is not a surgical 5 candidate; correct? 6 A. That is correct. 7 Q. Are you able to comment at all on 8 whether or not the care that was provided by 9 Dr. Dowlati or any of his team seemed to comply 10 with accepted standards, or do you not have an 11 opinion one way or another on that? 12 A. I would not testify to an opinion, 13 but in my review of the medical records, I 14 believe that accepted standard of care was met 15 in their management of Mr. Gill. 16 Q. He received what type of therapy 17 when it was realized that it was too late to 18 operate? 19 A. I believe there were two separate 20 rounds of chemotherapy, as they like to say, I 21 think. If you'll give me one second, I'll look 22 through my notes here. 23 Q. While you're doing that, you're 24 looking at a legal pad which has a number of 25 pages of notes which has been marked as</p>

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1 Exhibit 4. I take it this was sort of a work in
2 progress. As you were reviewing the case, you
3 made notes and continued to make notes as you
4 reviewed additional information?
5 A. The exhibit that I'm reviewing is
6 Plaintiff's Exhibit 4 which are the notes that I
7 make as I review the case to originally generate
8 my report, and it's a synopsis of what I feel
9 are the important points of the medical record
10 and allows me to review the case in a more
11 succinct fashion so that I don't have to dig
12 through a large chart at times when we're
13 undergoing a deposition.
14 Q. You at no time in your notes comment
15 at all on the level of care provided by
16 Dr. Mansnerus; true?
17 A. No, I do not. This is specifically
18 factual information that is generated from my
19 review of the medical record.
20 Q. Did you ever make any notes when you
21 read the deposition transcripts and the expert
22 reports that were sent to you at a later point
23 in time?
24 A. No, I did not.
25 Q. Please, continue.

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1 A. The initial chemotherapy that was
2 rendered by Dr. Dowlati consisted of carboplatin
3 and taxol, and I believe at one point in time he
4 was a candidate for robimycin therapy, and I
5 think he started that therapy but did not
6 respond well and was subsequently removed from
7 that study.
8 Q. His diagnosis was July-August and
9 then he died in February of the following year.
10 Is that a fairly common stretch of time in a
11 Stage IV cancer of this type, for someone to
12 live that length of time, or did he hold on
13 longer than you would expect for a patient to
14 survive?
15 A. I don't believe that this is an
16 unusual sequence of events for somebody with
17 Stage IV bronchogenic carcinoma.
18 Q. Fortunately, never having had the
19 experience of a family member going through this
20 in a terminal phase, can you educate me just a
21 bit in terms of once you get past the
22 realization that you have a terminal disease and
23 surgery is out of the question, how painful is
24 the dying process and how painful is the
25 treatment that's being given to this patient

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1 from August up until the time that he died?
2 MR. WARNER: Note my objection.
3 A. That's a little out of my realm, the
4 realm of my involvement from a medical
5 standpoint. Unfortunately, I don't get involved
6 in the chemotherapeutic or radiation therapy for
7 patients with either recurrent or Stage IV
8 bronchogenic carcinoma, and I think it would be
9 difficult for me to fairly answer that question.
10 Q. We know that he had a bone scan that
11 showed that he had metastasis into the femur,
12 but as it relates to the degree of pain that the
13 patient was experiencing because of the
14 metastatic disease, you would just defer on
15 those issues?
16 A. Yes. I think that's probably the
17 fairest thing.
18 Q. Now, I'm going to take you back to
19 your medical-legal and hopefully finish that and
20 move on to the balance of your opinions. You
21 have been doing medical-legal work since about
22 1988?
23 A. That is correct.
24 Q. In terms of reviewing records, tell
25 me how many cases you review on average in a

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1 given year.
2 A. It varies between years. It can go
3 anywhere between five to six to probably a high
4 of 13 or 14 per year.
5 Q. Have you ever reviewed as many as 15
6 to 20 cases in a year?
7 A. It's certainly possible. I don't
8 keep track of the numbers of cases I do, and
9 usually once they're done I get rid of the
10 records. It's certainly possible that I may
11 have done that many in one year. It would be a
12 busy year for me.
13 Q. That's not something you readily
14 recall having done in the recent past?
15 A. I may have. I don't recall.
16 Q. All the cases that you've been
17 involved in, have they all been in state court?
18 A. I have recently reviewed I believe a
19 case for the State of Ohio which is not a civil
20 suit related to a physician. It's a case that
21 is I think being defended by the State of Ohio.
22 But other than that, they have all been cases
23 similar to what you mentioned.
24 Q. It was probably poorly worded on my
25 part, but what I was actually getting at is have

<p style="text-align: right;">Page 33</p> <p>1 you been an expert in a case that was venued in 2 federal court? 3 A. No, I have not. 4 Q. You have never been known to have 5 prepared a Rule 26 disclosure of the cases and 6 the subject matter from which those cases 7 evolved for any court? 8 A. No, I have not. 9 Q. Or for any attorney for that matter? 10 A. No, I have not. 11 Q. Have you ever reviewed a case 12 similar to Mr. Gill where you were asked to 13 provide an opinion on the issues of proximate 14 cause in a patient where an allegation was 15 asserted that there was a delay in timely 16 diagnosing lung cancer? 17 A. Yes, I have. 18 Q. How many cases would fall in that 19 description? 20 A. Boy, I think probably only one that 21 I can remember. 22 Q. Tell me, by that answer there might 23 be more but -- 24 A. One that I remember for sure, and I 25 don't recall specifically other cases.</p>	<p style="text-align: right;">Page 35</p> <p>1 last two to three years? 2 A. I'm not sure I've been monopolized. 3 I think it's been probably by my choice. There 4 are two specific reasons. Since becoming a 5 Cleveland Clinic Foundation clinic, we're 6 discouraged from reviewing cases for plaintiffs' 7 counsels, and I've had a couple of bad 8 experiences in the past with plaintiffs' 9 counsels who decided they didn't want to pay for 10 their services. 11 Q. There are black sheep in every 12 family. 13 A. Yes. I agree. 14 Q. Since you haven't met me until now, 15 we can honestly say that experience wasn't with 16 me. 17 A. That is correct. 18 Q. I want to talk a moment about the 19 topic of your own claim history. I think, at 20 least from some of my homework, that you've been 21 named is it five times as a defendant? 22 A. I believe so. 23 Q. Are any of those cases currently 24 pending? 25 A. No. They are all resolved.</p>
<p style="text-align: right;">Page 34</p> <p>1 Q. Tell me about the one that you do 2 remember. 3 A. It was a case I believe back in 4 1996. I was asked by Steve Charms to review a 5 case for a plaintiff in the same similar 6 situation where there was a four- or six-month 7 delay in making a diagnosis of bronchogenic 8 carcinoma. At that time they did not feel that 9 the delay was significant in terms of proximate 10 cause, and I don't believe that Mr. Charms 11 proceeded with the case, but that would be 12 something that you would have to ask him. 13 Q. Have you ever testified as an expert 14 in a case on either side in a case with similar 15 issues to what we have in Mr. Gill's case? 16 A. No, I have not. 17 Q. In the last two to three years in 18 terms of your review of cases in the medical 19 malpractice area, tell me what the breakdown has 20 been of plaintiff versus defendant where you've 21 been asked. 22 A. In the last two to three years, 23 100 percent for the defense. 24 Q. Do you know the reason why you have 25 been monopolized by the defense bar over the</p>	<p style="text-align: right;">Page 36</p> <p>1 Q. One got dismissed after voir dire? 2 A. That is correct. 3 Q. One was dismissed during the case, 4 perhaps opening statements, or dropped I should 5 say? 6 A. I'm only aware of one case being 7 dismissed. Actually, I think it was after voir 8 dire. It was right at the time of opening 9 statements. 10 Q. Have any of the cases that you've 11 been a defendant in involved issues arising out 12 of cancer treatment? 13 A. Yes, an esophageal carcinoma case. 14 Q. Was that a Mt. Sinai case or a 15 Cleveland Clinic case? 16 A. A University Hospital case. 17 Q. You were originally at Mt. Sinai; 18 correct? 19 A. That is correct. 20 Q. Then University, and your Cleveland 21 Clinic affiliation has been for how long now? 22 A. A little more than three years. 23 Q. So were you with Alan Markowitz back 24 at Mt. Sinai? 25 A. Yes.</p>

<p style="text-align: right;">Page 37</p> <p>1 Q. And Holland and all those guys?</p> <p>2 A. Yes.</p> <p>3 Q. I'm starting to show my age. The</p> <p>4 esophageal cancer case, do you remember the name</p> <p>5 of the plaintiff in that matter?</p> <p>6 A. Sidney Segal.</p> <p>7 Q. Was the allegation against you</p> <p>8 relative to surgical approach to the --</p> <p>9 A. No. I believe it was management,</p> <p>10 postoperative management.</p> <p>11 Q. Do you happen to remember who the</p> <p>12 plaintiff's attorney was in that case?</p> <p>13 A. Peter Weinberger.</p> <p>14 Q. How many times would you say in your</p> <p>15 best estimate that you have been deposed since</p> <p>16 1988 so now 16 years?</p> <p>17 A. Gee, it's got to be 60, 70, 80</p> <p>18 times.</p> <p>19 Q. When was the last time you were</p> <p>20 deposed in a medical malpractice case before</p> <p>21 today?</p> <p>22 A. Probably three months ago.</p> <p>23 Q. Obviously, you were serving as an</p> <p>24 expert for the defense in that case.</p> <p>25 A. That is correct.</p>	<p style="text-align: right;">Page 39</p> <p>1 Q. Dr. Rozman has referred his patients</p> <p>2 for surgical intervention, not just for cancer</p> <p>3 issues, but for other cardiothoracic issues to</p> <p>4 you?</p> <p>5 A. I think they have all been for</p> <p>6 patients who have had cardiothoracic issues who</p> <p>7 have been referred to a cardiologist who has</p> <p>8 called me regarding surgical interventions on</p> <p>9 those patients. He himself specifically I don't</p> <p>10 believe has ever called me.</p> <p>11 Q. There has been a middleman?</p> <p>12 A. Yes.</p> <p>13 Q. Have you ever had any professional</p> <p>14 dealings with Dr. Rozman other than knowing that</p> <p>15 he was the attending for that patient that</p> <p>16 actually came to you?</p> <p>17 A. No, I have not.</p> <p>18 Q. Dr. Levitan, you said that you've</p> <p>19 done some surgical work on some of his patients?</p> <p>20 A. We have had patients where we have</p> <p>21 interacted together managing thoracic oncologic</p> <p>22 issues, be they lung carcinoma or esophageal</p> <p>23 carcinoma or other malignancies of the chest,</p> <p>24 where I have operated upon them, and then they</p> <p>25 have either somehow developed a recurrent</p>
<p style="text-align: right;">Page 38</p> <p>1 Q. That was a Reminger & Reminger case?</p> <p>2 A. I believe so.</p> <p>3 Q. When are you scheduled next to give</p> <p>4 a deposition, assuming that we ever finish this</p> <p>5 one?</p> <p>6 A. I'm actually not, believe it or not.</p> <p>7 Q. This case is scheduled for trial in</p> <p>8 April, I think. Rob and I were scratching our</p> <p>9 heads before. Are you scheduled for any other</p> <p>10 trials in the foreseeable future other than this</p> <p>11 matter?</p> <p>12 A. I don't believe so.</p> <p>13 Q. I presume that Mr. Warner has asked</p> <p>14 you to testify in the trial of this case?</p> <p>15 A. Yes, he has.</p> <p>16 Q. What has your answer been?</p> <p>17 A. I'd be happy to, yes.</p> <p>18 Q. Do you know Dr. Mansnerus?</p> <p>19 A. I do not.</p> <p>20 Q. Do you know any of the experts in</p> <p>21 this case?</p> <p>22 A. I have operated upon a few patients</p> <p>23 of Dr. Rozman's, and I have interacted with</p> <p>24 patients with general thoracic malignancies with</p> <p>25 Dr. Levitan.</p>	<p style="text-align: right;">Page 40</p> <p>1 disease or had significant enough disease that</p> <p>2 they require oncologic consultation, and he has</p> <p>3 been the oncologist of choice.</p> <p>4 Q. Do you have an ongoing professional</p> <p>5 relationship?</p> <p>6 A. Not really. He is a University</p> <p>7 Hospital physician, and I am now a Cleveland</p> <p>8 Clinic physician. So we don't interact as we</p> <p>9 perhaps might have in the past. We do still</p> <p>10 have some patients that I see in follow-up that</p> <p>11 he sees in follow-up that are patients of both</p> <p>12 of us. But, obviously, that number becomes less</p> <p>13 and less as I do more and more within the</p> <p>14 confines of the Cleveland Clinic Foundation, and</p> <p>15 his practice is within the confines of the</p> <p>16 University Hospitals Health System.</p> <p>17 Q. Doctor, there's another expert</p> <p>18 pathologist whose name is escaping me.</p> <p>19 A. Dr. Casey. Yes, I do know her.</p> <p>20 Q. You know Dr. Casey?</p> <p>21 A. Yes.</p> <p>22 Q. How do you know Dr. Casey?</p> <p>23 A. She's a pathologist at Parma</p> <p>24 Community General Hospital.</p> <p>25 Q. Other than knowing she's a</p>

<p style="text-align: right;">Page 41</p> <p>1 pathologist at Parma, what type of 2 relationship -- 3 A. She has reviewed pathologic slides 4 of mine in cases that I've done in the past. 5 Q. Have you ever served as an expert to 6 your knowledge in a case where Dr. Rozman, 7 Dr. Levitan, or Dr. Casey were also serving as 8 an expert? 9 A. I don't believe so. There may have 10 been cases where Dr. Levitan was serving as an 11 expert. Again, I can't tell you that with 12 certainty, but I know he does a fair amount of 13 medical malpractice work, and we may have 14 interacted in the past on a case. Again, I 15 don't know a specific name clearly. I have not 16 with Dr. Rozman or Dr. Casey. 17 Q. Flipping tabs, Dr. Steele, 18 Dr. Sutherland and Dr. Bass, do you know any one 19 of them? 20 A. No, I do not. 21 Q. The young man seated to your left -- 22 you're looking for a young man. 23 MR. WARNER: You've got to look for 24 a young man. 25 Q. A number of years ago that would</p>	<p style="text-align: right;">Page 43</p> <p>1 at Reminger & Reminger? 2 A. Yes, I have. 3 Q. Besides Mr. Warner, are there any 4 active files in your office that you are serving 5 as an expert on for other attorneys from 6 Reminger & Reminger currently? 7 A. I don't believe so for Reminger & 8 Reminger. There are other firms, but I don't 9 believe so for Reminger & Reminger. 10 Q. Those would be other defense firms? 11 A. Yes. 12 Q. Other local Cleveland defense firms? 13 A. Yes. 14 Q. In terms of the attorneys that you 15 have worked with in the past from Reminger & 16 Reminger, can you help me out with any of the 17 names? 18 A. I believe I have served as an expert 19 witness for Marc Groedel, Bill Meadows, 20 P.J. Malnar, and I think that really probably is 21 about it. 22 Q. You have also, have you not, served 23 as an expert for Steve Walters? 24 A. I may have. 25 Q. Jim Malone?</p>
<p style="text-align: right;">Page 42</p> <p>1 have been applicable had someone said that, but 2 I guess as we get older that's just a 3 compliment. 4 You have had occasion, have you not, 5 to serve as an expert representing doctors that 6 Mr. Warner has represented? 7 A. Yes, I have. 8 Q. On how many occasions have you been 9 called on by Mr. Warner? 10 A. A guesstimate, six or eight. 11 Q. Have you testified at trial in any 12 of those cases? 13 A. Yes, I have. 14 Q. How many? 15 A. Three or four. 16 Q. Was one of those in the fall of this 17 last year? 18 A. I believe so, yes. 19 Q. Do you remember the name of the 20 doctor or patient in that matter? 21 A. I think as I get older I remember 22 less and less of the names. I can't, to be 23 honest with you. I can't remember specifically. 24 Q. What was I just asking you? You've 25 also had occasion to work with other attorneys</p>	<p style="text-align: right;">Page 44</p> <p>1 A. I have for Jim Malone. He's not 2 with Reminger & Reminger, though, is he? 3 Q. He is unless he has gotten kicked 4 out recently. 5 MR. WARNER: Yes, he is. 6 Q. Steve Crandall when Steve Crandall 7 was at Reminger? 8 A. A long time ago, yes. 9 MR. WARNER: He's now a plaintiff's 10 counsel. 11 A. Yes, he is. But at times in the 12 past, yes. 13 Q. But your testimony is that currently 14 you don't have any open cases with Reminger & 15 Reminger? 16 A. I don't believe that I do. 17 Q. Hopefully, I'm going to confine the 18 remainder of my questions to your report. So if 19 you want to get that, I'm not going to have you 20 read over your notes, but I am going to want to 21 get copies of that, if you would, just for 22 purposes of housekeeping. If you could, just 23 identify it. I think Exhibit 4 are your notes. 24 A. Yes. That is correct. 25 Q. If you could just count the pages,</p>

<p style="text-align: right;">Page 45</p> <p>1 and I'm just going to trust you to or you'll</p> <p>2 work out arrangements with the court reporter</p> <p>3 for copies.</p> <p>4 A. There are a total of seven pages in</p> <p>5 Plaintiff's Exhibit 4.</p> <p>6 Q. The last three words in your report</p> <p>7 are aggressive bronchogenic carcinoma?</p> <p>8 A. Correct.</p> <p>9 Q. Can you tell me when this</p> <p>10 bronchogenic carcinoma became aggressive?</p> <p>11 A. I think that term is used in</p> <p>12 relationship to bronchogenic carcinomas that are</p> <p>13 less aggressive, and it may end up with survival</p> <p>14 at times measured in years from the time of</p> <p>15 diagnosis, whereas this one is measured in terms</p> <p>16 of months. I think all bronchogenic carcinomas</p> <p>17 are clearly aggressive because if untreated</p> <p>18 people die from them. His form I think was</p> <p>19 reasonably virulent given the fact that his</p> <p>20 diagnosis was in August and his expiration was</p> <p>21 in February.</p> <p>22 Q. Do you have an opinion as to when he</p> <p>23 first developed the bronchogenic carcinoma?</p> <p>24 A. I would suspect years anteceding the</p> <p>25 actual diagnosis.</p>	<p style="text-align: right;">Page 47</p> <p>1 at in terms of determining how anaplastic a</p> <p>2 tumor is.</p> <p>3 Q. In the same last paragraph of your</p> <p>4 letter, the incurability of Mr. Gill's disease</p> <p>5 was present at the time of his presentation in</p> <p>6 December 1999, et cetera, that is an opinion</p> <p>7 that you hold in this case; correct?</p> <p>8 A. That is correct.</p> <p>9 Q. Can you tell me when, if you are</p> <p>10 correct in regard to that opinion, when prior to</p> <p>11 December of 1999 did his lung cancer become</p> <p>12 incurable?</p> <p>13 A. I don't know that. I can't</p> <p>14 stipulate that. That again would be</p> <p>15 supposition. The only information I have is the</p> <p>16 time of his initial presentation in December of</p> <p>17 1999. It is my opinion that at that point in</p> <p>18 time his cancer was incurable. I can't make a</p> <p>19 projection back retrospectively from there</p> <p>20 because I have no information as to what the</p> <p>21 clinical status was prior to that.</p> <p>22 Q. Jump back to the first page of your</p> <p>23 report. On December 9 when Mr. Gill presented,</p> <p>24 is it your recollection that these are the only</p> <p>25 symptoms that he presented to Dr. Mansnerus</p>
<p style="text-align: right;">Page 46</p> <p>1 Q. Can you be more specific than years?</p> <p>2 A. No, because I don't have factual</p> <p>3 evidence to stipulate what the tumor doubling</p> <p>4 time is. In general, what we know from tumor</p> <p>5 biology is that it takes years for something</p> <p>6 like this to develop from one or two cells to</p> <p>7 something that can be detectable by a CAT scan</p> <p>8 at 5 millimeters to something that then becomes</p> <p>9 detectable in a size similar to this at</p> <p>10 4 centimeters.</p> <p>11 Q. Do bronchogenic carcinomas always</p> <p>12 follow a linear pattern in terms of growth, or</p> <p>13 are there certain cancers that the longer they</p> <p>14 go untreated the more aggressive they become?</p> <p>15 A. I think the correct ideation here is</p> <p>16 the more anaplastic the tumor is, the more</p> <p>17 likely it is to have rapid growth, the more</p> <p>18 likely it is to spread systemically rather than</p> <p>19 local regionally, and the greater the likelihood</p> <p>20 is that the outcome will be poor.</p> <p>21 Q. Tell me what you mean by anaplastic.</p> <p>22 A. The character of the tumor as you</p> <p>23 view it under the microscope, its histologic</p> <p>24 picture, how it invades things, the cytologic</p> <p>25 appearance of it. Those are things that we look</p>	<p style="text-align: right;">Page 48</p> <p>1 with, that being the left-sided chest pain and</p> <p>2 numbness or weakness of the left arm?</p> <p>3 A. These may not have been the only</p> <p>4 symptoms, but they were the ones that I felt</p> <p>5 were pertinent to his clinical condition.</p> <p>6 Q. Do you know how long he had had as</p> <p>7 of December 9 the symptoms that he described to</p> <p>8 Dr. Mansnerus during that December 9 visit?</p> <p>9 A. I would have to review</p> <p>10 Dr. Mansnerus' office records. If you'd like, I</p> <p>11 can do that. It doesn't specifically stipulate</p> <p>12 in the transcribed letter of 12-9-99 how long</p> <p>13 those symptoms had occurred.</p> <p>14 Q. In retrospect, I believe you feel</p> <p>15 that the symptoms that Mr. Gill presented with</p> <p>16 on December 30, 1999, were consistent with the</p> <p>17 bronchogenic carcinoma?</p> <p>18 A. I think that they were consistent</p> <p>19 with a probable postobstructive pneumonia. I</p> <p>20 think he probably did have a pneumonia at that</p> <p>21 point in time. Perhaps, and again this is still</p> <p>22 supposition, he had a bronchial mass that was</p> <p>23 obstructing the airway up to the left upper lobe</p> <p>24 that caused pneumonia to develop. Clearly, we</p> <p>25 do know retrospectively that he did have a</p>

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1 bronchogenic malignancy, and that in concert
2 with his presentation puts together the picture
3 with these symptoms.
4 Q. With left-sided chest pain
5 associated with numbness and weakness of the
6 left arm in a patient who has obstructive
7 bronchogenic carcinoma that first manifested
8 itself by a pneumonia, would those types of
9 symptoms be consistent with obstructive
10 bronchogenic carcinoma?
11 A. The left-sided chest pain clearly
12 would be a reflection of pleuritic irritation
13 from the obstructive pneumonia. It is my
14 opinion that the numbness and weakness of the
15 left arm is a result of metastatic nodal disease
16 in the supraclavicular fossa that is either
17 irritating or perhaps invading his brachial
18 plexus resulting in the numbness and motor
19 difficulties he was experiencing in his left
20 arm.
21 Q. Clinically, did Dr. Mansnerus from
22 what you can see from his deposition or the
23 records do an exam where he palpated or
24 discovered any nodal involvement?
25 MR. WARNER: Objection. Go ahead.

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1 A. He may or may not have done the
2 examination. That's a question that you would
3 have to ask. It's not stipulated specifically
4 in the medical record that he did the
5 examination, and he did not note any palpable
6 lymph nodes.
7 Q. Would you expect that palpable lymph
8 nodes would be detectable given what we know at
9 the end of the story, if you will?
10 A. They may or may not have. You can
11 get this symptom complex without palpable lymph
12 nodes. You can get this symptom complex with a
13 small lung tumor in the apex of the left chest
14 without any discernible nodal station
15 involvement as well. It's not always a
16 situation where you have to feel the lymph nodes
17 or have palpable lymph nodes to have this type
18 of disease.
19 Q. If Mr. Gill had a repeat chest X-ray
20 at the end of January or early part of February
21 and knowing what we know in July or August, do
22 you have an opinion as to what that repeat chest
23 X-ray more likely than not would have shown?
24 MR. WARNER: Objection. Go ahead.
25 A. I don't know that I can answer that

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1 question. I think that would be unfair for me
2 to do so. I think it would again be
3 supposition.
4 It would depend upon how his
5 postobstructive pneumonia responded to the
6 antibiotic therapy and whether or not the
7 radiograph was clear enough to ascertain the
8 absence or presence of a lung mass, and I can't
9 do that without having the film to look at.
10 Q. If a film had been taken and it
11 showed continued infiltrates at a six-week time
12 period, would that be unusual or would that be
13 concerning at all in a patient with a diagnosis
14 of garden variety pneumonia?
15 A. I think both. I think it would be
16 concerning. It would be unusual if there was no
17 other reason for the pneumonia or if the wrong
18 antibiotic therapy had been administered and the
19 pneumonia had not resolved. Potentially, both
20 of those issues could have been present.
21 Q. In a patient that is a former smoker
22 but yet a smoker of substantial years, if a
23 chest X-ray had been done, a follow-up chest
24 X-ray, and it showed continued infiltrates, does
25 one normally have to at least have within their

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1 index of suspicion the possibility that there
2 may be nodal involvement?
3 MR. WARNER: Objection.
4 Q. That there may be a potential cancer
5 in the lungs?
6 MR. WARNER: Objection.
7 A. I think an astute clinician at six
8 to eight weeks subsequent to an initial X-ray,
9 if there still is persistent infiltrates that
10 has not completely resolved, an astute clinician
11 should keep in the back of his mind that that is
12 a possibility, yes.
13 Q. What types of diagnostic tools are
14 available to that astute clinician to rule out
15 or confirm the presence of something more
16 serious?
17 A. I believe there are probably two
18 things that you would do at that point in time.
19 MR. WARNER: Note my objection. I
20 think you're getting into standard of care, and
21 we've already indicated he is not an internist
22 or family doctor.
23 A. One might then obtain a chest CAT
24 scan and potentially refer the patient to a
25 pulmonologist for further evaluation.

<p>Page 53</p> <p>1 Q. Is the CAT scan more the gold 2 standard in terms of the initial diagnostic 3 workup for a patient that you have a suspicion 4 that there might be a carcinoma? 5 A. I think the gold standard still is a 6 screen chest radiograph. If there are 7 abnormalities there that lead you to believe 8 there is a potential for there to be a 9 pathologic process going on in the lung, most 10 clinicians at this point in time would then 11 obtain a CAT scan. 12 Q. You typically don't diagnose lung 13 cancer on a plain X-ray, though, do you? 14 A. Frequently you do, yes. 15 Q. Really. But a CT scan is more 16 sensitive; is it not? 17 A. It provides you with more 18 information. 19 Q. Is the fact that Mr. Gill is still 20 able to exercise vigorously even as late as June 21 of 2000 and able to exercise earlier than that, 22 to start and to compete in or to attempt to 23 compete in a marathon, is that at all clinically 24 significant to you in terms of trying to 25 evaluate what was going on with this cancer that</p>	<p>Page 55</p> <p>1 December 9th to base our clinical judgment and 2 clinical suspicion on. 3 Q. Can you say to a probability that it 4 wasn't the month before? 5 A. I don't know that I could give you 6 any specific time before that. 7 Q. The July 2000 exam was remarkable 8 for a 3 centimeter smooth firm tender mass at 9 the anterior angle of the left clavicle. Of 10 what significance is a 3 centimeter mass at this 11 stage of the process? What does that tell you? 12 A. It's a reflection of an N3 nodal 13 station that is involved with metastatic 14 carcinoma. 15 MR. MISHKIND: Off the record. 16 (Brief recess.) 17 Q. Can we agree that generally speaking 18 the earlier you diagnose lung cancer the better? 19 A. That's a fair statement. 20 Q. Sort of the corollary of that, it's 21 always best to diagnose lung cancer as early as 22 possible? 23 A. That's a fair statement as well. 24 Q. Can we agree the patient has the 25 best chance of a good outcome the earlier the</p>
<p>Page 54</p> <p>1 we know he had? 2 A. No. It's of no import. We've got a 3 gentleman who had widely metastatic testicular 4 cancer who won the Tour de France with it. 5 People can be very functional and healthy and 6 athletic with widely metastatic cancer. 7 Q. In terms of when he became 8 metastatic, are you able to state to a 9 probability a particular month or months in the 10 continuum of time where you are comfortable 11 saying Dan Gill developed or advanced into 12 metastatic cancer at X month of X year? 13 A. It's my strong opinion that at the 14 time of his initial presentation on December 9th 15 with the complaints that he had and the eventual 16 clinical course, at that time on December 9th, 17 1999, when he presented he had metastatic 18 disease at that time, almost assuredly 19 Stage III-B disease. 20 Q. Are you intending to provide an 21 opinion as to how much earlier than December 9 22 he acquired, if you will, the metastatic 23 component to the disease? 24 A. There's no way to know because we 25 don't have a clinical presentation prior to</p>	<p>Page 56</p> <p>1 lung cancer is diagnosed? 2 MR. WARNER: Objection. Go ahead. 3 A. Yes. 4 Q. Mr. Gill had nonsmall cell lung 5 cancer; correct? 6 A. Correct. 7 Q. Is the prognosis for a patient that 8 has nonsmall cell lung cancer that's diagnosed 9 at Stage I-A or Stage I-B better than a patient 10 that has the other type of small cell carcinoma? 11 A. Generally, yes. 12 Q. We can agree that Mr. Gill was not 13 diagnosed until he was clinically and 14 diagnostically a Stage IV? 15 A. Correct. 16 Q. By that time the probability of 17 Mr. Gill beating the cancer with optimal care 18 and blessing from above was what, what percent 19 chance? 20 A. Extremely small. 21 Q. Are we talking 10, 15? 22 A. Less. 23 Q. Are you able to tell me in January 24 and February how large the tumor was in the lung 25 had it been found at that time?</p>

<p style="text-align: right;">Page 57</p> <p>1 MR. WARNER: Objection. 2 A. No, I'm not. 3 Q. Do you know how large the tumor was 4 in the lung in April of 2000? 5 A. I couldn't tell you that, either. 6 Q. In May of 2000? 7 A. Again, I couldn't tell you that. 8 Q. In June of 2000? 9 A. I could not tell you that. 10 Q. In July it's anywhere between 4 and 11 5 centimeters depending upon which view we're 12 looking at; right? 13 A. Correct. 14 Q. Do you see any evidence on exam or 15 anything that Dr. Mansnerus described in terms 16 of nodal involvement in January of 2000? 17 A. No, I do not. 18 Q. Do you have any evidence that there 19 was nodal involvement in March of 2000? 20 A. The clinical evidence that we have 21 is the symptom complex that he presented with in 22 December of 1999, that being the numbness and 23 loss of motor function in the left arm. That's 24 consistent with nodal disease involving a 25 supraclavicular scalene node station.</p>	<p style="text-align: right;">Page 59</p> <p>1 of cancer cells in bronchogenic carcinoma it 2 takes to establish a clinically significant 3 metastasis? 4 THE WITNESS: Could you repeat that 5 question one more time? 6 (Record read.) 7 A. One cell. 8 Q. Just one cell? 9 A. That's correct. 10 Q. Don't tumors shed millions of cells? 11 A. They may. 12 Q. Doesn't it normally take the 13 shedding of millions of cells before one 14 actually gets set up and succeeds in forming a 15 metastasis? 16 A. That depends upon the host's 17 response to a shower of tumor emboli. 18 Q. The host being the patient? 19 A. That would be correct. 20 Q. I'm sorry. I may have cut you off. 21 You started to say some -- 22 A. That would be correct. Some host's 23 response to a tumor embolus can be that of cell 24 death. It can either kill the tumor cell, or it 25 can allow it to replicate. So one can develop</p>
<p style="text-align: right;">Page 58</p> <p>1 Q. There's no reference to those 2 symptoms when he's seen in January in 3 Dr. Mansnerus' records; are there? 4 A. There is not. 5 Q. Are you able to explain why there is 6 no reference to them? 7 A. No, I am not. 8 Q. In June when Dr. Mansnerus saw him, 9 from what you can tell from looking at the 10 records or the deposition, did he perform an 11 exam of the lymph nodes? 12 MR. WARNER: You're in June now? 13 MR. MISHKIND: June, yes. 14 A. There is nothing specific in the 15 record that stipulates a nodal examination. 16 However, on physical examination he described a 17 tender left sternomastoid which is in the region 18 of the supraclavicular lymph node change. 19 Q. Can a patient have micrometastasis 20 of cancer cells and not necessarily develop a 21 clinically significant metastasis? 22 A. With bronchogenic carcinoma? 23 Q. Yes. 24 A. It is very unlikely. 25 Q. Can you tell me how many metastases</p>	<p style="text-align: right;">Page 60</p> <p>1 clinically significant metastasis from as little 2 as one cell or develop no metastasis from one 3 cell. Be it as it may, it still is important if 4 you have a cell embolus that results in the 5 active development of the potential clinical 6 metastasis that it be identified. 7 Q. Do you know with this host what the 8 likely scenario was in terms of how many cells 9 needed to be shed, if you will, before he was 10 able to set up and succeed in forming a 11 clinically significant metastasis? 12 A. I don't know that you would know 13 that, nor would you ever be able to estimate 14 that. 15 Q. Have you ever seen any studies that 16 have talked about the shedding of cancer cells 17 and the fact that you and I may have cells that 18 potentially could be metastatic in nature going 19 through our body, but they aren't necessarily 20 clinically significant? 21 A. I'm not aware of studies that have 22 been written. I'm sure, though, there are 23 theories about that. In terms of an actually 24 scientific factual basis for that, I'm not aware 25 of it.</p>

<p style="text-align: right;">Page 61</p> <p>1 Q. Did Mr. Gill have metastasis to the</p> <p>2 hilar nodes as of May in your opinion?</p> <p>3 A. In May of that year?</p> <p>4 Q. Yes.</p> <p>5 A. Prior to the CAT scan that was done?</p> <p>6 MR. WARNER: In May of '99 or May of</p> <p>7 2000?</p> <p>8 MR. MISHKIND: May of 2000.</p> <p>9 A. I would believe so knowing his</p> <p>10 clinical presentation. We don't have scan</p> <p>11 evidence that stipulates to that.</p> <p>12 Q. But that would be your opinion, that</p> <p>13 he had metastasis to the hilar?</p> <p>14 A. Yes.</p> <p>15 Q. Do you have any basis to say that he</p> <p>16 had metastasis to any other nodes other than the</p> <p>17 hilar nodes as of May?</p> <p>18 A. There's no way to actually tell you</p> <p>19 that with 100 percent certainty, but in general</p> <p>20 they are spread along a specific nodal chain</p> <p>21 beginning with the intrapulmonary and then the</p> <p>22 hilar and then the mediastinal and then last the</p> <p>23 scalene supraclavicular node.</p> <p>24 Q. Would you agree that the less nodal</p> <p>25 involvement that there is, the better the</p>	<p style="text-align: right;">Page 63</p> <p>1 that question to an oncologist?</p> <p>2 A. Yes, I would.</p> <p>3 Q. In light of what you just said about</p> <p>4 deferring to an oncologist, do you have an</p> <p>5 opinion as to what Mr. Gill's life expectancy</p> <p>6 would have been had his diagnosis been made in</p> <p>7 your opinion consistent with your opinion in</p> <p>8 January or February as opposed to July and</p> <p>9 August?</p> <p>10 We know he died in February of the</p> <p>11 next year, but had he been diagnosed with the</p> <p>12 type of cancer that you believe he had in</p> <p>13 January or February, what would his life</p> <p>14 expectancy have been?</p> <p>15 A. I think his life expectancy would</p> <p>16 have been identical to what it was when he was</p> <p>17 diagnosed in July or August. I don't think it</p> <p>18 would have changed at all.</p> <p>19 Q. You believe he still would have more</p> <p>20 likely than not died in February of the</p> <p>21 following year?</p> <p>22 A. I think there's no question he would</p> <p>23 have.</p> <p>24 Q. When you say there's no question, on</p> <p>25 what basis do you say that there's no question?</p>
<p style="text-align: right;">Page 62</p> <p>1 prognosis?</p> <p>2 A. It depends upon where the nodal</p> <p>3 stations are that are involved. I think once</p> <p>4 you had mediastinal nodal disease, be it</p> <p>5 microscopic or bulky nodal disease, your</p> <p>6 prognosis is quite dismal.</p> <p>7 Q. If Mr. Gill had been diagnosed with</p> <p>8 lung cancer in January or early February, I take</p> <p>9 it your opinion is that he would not have been a</p> <p>10 surgical candidate for the reasons we've</p> <p>11 discussed and are set forth in your report?</p> <p>12 A. I believe so, yes.</p> <p>13 Q. Do you have an opinion as to what</p> <p>14 treatment modalities would have been appropriate</p> <p>15 for the patient in January or February as</p> <p>16 compared to the treatment modalities that were</p> <p>17 implemented as of July and August?</p> <p>18 A. I believe they would have been the</p> <p>19 same.</p> <p>20 Q. Any differences at all?</p> <p>21 A. Again, I'm not an oncologist, so</p> <p>22 it's difficult for me to answer that question,</p> <p>23 but I believe the same type of systemic</p> <p>24 chemotherapy would have been given to him.</p> <p>25 Q. Would you defer on the specifics of</p>	<p style="text-align: right;">Page 64</p> <p>1 A. Because I feel very strongly that at</p> <p>2 the time of his initial presentation in December</p> <p>3 he had Stage III-B disease at the least,</p> <p>4 potentially Stage IV disease knowing the</p> <p>5 eventual involvement in his femur and the</p> <p>6 micrometastasis or small metastasis in his left</p> <p>7 lung tissue itself.</p> <p>8 The III-B disease would have been</p> <p>9 treated identical to Stage IV disease, that</p> <p>10 being chemotherapy, potentially chemotherapy</p> <p>11 with radiation therapy. Surgical therapy would</p> <p>12 not have been an option for him. As that is the</p> <p>13 case, the prognostic limb of his therapy would</p> <p>14 not have changed given the fact that he would</p> <p>15 not have been a candidate for surgical</p> <p>16 intervention.</p> <p>17 Q. Mr. Gill was seen in December by</p> <p>18 Dr. Mansnerus twice, on December 9 and</p> <p>19 December 30?</p> <p>20 A. That is correct.</p> <p>21 Q. And then seen again I think</p> <p>22 January 6th of 2000; correct?</p> <p>23 A. That is correct.</p> <p>24 Q. At no time during any of those three</p> <p>25 visits is there any reference to or suggestion</p>

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1 of his clinical course being consistent with or
2 potentially consistent with cancer; correct?
3 A. I believe his clinical course is
4 consistent with what we know retrospectively.
5 There was no mention made in the record about it
6 potentially being consistent with that. We have
7 the benefit of retrospectively looking back and
8 seeing what initially he presented with and what
9 his eventual demise was from.
10 Q. Right. I understand that. I'm just
11 asking just as a matter of fact, the symptoms in
12 December, two visits, and the symptoms in
13 January were not, right, wrong, or otherwise,
14 were not correlated by Dr. Mansnerus to be
15 potentially consistent with what ultimately was
16 diagnosed?
17 MR. WARNER: Objection.
18 A. I can't answer that question.
19 That's a question that only he can answer
20 because I can't get into his head and know what
21 he was thinking at the time.
22 Q. You don't see any evidence from the
23 deposition or from the records that he was
24 thinking or considering lung cancer as an
25 explanation?

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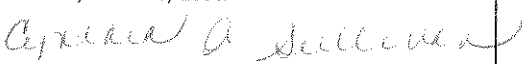
1 A. I do not see that in the medical
2 record.
3 Q. What I want to do is tie loose ends
4 together, and we will be done.
5 I think in essence your opinions on
6 proximate cause, without restating them again,
7 are that by the early part of 2000 unfortunately
8 in your professional opinion Mr. Gill was not a
9 surgical candidate and that an earlier
10 diagnosis, even if a jury is to conclude that an
11 earlier diagnosis should have been made and that
12 the standard of care was violated, your opinion
13 would be that it wouldn't have made any
14 difference anyway?
15 A. Correct. He would not have been a
16 surgical candidate even in December of 1999; and
17 therefore, his treatment limb would not have
18 changed.
19 Q. Are you in a position to comment at
20 all on the opinions that were expressed by
21 Dr. Steele or Dr. Bass or Dr. Sutherland with
22 regard to the prognosis of Mr. Gill? You recall
23 that they indicated that they felt that had a
24 diagnosis been made in January or February, he
25 would have had a greater than 50 percent

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1 likelihood of survival?
2 A. I don't believe that's remotely the
3 case. I think any appropriate cardiothoracic
4 surgeon would have done a mediastinoscopy on him
5 at the least to ascertain the absence or
6 presence of mediastinal nodal involvement. Even
7 if he presented and was diagnosed as early as
8 December of 1999, it's my strong belief that
9 those nodal stations along with potentially even
10 the scalene node would have been positive if not
11 clear microscopically, and that would have
12 precluded him from being an operative candidate
13 in any way, shape, or form.
14 Q. Did Dr. Mansnerus, from what you can
15 see in the record, refer Mr. Gill to a surgeon
16 for any type of evaluation in January or
17 February?
18 A. I don't believe so.
19 Q. I don't want to cut you off, but
20 have we covered the opinions on the issue of
21 proximate cause in terms of treatment
22 modalities, likelihood of survival, and the
23 impact of this cancer that you believe you have
24 as it relates to this case?
25 A. Yes.

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1 Q. Are there any other areas that you
2 believe that because I haven't taken a thorough
3 enough deposition you hold opinions on that you
4 anticipate providing testimony at the time of
5 trial on that we have not covered?
6 A. I don't believe so.
7 Q. To the extent that you do arrive at
8 any additional opinions, would you please let
9 Mr. Warner know and within two to three weeks
10 he'll probably let me know?
11 A. Yes, I will.
12 MR. MISHKIND: Doctor, thank you for
13 your time. It's nice to meet you.
14 THE WITNESS: I would like to read
15 it.
16 -----
17 (Deposition concluded at 7:00 p.m.)
18 (Signature not waived.)
19 -----
20
21
22
23
24
25

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1	AFFIDAVIT	1	INDEX
2	I have read the foregoing transcript from	2	DEPOSITION OF MARK J. BOTHAM, M.D.
3	page 1 through 68 and note the following	3	
4	corrections:	4	BY MR. MISHKIND:..... 3:12
5	PAGE LINE REQUESTED CHANGE	5	
6		6	Plaintiff's Deposition
7		7	Exhibits 1 through 4 were marked..... 3:2
8		8	
9		9	
10		10	
11		11	
12		12	
13		13	
14		14	
15		15	
16		16	
17		17	
18	MARK J. BOTHAM, M.D.	18	
19		19	
20	Subscribed and sworn to before me this	20	
21	day of _____, 2004.	21	
22		22	
23		23	
24	Notary Public	24	
25	My commission expires _____.	25	
	Page 70		
1	CERTIFICATE		
2			
3	State of Ohio,)		
4) SS:		
5	County of Cuyahoga.)		
6			
7			
8			
9	I, Cynthia A. Sullivan, a Notary Public		
10	within and for the State of Ohio, duly		
11	commissioned and qualified, do hereby certify		
12	that the within named MARK J. BOTHAM, M.D. was		
13	by me first duly sworn to testify to the truth,		
14	the whole truth and nothing but the truth in the		
15	cause aforesaid; that the testimony as above set		
16	forth was by me reduced to stenotypy, afterwards		
17	transcribed, and that the foregoing is a true		
18	and correct transcription of the testimony.		
19			
20	I do further certify that this deposition		
21	was taken at the time and place specified and		
22	was completed without adjournment; that I am not		
23	a relative or attorney for either party or		
24	otherwise interested in the event of this		
25	action. I am not, nor is the court reporting		
	firm with which I am affiliated, under a		
	contract as defined in Civil Rule 28(D).		
	IN WITNESS WHEREOF, I have hereunto set my		
	hand and affixed my seal of office at Cleveland,		
	Ohio, on this 9th day of February 2004.		
			
	Cynthia A. Sullivan, Notary Public		
	Within and for the State of Ohio		
	My commission expires October 6, 2006.		

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