IN THE COURT OF COMMON PLEAS
OF CUYAHOGA COUNTY, OHIO

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WILLIAM J. GILL, III,
Executor of the Estate of
DANIEL P. GILL, deceased,
Plaintiff,
vs. Case No. 457634
ROGER A. MANSNERUS, M.D.,
et al.,
Defendants.

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DEPOSITION OF MARK J. BOTHAM, M.D.
TUESDAY, FEBRUARY 3, 2004

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Deposition of MARK J. BOTHAM, M.D., a Witness herein, called by the Plaintiff for examination under the statute, taken before me, Cynthia A. Sullivan, a Registered Professional Reporter and Notary Public in and for the State of Ohio, pursuant to notice and stipulations of counsel, at the offices of Hillcrest Hospital, 6780 Mayfield Road, Mayfield Heights, Ohio, on the day and date set forth above, at 5:15 p.m.

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APPEARANCES:
On behalf of the Plaintiff:
Becker & Mishkind Co., LPA, by
HOWARD D. MISHKIND, ESQ.
Skylight Office Tower
1660 West Second Street
Suite 660
Cleveland, Ohio 44113
(216) 241-2600

On behalf of the Defendant:
Reminger & Reminger, by
ROBERT D. WARNER, ESQ.
1400 Midland Building
101 West Prospect Avenue
Cleveland, Ohio 44115
(216) 687-1311

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(Thereupon, Plaintiff's Deposition Exhibits 1 through 4 were marked for purposes of identification.)

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MARK J. BOTHAM, M.D., of lawful age, called for examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

EXAMINATION OF MARK J. BOTHAM, M.D.
BY MR. MISHKIND:

Q. Could you state your name for the record?
A. Mark Judson Botham.
Q. You are a physician; is that correct?
A. That is correct.
Q. Dr. Botham, you and I have never met before, have we?
A. No, we have not.
Q. My name is Howard Mishkind, and I represent the estate of Mr. Gill. I'm going to be asking you some questions concerning the opinions that you have expressed in your report

of November 29, 2002, that you sent to Mr. Warner and also some questions about your background, and hopefully, we won't be terribly long. Famous last words.

You have had your deposition taken before, I know, so you know the routine in terms of waiting and making sure that you understand my question before you answer it; right?
A. Yes.
Q. If you don't understand a question or if for some reason I ask a question that somehow isn't intelligible, you'll tell me it isn't, and I'll rephrase it; okay?
A. That sounds fair.
Q. If you do answer the question, I have every reason to accept that you understood the question; is that fair?
A. That is fair.
Q. Exhibit 1 is a copy of your report that you wrote to Mr. Warner; is that correct?
A. That is correct.
Q. It appears that you were contacted sometime in September of 2002 to review the case. Exhibit 3 which I've just handed to you, does that --

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

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attached to Exhibit 3 and the report that you signed that is Exhibit 1 without going through it line and verse?
A. I don't believe so, no.
Q. Exhibit 2 is a copy of your CV; is that correct?
A. That is correct.
Q. If I could see Exhibit 3 for a moment?
A. (Indicating.)
Q. Your report, Exhibit 1, identifies certain information that you apparently had at the time that you reviewed the case and considered for purposes of that report; is that correct?
A. That is correct.
Q. Does that list of items that's contained in Exhibit 1 constitute all of the information at that time that you had reviewed for purposes of your opinions?
A. I believe so, yes.
Q. You are a cardiothoracic surgeon; is that correct?
A. That's correct.
Q. The overwhelming percentage of your

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cardiothoracic surgeries that you do are coronary artery bypass surgeries; is that correct?
A. Well, things have changed in the last five years. I would suspect that probably 60 to 70 percent of my present surgery involves cardiac surgery and 30 percent noncardiac thoracic surgery. Of the cardiac surgery that I do, probably 70 to 80 percent of that is bypass, coronary bypass surgery.
Q. When did the percentages of your surgical experience change?
A. When the cardiologists became more adept at doing balloon interventions, percutaneous interventions, the number of coronary bypass surgeries that we do as cardiothoracic surgeons decreased.
Q. If a patient such as Mr. Gill came to you at a point in time where he was Stage I nonsmall cell carcinoma and a patient that was an appropriate surgical candidate, would you be the type of surgeon that would perform surgery on a Stage I nonsmall cell carcinoma lung cancer?
A. If it was a clinical Stage I

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carcinoma of the lung and we had done the appropriate preoperative evaluation to ascertain that it was indeed a clinical Stage I disease and that he was a candidate for surgical resection based upon his medical condition and his pulmonary function test, yes, I would then be the surgeon who would perform that surgery.
Q. What type of surgery would be performed?
A. It can vary anywhere between a preoperative nodal sampling, be it a scalene node biopsy or a mediastinoscopy to ascertain the absence or presence of microscopic nodal disease that might preclude formal thoracotomy and surgical resection of the primary tumor to actual resection of that primary tumor along with the mediastinal lymph node dissection.
The surgical resections that can be encompassed in that type of resection can vary anywhere between a wedge resection, a lobectomy, or a pneumonectomy.
Q. In terms of the initial intervention, surgical intervention, that you mentioned, if there has been expansion of the tumor into the mediastinum, that would by

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

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

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

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

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below the standard of care for an internist or family practice doctor in evaluating Mr. Gill in December and early January of the years involved?
A. That assumption would be correct.
Q. You will be providing testimony as it relates to that legal term called proximate cause; is that correct?
A. That is correct.
Q. If Mr. Gill had been diagnosed Stage I and knowing the histology that ultimately was appreciated in terms of the poorly differentiated components, but if you back up in time to a snippet in time, whenever that may have been, and he had been diagnosed Stage I-A or Stage I-B and had come to someone like you without any mediastinal involvement, he would have been an appropriate candidate for surgical treatment; correct?
A. In order to accurately answer that question, I just want to make sure I understand the question. Are we talking at any point in time prior to and/or including the presentation on 12-9-99? Because it is my belief that on 12-9-99 he probably was not a Stage I-A or B.

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So if you're asking the question could it potentially be prior to that, if he had presented and at that time been clinically Stage I-A or I-B, yes, I do believe that he might have been a candidate for surgical resection.
Q. I understand from reading your report -- and we'll talk about certain snippets of it, but we're not going to go through the entire thing because they taught me how to read in law school -- but my question is really, regardless of whether that point in time was December or whether it was months or years before that, if we got to that snippet in time and everyone agreed that he was a Stage I-A or Stage I-B and he fell into your lap and you then had the benefit of knowing, which this would never happen, but at Stage IV what the cancer looked like, but you were fortunate enough to be able to turn the hands of the clock back and treat him at Stage I-A or Stage I-B nonsmall cell carcinoma, in a man of Mr. Gill's age and comorbidity factors, he would have been an appropriate candidate for surgical consideration?
A. I believe he would have been, yes.

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Q. More likely than not, if he had been operated on at a point in time where he was Stage I-A or Stage I-B, would he have had more likely than not a greater than 50 percent probability of a good outcome?
A. I think it's safe to say that he would have had a greater than 50 percent probability of surviving more than five years.
Q. That's sort of the magic period, is it not, that you use, a five-year survival, or do you go out further than that?
A. Five-year survival is how we delineate percentages of survival. In bronchogenic carcinoma, most patients who reach five years without evidence of a clinical recurrence are more than likely going to stay that way throughout the duration as it pertains to bronchogenic carcinoma. So that's the reason why we use those numbers as a percentage of survival.
Q. They're sort of out of harm's way, if you will, if they make the five-year period of time without any recurrence or distal metastasis?
A. The likelihood is extremely high

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that they are out of harm's way from their original bronchogenic carcinoma. They still are at risk, however, to develop a second primary which is the reason we continue to follow them even after five years' time.
Q. You mean they can't say good-bye to the doctor after five years and a good report?
A. No, they can't.
Q. That's what you call job security; right?
A. It's not so much job security but just making sure that our patients continue to do well.
Q. I know. I say that obviously in jest. Obviously, if you reach the five-year time period after surgery in a patient without any significant comorbidities, the prognosis would be favorable for long-term survival?
A. Ideally, yes.
Q. In a patient of Mr. Gill's age, his comorbidity or lack thereof, and obviously he was a smoker -- which in your opinion is the smoking a probable cause of the lung cancer?
A. Almost assuredly, yes.
Q. Even though his smoking caused the

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lung cancer, there are literally thousands of patients in which smoking causes lung cancer but yet are fortunate enough to be diagnosed at a Stage I-A or Stage I-B and have a good outcome; correct?
A. That's correct.
Q. So while it's not good to smoke because it creates the risk of cancer, if you're in the right place at the right time and a doctor diagnoses it at an early stage, there can be a happy ending as long as the person doesn't continue to smoke after having the surgery; is that a fair statement?
A. That's a fair statement.
Q. Again, with the assumption that Mr. Gill was diagnosed Stage I-A or Stage I-B, would he have required adjunctive therapy as well to maximize his long-term survival?
A. At the time of his diagnosis, no. I think we are now revisiting that. More recently we've looked at patients who are Stage II and are recommending that they get adjunctive chemotherapy and at times radiation therapy. There were some studies that now suggest a small but definitely significant benefit for those

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patients.
The overwhelming percentage of oncologists now I think probably still do not recommend adjunctive therapy for Stage I disease.
Q. Stage II-A would be what, T1-N1?
A. T1 or T2 and N1 lesions.
Q. There's some discrepancy, as I see it, in the records as to what the size of the tumor was when it was first diagnosed. At one point I see 4 centimeters, and then at one point -- it's been a while since I've looked at this -- but at one point I think it was maybe 4.5 centimeters. Is that significant, the difference between 4 and 4.5 centimeters?
A. No. I think that really depends on when and how the CAT scans are done and the radiologist's interpretation. It's similar to taking a tennis ball and slicing it into multiple little pieces. It depends upon where in the ball you slice it, whether you slice it in the absolute maximum diameter or you miss that by 2 or 3 or 4 millimeters.
It may look smaller on one slice, but in actuality you haven't actually hit the

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largest portion of the tennis ball. So it's subject to error, and it's subject to interpretation. In general it does not change the clinical presence of the tumor.
Q. Could I borrow that?
A. (Indicating.)
Q. I think you indicated that in your opinion in this case had Mr. Gill's disease been diagnosed at the end of '99 or the early part of 2000 that the tumor would have been less bulky in size; correct? In that last paragraph about the fourth line down, do you see that?
A. Yes. I see that. The question is? I'm sorry.
Q. That the tumor had it been diagnosed at the end of December or January or that time period, and I understand what your opinions are, but you do acknowledge that there is a probability that the tumor would have been less bulky in size at that earlier period of time?
A. I believe so, yes.
Q. Just so I understand, because sometimes the term bulky may mean one thing to one person, if we use that 4.5 or 4 centimeter tumor and we reduce it in size to say 3.5, is

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the difference between 3.5 and 4 that 4 is bulkier than 3.5?
A. By definition if it's larger in size, it truly is bulkier. In terms of the histopathological classification and stages, it does not change the stage of the lesion at that time.
Q. Can you tell me, if you have an opinion, what size the tumor would have been in let's take from December of '99 into the turn of the year, into January and maybe the early part of February, if it was less bulky in size? I'll give you sort of a range. Tell me the smallest you believe it would have been and the largest you believe it may have been as well those months earlier.
MR. WARNER: Objection. Go ahead.
A. Again, it's pure supposition because I don't have the radiographs to look at and we don't have the benefit of retroactive staging with any other study back in December, but if I were to make that supposition, I would say the smallest the tumor size would have been would have probably been around 3 centimeters, and probably the largest it would have been would

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have been similar to what it was when it was diagnosed eventually later that year, roughly 4 to 4.5 centimeters.

Q. If there were no other clinical, pathological, or histological findings other than a tumor of 3 centimeters, then that would by definition be a T1 nonsmall cell carcinoma?

A. It would be a T2 lesion. Anything 3 centimeters or larger is a T2 tumor.

Q. So once it hits 3, it kicks from T1 to T2?

A. That is correct.

Q. Are there studies that indicate anything above 3 centimeters is T2 and anything 3 centimeters and below is T1?

A. That's the standard classification for bronchogenic carcinoma. A T1 tumor is less than 3 centimeters, and a T2 tumor is greater than 3 centimeters. That's the specific size criteria that delineates a T1 and T2 tumor.

Q. Maybe I wasn't clear. If anything greater than 3 centimeters is T2 and anything less than 3 centimeters is T1, what is a tumor that is 3 centimeters right on the button?

A. That would be by definition a T2

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tumor.

Q. Have you seen any studies in this area that describe a 3 centimeter nodule, not more than 3 centimeters but just 3 centimeters exactly, as being T1 as opposed to T2?

A. I have not.

Q. In your CV, Doctor, you have nine publications?

A. Correct.

Q. Are there any in the works?

A. Presently, no.

Q. Are all of the nine publications peer reviewed?

A. Yes, they are.

Q. Do any of them touch on the topic of the diagnosis and treatment of nonsmall cell lung tumors or lung cancer in general?

A. No, they do not.

Q. Are all of the articles more in the area of the coronary artery and cardiac end of your surgical interests?

A. They are related to both cardiac as well as general thoracic topics. There is nothing specifically there related to bronchogenic carcinoma, though.

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Q. Just to give me an idea, in 2003 -- I won't ask you in 2004 because it's not old enough -- in your surgical practice, how many situations were you called upon to perform resection on a lung cancer patient?

A. Without having the specific numbers, I would guesstimate probably somewhere between 100 and 150.

Q. All of those patients were Stage I-A or Stage I-B?

A. No. I suspect probably 20 or 30 percent of that group of patients were Stage I.

Q. Until you went in and did the initial intervention, diagnostic intervention, you didn't know whether or not they were Stage I-A or Stage I-B?

A. That is correct.

Q. Have you reviewed any literature on the topic of nonsmall cell lung cancer in terms of staging and prognosis that would be germane and relevant to the topic in this case for purposes of preparing your report?

A. No, not specifically for purposes of preparing the report.

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Q. Since you prepared your report, have you reviewed any literature again on that same topic that you believe to be relevant or germane to the issues in this case?

A. Not specifically, no.

Q. Are there any articles, journal articles, or studies that you consider to be reasonably reliable or, as the lawyers like to say, authoritative on the topic of prognostic indicators for nonsmall cell lung cancer in terms of the diagnosis and treatment as well as the prognosis for those types of patients?

A. I believe that all articles that are written are opinions of their authors, and they're generated in an effort to educate their colleagues. The appropriate nature of education for colleagues is to read those and to formulate their own opinions based upon them.

There are numerous historical clinical as well as histopathological staging papers in terms of how they relate to prognosis in lung carcinoma which most cardiothoracic surgeons have read and hopefully encompassed into their practice in terms of how they present information to their patients.

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Q. Are you able to cite me to any that you, Dr. Botham, consider to be very reliable or reasonably reliable on this very topic?
A. Specifically, I don't think I could give you the name of an article. Over the last 16 years I've read hundreds and hundreds of articles that pertain to staging in lung carcinoma and how it affects prognosis in an attempt to assimilate all those and generate my opinions at to how we go about managing this type of problem.
Q. Did you review the article that Dr. Steele had referenced that was attached to his deposition?
A. I don't believe that I did.
Q. The reason I ask you not about Dr. Steele but about whether there are any articles that you consider to be reliable is that I want to find out whether or not you are currently in a position to acknowledge a journal article or a section from a journal article on the topic of nonsmall cell lung cancer as being reliable from the standpoint of having any evidentiary value in this case, and if I understand what you're saying, it is that there

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may be articles out there, but as you're sitting here right now there's nothing that you can cite me to?
A. Correct.
Q. To the extent that that position changes and you are likely to take the stand and acknowledge anything as being reasonably reliable or authoritative, just for the record I would ask that I be notified before you take the stand to that effect.
A. I would be happy.
Q. Do you still charge $250 an hour for depositions?
A. Yes.
Q. Trial testimony is $4,000 to $5,000 for half a day?
A. $5,000 for a day.
Q. So the $4,000 is no longer current?
A. It has never been $4,000. My fees haven't changed in 14 years.
Q. In one deposition you may have slipped to say $4,000 to $5,000.
A. It has always been $5,000.
Q. $10,000 for the day?
A. No. $5,000 for a day. I've never

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charged more than that unless I'm away for two days' worth of work. If I have to fly somewhere and stay for the night, then it may be two days' worth of work.
Q. After the diagnosis -- here I go again. I'm jumping off one topic and going on to another, but I'm going to come back to your medical-legal again, so you're not out of the woods yet.
After the diagnosis was made of the cancer, it was a Grade IV at that time?
A. At the time it was diagnosed, it was a Stage IV.
Q. Stage IV, I'm sorry. He was seen at both the Cleveland Clinic and University Hospitals, but I think his treatment was pretty much confined to one institution. Do you remember which one that was?
A. I believe it was at University Hospitals.
Q. Do you know any of the doctors that were involved in Mr. Gill's care after the diagnosis of cancer was made?
A. The only one that I know by reputation is Dr. Dowlati. I have not had

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patient interactions with him.
Q. Well, you're not an oncologist, so you would not be treating from a nonsurgical standpoint a patient that is not a surgical candidate; correct?
A. That is correct.
Q. Are you able to comment at all on whether or not the care that was provided by Dr. Dowlati or any of his team seemed to comply with accepted standards, or do you not have an opinion one way or another on that?
A. I would not testify to an opinion, but in my review of the medical records, I believe that accepted standard of care was met in their management of Mr. Gill.
Q. He received what type of therapy when it was realized that it was too late to operate?
A. I believe there were two separate rounds of chemotherapy, as they like to say, I think. If you'll give me one second, I'll look through my notes here.
Q. While you're doing that, you're looking at a legal pad which has a number of pages of notes which has been marked as

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

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

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

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

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you been an expert in a case that was venued in federal court?
A. No, I have not.
Q. You have never been known to have prepared a Rule 26 disclosure of the cases and the subject matter from which those cases evolved for any court?
A. No, I have not.
Q. Or for any attorney for that matter?
A. No, I have not.
Q. Have you ever reviewed a case similar to Mr. Gill where you were asked to provide an opinion on the issues of proximate cause in a patient where an allegation was asserted that there was a delay in timely diagnosing lung cancer?
A. Yes, I have.
Q. How many cases would fall in that description?
A. Boy, I think probably only one that I can remember.
Q. Tell me, by that answer there might be more but --
A. One that I remember for sure, and I don't recall specifically other cases.

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Q. Tell me about the one that you do remember.
A. It was a case I believe back in 1996. I was asked by Steve Charms to review a case for a plaintiff in the same similar situation where there was a four- or six-month delay in making a diagnosis of bronchogenic carcinoma. At that time they did not feel that the delay was significant in terms of proximate cause, and I don't believe that Mr. Charms proceeded with the case, but that would be something that you would have to ask him.
Q. Have you ever testified as an expert in a case on either side in a case with similar issues to what we have in Mr. Gill's case?
A. No, I have not.
Q. In the last two to three years in terms of your review of cases in the medical malpractice area, tell me what the breakdown has been of plaintiff versus defendant where you've been asked.
A. In the last two to three years, 100 percent for the defense.
Q. Do you know the reason why you have been monopolized by the defense bar over the

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last two to three years?
A. I'm not sure I've been monopolized. I think it's been probably by my choice. There are two specific reasons. Since becoming a Cleveland Clinic Foundation clinic, we're discouraged from reviewing cases for plaintiffs' counsels, and I've had a couple of bad experiences in the past with plaintiffs' counsels who decided they didn't want to pay for their services.
Q. There are black sheep in every family.
A. Yes. I agree.
Q. Since you haven't met me until now, we can honestly say that experience wasn't with me.
A. That is correct.
Q. I want to talk a moment about the topic of your own claim history. I think, at least from some of my homework, that you've been named is it five times as a defendant?
A. I believe so.
Q. Are any of those cases currently pending?
A. No. They are all resolved.

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Q. One got dismissed after voir dire?
A. That is correct.
Q. One was dismissed during the case, perhaps opening statements, or dropped I should say?
A. I'm only aware of one case being dismissed. Actually, I think it was after voir dire. It was right at the time of opening statements.
Q. Have any of the cases that you've been a defendant in involved issues arising out of cancer treatment?
A. Yes, an esophageal carcinoma case.
Q. Was that a Mt. Sinai case or a Cleveland Clinic case?
A. A University Hospital case.
Q. You were originally at Mt. Sinai; correct?
A. That is correct.
Q. Then University, and your Cleveland Clinic affiliation has been for how long now?
A. A little more than three years.
Q. So were you with Alan Markowitz back at Mt. Sinai?
A. Yes.

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Q. And Holland and all those guys?
A. Yes.
Q. I'm starting to show my age. The esophageal cancer case, do you remember the name of the plaintiff in that matter?
A. Sidney Segal.
Q. Was the allegation against you relative to surgical approach to the --
A. No. I believe it was management, postoperative management.
Q. Do you happen to remember who the plaintiff's attorney was in that case?
A. Peter Weinberger.
Q. How many times would you say in your best estimate that you have been deposed since 1988 so now 16 years?
A. Gee, it's got to be 60, 70, 80 times.
Q. When was the last time you were deposed in a medical malpractice case before today?
A. Probably three months ago.
Q. Obviously, you were serving as an expert for the defense in that case.
A. That is correct.

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Q. That was a Reminger & Reminger case?
A. I believe so.
Q. When are you scheduled next to give a deposition, assuming that we ever finish this one?
A. I'm actually not, believe it or not.
Q. This case is scheduled for trial in April, I think. Rob and I were scratching our heads before. Are you scheduled for any other trials in the foreseeable future other than this matter?
A. I don't believe so.
Q. I presume that Mr. Warner has asked you to testify in the trial of this case?
A. Yes, he has.
Q. What has your answer been?
A. I'd be happy to, yes.
Q. Do you know Dr. Mansnerus?
A. I do not.
Q. Do you know any of the experts in this case?
A. I have operated upon a few patients of Dr. Rozman's, and I have interacted with patients with general thoracic malignancies with Dr. Levitan.

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Q. Dr. Rozman has referred his patients for surgical intervention, not just for cancer issues, but for other cardiothoracic issues to you?
A. I think they have all been for patients who have had cardiothoracic issues who have been referred to a cardiologist who has called me regarding surgical interventions on those patients. He himself specifically I don't believe has ever called me.
Q. There has been a middleman?
A. Yes.
Q. Have you ever had any professional dealings with Dr. Rozman other than knowing that he was the attending for that patient that actually came to you?
A. No, I have not.
Q. Dr. Levitan, you said that you've done some surgical work on some of his patients?
A. We have had patients where we have interacted together managing thoracic oncologic issues, be they lung carcinoma or esophageal carcinoma or other malignancies of the chest, where I have operated upon them, and then they have either somehow developed a recurrent

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disease or had significant enough disease that they require oncologic consultation, and he has been the oncologist of choice.
Q. Do you have an ongoing professional relationship?
A. Not really. He is a University Hospital physician, and I am now a Cleveland Clinic physician. So we don't interact as we perhaps might have in the past. We do still have some patients that I see in follow-up that he sees in follow-up that are patients of both of us. But, obviously, that number becomes less and less as I do more and more within the confines of the Cleveland Clinic Foundation, and his practice is within the confines of the University Hospitals Health System.
Q. Doctor, there's another expert pathologist whose name is escaping me.
A. Dr. Casey. Yes, I do know her.
Q. You know Dr. Casey?
A. Yes.
Q. How do you know Dr. Casey?
A. She's a pathologist at Parma Community General Hospital.
Q. Other than knowing she's a

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pathologist at Parma, what type of relationship --
A. She has reviewed pathologic slides of mine in cases that I've done in the past.
Q. Have you ever served as an expert to your knowledge in a case where Dr. Rozman, Dr. Levitan, or Dr. Casey were also serving as an expert?
A. I don't believe so. There may have been cases where Dr. Levitan was serving as an expert. Again, I can't tell you that with certainty, but I know he does a fair amount of medical malpractice work, and we may have interacted in the past on a case. Again, I don't know a specific name clearly. I have not with Dr. Rozman or Dr. Casey.
Q. Flipping tabs, Dr. Steele, Dr. Sutherland and Dr. Bass, do you know any one of them?
A. No, I do not.
Q. The young man seated to your left -- you're looking for a young man.
MR. WARNER: You've got to look for a young man.
Q. A number of years ago that would

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have been applicable had someone said that, but I guess as we get older that's just a compliment.
You have had occasion, have you not, to serve as an expert representing doctors that Mr. Warner has represented?
A. Yes, I have.
Q. On how many occasions have you been called on by Mr. Warner?
A. A guesstimate, six or eight.
Q. Have you testified at trial in any of those cases?
A. Yes, I have.
Q. How many?
A. Three or four.
Q. Was one of those in the fall of this last year?
A. I believe so, yes.
Q. Do you remember the name of the doctor or patient in that matter?
A. I think as I get older I remember less and less of the names. I can't, to be honest with you. I can't remember specifically.
Q. What was I just asking you? You've also had occasion to work with other attorneys

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at Reminger & Reminger?
A. Yes, I have.
Q. Besides Mr. Warner, are there any active files in your office that you are serving as an expert on for other attorneys from Reminger & Reminger currently?
A. I don't believe so for Reminger & Reminger. There are other firms, but I don't believe so for Reminger & Reminger.
Q. Those would be other defense firms?
A. Yes.
Q. Other local Cleveland defense firms?
A. Yes.
Q. In terms of the attorneys that you have worked with in the past from Reminger & Reminger, can you help me out with any of the names?
A. I believe I have served as an expert witness for Marc Groedel, Bill Meadows, P.J. Malnar, and I think that really probably is about it.
Q. You have also, have you not, served as an expert for Steve Walters?
A. I may have.
Q. Jim Malone?

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A. I have for Jim Malone. He's not with Reminger & Reminger, though, is he?
Q. He is unless he has gotten kicked out recently.
MR. WARNER: Yes, he is.
Q. Steve Crandall when Steve Crandall was at Reminger?
A. A long time ago, yes.
MR. WARNER: He's now a plaintiff's counsel.
A. Yes, he is. But at times in the past, yes.
Q. But your testimony is that currently you don't have any open cases with Reminger & Reminger?
A. I don't believe that I do.
Q. Hopefully, I'm going to confine the remainder of my questions to your report. So if you want to get that, I'm not going to have you read over your notes, but I am going to want to get copies of that, if you would, just for purposes of housekeeping. If you could, just identify it. I think Exhibit 4 are your notes.
A. Yes. That is correct.
Q. If you could just count the pages,

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and I'm just going to trust you to or you'll work out arrangements with the court reporter for copies.
A. There are a total of seven pages in Plaintiff's Exhibit 4.
Q. The last three words in your report are aggressive bronchogenic carcinoma?
A. Correct.
Q. Can you tell me when this bronchogenic carcinoma became aggressive?
A. I think that term is used in relationship to bronchogenic carcinomas that are less aggressive, and it may end up with survival at times measured in years from the time of diagnosis, whereas this one is measured in terms of months. I think all bronchogenic carcinomas are clearly aggressive because if untreated people die from them. His form I think was reasonably virulent given the fact that his diagnosis was in August and his expiration was in February.
Q. Do you have an opinion as to when he first developed the bronchogenic carcinoma?
A. I would suspect years anteceding the actual diagnosis.

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Q. Can you be more specific than years?
A. No, because I don't have factual evidence to stipulate what the tumor doubling time is. In general, what we know from tumor biology is that it takes years for something like this to develop from one or two cells to something that can be detectable by a CAT scan at 5 millimeters to something that then becomes detectable in a size similar to this at 4 centimeters.
Q. Do bronchogenic carcinomas always follow a linear pattern in terms of growth, or are there certain cancers that the longer they go untreated the more aggressive they become?
A. I think the correct ideation here is the more anaplastic the tumor is, the more likely it is to have rapid growth, the more likely it is to spread systemically rather than local regionally, and the greater the likelihood is that the outcome will be poor.
Q. Tell me what you mean by anaplastic.
A. The character of the tumor as you view it under the microscope, its histologic picture, how it invades things, the cytologic appearance of it. Those are things that we look

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at in terms of determining how anaplastic a tumor is.
Q. In the same last paragraph of your letter, the incurability of Mr. Gill's disease was present at the time of his presentation in December 1999, et cetera, that is an opinion that you hold in this case; correct?
A. That is correct.
Q. Can you tell me when, if you are correct in regard to that opinion, when prior to December of 1999 did his lung cancer become incurable?
A. I don't know that. I can't stipulate that. That again would be supposition. The only information I have is the time of his initial presentation in December of 1999. It is my opinion that at that point in time his cancer was incurable. I can't make a projection back retrospectively from there because I have no information as to what the clinical status was prior to that.
Q. Jump back to the first page of your report. On December 9 when Mr. Gill presented, is it your recollection that these are the only symptoms that he presented to Dr. Mansnerus

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with, that being the left-sided chest pain and numbness or weakness of the left arm?
A. These may not have been the only symptoms, but they were the ones that I felt were pertinent to his clinical condition.
Q. Do you know how long he had had as of December 9 the symptoms that he described to Dr. Mansnerus during that December 9 visit?
A. I would have to review Dr. Mansnerus' office records. If you'd like, I can do that. It doesn't specifically stipulate in the transcribed letter of 12-9-99 how long those symptoms had occurred.
Q. In retrospect, I believe you feel that the symptoms that Mr. Gill presented with on December 30, 1999, were consistent with the bronchogenic carcinoma?
A. I think that they were consistent with a probable postobstructive pneumonia. I think he probably did have a pneumonia at that point in time. Perhaps, and again this is still supposition, he had a bronchial mass that was obstructing the airway up to the left upper lobe that caused pneumonia to develop. Clearly, we do know retrospectively that he did have a

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

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

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

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

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Q. Is the CAT scan more the gold standard in terms of the initial diagnostic workup for a patient that you have a suspicion that there might be a carcinoma?
A. I think the gold standard still is a screen chest radiograph. If there are abnormalities there that lead you to believe there is a potential for there to be a pathologic process going on in the lung, most clinicians at this point in time would then obtain a CAT scan.
Q. You typically don't diagnose lung cancer on a plain X-ray, though, do you?
A. Frequently you do, yes.
Q. Really. But a CT scan is more sensitive; is it not?
A. It provides you with more information.
Q. Is the fact that Mr. Gill is still able to exercise vigorously even as late as June of 2000 and able to exercise earlier than that, to start and to compete in or to attempt to compete in a marathon, is that at all clinically significant to you in terms of trying to evaluate what was going on with this cancer that

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we know he had?
A. No. It's of no import. We've got a gentleman who had widely metastatic testicular cancer who won the Tour de France with it. People can be very functional and healthy and athletic with widely metastatic cancer.
Q. In terms of when he became metastatic, are you able to state to a probability a particular month or months in the continuum of time where you are comfortable saying Dan Gill developed or advanced into metastatic cancer at X month of X year?
A. It's my strong opinion that at the time of his initial presentation on December 9th with the complaints that he had and the eventual clinical course, at that time on December 9th, 1999, when he presented he had metastatic disease at that time, almost assuredly Stage III-B disease.
Q. Are you intending to provide an opinion as to how much earlier than December 9 he acquired, if you will, the metastatic component to the disease?
A. There's no way to know because we don't have a clinical presentation prior to

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December 9th to base our clinical judgment and clinical suspicion on.
Q. Can you say to a probability that it wasn't the month before?
A. I don't know that I could give you any specific time before that.
Q. The July 2000 exam was remarkable for a 3 centimeter smooth firm tender mass at the anterior angle of the left clavicle. Of what significance is a 3 centimeter mass at this stage of the process? What does that tell you?
A. It's a reflection of an N3 nodal station that is involved with metastatic carcinoma.
MR. MISHKIND: Off the record.
(Brief recess.)
Q. Can we agree that generally speaking the earlier you diagnose lung cancer the better?
A. That's a fair statement.
Q. Sort of the corollary of that, it's always best to diagnose lung cancer as early as possible?
A. That's a fair statement as well.
Q. Can we agree the patient has the best chance of a good outcome the earlier the

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lung cancer is diagnosed?
MR. WARNER: Objection. Go ahead.
A. Yes.
Q. Mr. Gill had nonsmall cell lung cancer; correct?
A. Correct.
Q. Is the prognosis for a patient that has nonsmall cell lung cancer that's diagnosed at Stage I-A or Stage I-B better than a patient that has the other type of small cell carcinoma?
A. Generally, yes.
Q. We can agree that Mr. Gill was not diagnosed until he was clinically and diagnostically a Stage IV?
A. Correct.
Q. By that time the probability of Mr. Gill beating the cancer with optimal care and blessing from above was what, what percent chance?
A. Extremely small.
Q. Are we talking 10, 15?
A. Less.
Q. Are you able to tell me in January and February how large the tumor was in the lung had it been found at that time?

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MR. WARNER: Objection.
A. No, I'm not.
Q. Do you know how large the tumor was in the lung in April of 2000?
A. I couldn't tell you that, either.
Q. In May of 2000?
A. Again, I couldn't tell you that.
Q. In June of 2000?
A. I could not tell you that.
Q. In July it's anywhere between 4 and 5 centimeters depending upon which view we're looking at; right?
A. Correct.
Q. Do you see any evidence on exam or anything that Dr. Mansnerus described in terms of nodal involvement in January of 2000?
A. No, I do not.
Q. Do you have any evidence that there was nodal involvement in March of 2000?
A. The clinical evidence that we have is the symptom complex that he presented with in December of 1999, that being the numbness and loss of motor function in the left arm. That's consistent with nodal disease involving a supraclavicular scalene node station.

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Q. There's no reference to those symptoms when he's seen in January in Dr. Mansnerus' records; are there?
A. There is not.
Q. Are you able to explain why there is no reference to them?
A. No, I am not.
Q. In June when Dr. Mansnerus saw him, from what you can tell from looking at the records or the deposition, did he perform an exam of the lymph nodes?
MR. WARNER: You're in June now?
MR. MISHKIND: June, yes.
A. There is nothing specific in the record that stipulates a nodal examination. However, on physical examination he described a tender left sternomastoid which is in the region of the supraclavicular lymph node change.
Q. Can a patient have micrometastasis of cancer cells and not necessarily develop a clinically significant metastasis?
A. With bronchogenic carcinoma?
Q. Yes.
A. It is very unlikely.
Q. Can you tell me how many metastases

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of cancer cells in bronchogenic carcinoma it takes to establish a clinically significant metastasis?
THE WITNESS: Could you repeat that question one more time?
(Record read.)
A. One cell.
Q. Just one cell?
A. That's correct.
Q. Don't tumors shed millions of cells?
A. They may.
Q. Doesn't it normally take the shedding of millions of cells before one actually gets set up and succeeds in forming a metastasis?
A. That depends upon the host's response to a shower of tumor emboli.
Q. The host being the patient?
A. That would be correct.
Q. I'm sorry. I may have cut you off. You started to say some --
A. That would be correct. Some host's response to a tumor embolus can be that of cell death. It can either kill the tumor cell, or it can allow it to replicate. So one can develop

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clinically significant metastasis from as little as one cell or develop no metastasis from one cell. Be it as it may, it still is important if you have a cell embolus that results in the active development of the potential clinical metastasis that it be identified.
Q. Do you know with this host what the likely scenario was in terms of how many cells needed to be shed, if you will, before he was able to set up and succeed in forming a clinically significant metastasis?
A. I don't know that you would know that, nor would you ever be able to estimate that.
Q. Have you ever seen any studies that have talked about the shedding of cancer cells and the fact that you and I may have cells that potentially could be metastatic in nature going through our body, but they aren't necessarily clinically significant?
A. I'm not aware of studies that have been written. I'm sure, though, there are theories about that. In terms of an actually scientific factual basis for that, I'm not aware of it.

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Q. Did Mr. Gill have metastasis to the hilar nodes as of May in your opinion?
A. In May of that year?
Q. Yes.
A. Prior to the CAT scan that was done?
MR. WARNER: In May of '99 or May of 2000?
MR. MISHKIND: May of 2000.
A. I would believe so knowing his clinical presentation. We don't have scan evidence that stipulates to that.
Q. But that would be your opinion, that he had metastasis to the hilar?
A. Yes.
Q. Do you have any basis to say that he had metastasis to any other nodes other than the hilar nodes as of May?
A. There's no way to actually tell you that with 100 percent certainty, but in general they are spread along a specific nodal chain beginning with the intrapulmonary and then the hilar and then the mediastinal and then last the scalene supraclavicular node.
Q. Would you agree that the less nodal involvement that there is, the better the

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prognosis?
A. It depends upon where the nodal stations are that are involved. I think once you had mediastinal nodal disease, be it microscopic or bulky nodal disease, your prognosis is quite dismal.
Q. If Mr. Gill had been diagnosed with lung cancer in January or early February, I take it your opinion is that he would not have been a surgical candidate for the reasons we've discussed and are set forth in your report?
A. I believe so, yes.
Q. Do you have an opinion as to what treatment modalities would have been appropriate for the patient in January or February as compared to the treatment modalities that were implemented as of July and August?
A. I believe they would have been the same.
Q. Any differences at all?
A. Again, I'm not an oncologist, so it's difficult for me to answer that question, but I believe the same type of systemic chemotherapy would have been given to him.
Q. Would you defer on the specifics of

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that question to an oncologist?
A. Yes, I would.
Q. In light of what you just said about deferring to an oncologist, do you have an opinion as to what Mr. Gill's life expectancy would have been had his diagnosis been made in your opinion consistent with your opinion in January or February as opposed to July and August?
We know he died in February of the next year, but had he been diagnosed with the type of cancer that you believe he had in January or February, what would his life expectancy have been?
A. I think his life expectancy would have been identical to what it was when he was diagnosed in July or August. I don't think it would have changed at all.
Q. You believe he still would have more likely than not died in February of the following year?
A. I think there's no question he would have.
Q. When you say there's no question, on what basis do you say that there's no question?

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A. Because I feel very strongly that at the time of his initial presentation in December he had Stage III-B disease at the least, potentially Stage IV disease knowing the eventual involvement in his femur and the micrometastasis or small metastasis in his left lung tissue itself.
The III-B disease would have been treated identical to Stage IV disease, that being chemotherapy, potentially chemotherapy with radiation therapy. Surgical therapy would not have been an option for him. As that is the case, the prognostic limb of his therapy would not have changed given the fact that he would not have been a candidate for surgical intervention.
Q. Mr. Gill was seen in December by Dr. Mansnerus twice, on December 9 and December 30?
A. That is correct.
Q. And then seen again I think January 6th of 2000; correct?
A. That is correct.
Q. At no time during any of those three visits is there any reference to or suggestion

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

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

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

Q. Are there any other areas that you believe that because I haven't taken a thorough enough deposition you hold opinions on that you anticipate providing testimony at the time of trial on that we have not covered?
A. I don't believe so.
Q. To the extent that you do arrive at any additional opinions, would you please let Mr. Warner know and within two to three weeks he'll probably let me know?
A. Yes, I will.
MR. MISHKIND: Doctor, thank you for your time. It's nice to meet you.
THE WITNESS: I would like to read it.
- - - - -
(Deposition concluded at 7:00 p.m.)
(Signature not waived.)
- - - - -

AFFIDAVIT

I have read the foregoing transcript from page 1 through 68 and note the following corrections:

PAGE	LINE	REQUESTED CHANGE

_____
MARK J. BOTHAM, M.D.

Subscribed and sworn to before me this _____ day of _____, 2004.

_____
Notary Public
My commission expires _____.

CERTIFICATE

State of Ohio,)
) SS:
County of Cuyahoga.)

I, Cynthia A. Sullivan, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named MARK J. BOTHAM, M.D. was by me first duly sworn to testify to the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony as above set forth was by me reduced to stenotypy, afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony.

I do further certify that this deposition was taken at the time and place specified and was completed without adjournment; that I am not a relative or attorney for either party or otherwise interested in the event of this 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

Cynthia A. Sullivan, Notary Public
Within and for the State of Ohio
My commission expires October 6, 2006.

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DEPOSITION OF MARK J. BOTHAM, M.D.