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APPEARANCES:

Sindell, Lowe & Guidubaldi,
By: Charles M. Young, Esq.,

On behalf of the Plaintiffs.

Jacobson, Maynard, Tuschman & Kalur,
By: Patrick Murphy, Esq.,

On behalf of Defendants Bert M. Brown, W.D. and Cleveland Ear, Nose and Throat,

Jacobson, Maynard, Tuschman & Kalur,
By: Kenneth A. Mallernee, Esq.,

On behalf of Defendants Victoria R. Alonso, M.D., and Garfield Pathology Association, Inc.

ALSO PRESENT:

Edward Galaska

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STIPULATIONS

It is stipulated by and between counsel for the respective parties that this deposition may be taken in stenotvpy by Lisa Hrovat; that her stenotype notes may be subsequently transcribed in the absence of the witness: and that all requirements of the Ohio Rules of Civil Procedure with regard to notice of time and place of taking this deposition are waived.

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BERT M. BROWN, M.D.,

a Defendant herein, called by the Plaintiffs €or the purpose of cross-examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposes and says as follows:

CROSS-EXAMINATION

BY MR. YOUNG:

Q. Doctor, would you state your name for the record, please?

A. Bert Brown.

Q. And your business address?

A. I have many offices. The one we're at presently?

Q. The central office. The mailing address for your group.

A. 12000 McCracken Road, Garfield Heights, Ohio. I'm not sure of the zip code.

Q. Where did you receive your undergraduate medica: training?

A. University of Cincinnati.

Q. Graduated when?

A. I believe it was 1983.

Q. And following your graduation from medical scnooi what did you do professionally?

A. I did an internship, a year of general surgery at

Huron Road Hospital in Cleveland.

Q. And following that'?

A. I did an ear, nose and throat residency at the Eye and Ear Hospital in Pittsburgh.

MR. YOUNG: Why don't we go off the record?

(Discussion was had off the record.)

Q. (BY MR. YOUNG) I'm sorry. You were saying you finished a year of internship in general surgery?

A. Yes.

Q. With the University of Cincinnati?

A. A year of general surgery at Huron Road Hospital.

Q. Following that what did you do professionally?

A. I did a residency program ear, nose and throat, otorhinolaryngology.

Q. Where was that?

A. Eye and Ear Hospital in Pittsburgh.

Q. Was that a three-pear residency?

A. A four-year residency in ear, nose and throat. Part of the residency does include one year of general surgery.

Q. Was your previous year of general surgery applied to your four years?

A. Yes. It is considered a five-year residency with one year of general residency. Four years of

otorhinolaryngology.

Q. Did you successfully complete that program?

A. Yes.

Q. Following that, what did you do professionally?

A. I started working for Cleveland Ear, Nose and Throat.

Q. When you started working with this group how many physicians were involved here?

A. Four others.

Q. Today, I believe, you have nine; is that correct?

A. I have to count. I think it is nine.

Q. Approximately nine?

A. Yes.

Q. You've been practicing ENT here in the Greater Cleveland area since that time?

A. Yes.

Q. You're on the medical staff of various hospitals?

A. Uh-huh.

Q. What hospitals do you serve?

A. I'm on the medical staff of many hospitals. I go to primarily two.

Q. And they are?

A. Hillcrest Hospital and Marymount Hospital.

Q. What other hospitals do you serve?

A. Parma Hospital.

Q. Now you're primarily with Hillcrest and Marymount. Did you serve others? And they are what?

A. Parma Hospital, Deaconess Hospital, we're on staff at University Hospital. I even have to think about this. We do have doctors, although I have not gone there yet, in Medina Hospital.

Q. Within your group you have a number of physicians. Are they assigned primarily to serve in a given office of your group?

A. We generally cover areas. Usually one to two offices, yes.

Q. And have you served in one primary location with this group?

A. Hillcrest and Marymount are my primary location.

Q. We're here at an office actually attached to the Marymount Hospital today. Are there other offices in which you serve?

A. Yes.

Q. Is there an office at Hillcrest?

A. Right, I have an office at Hillcrest.

Q. Any other offices in which you primarily function?

A. That I actually go to? Yes. I do go to, although it is one half a day a week, an office at Brainard Place in Lyndhurst, Ohio.

Q. Doctor, briefly, are you involved generally in the

practice of ENT, ear, nose and throat?

A. I don't understand that question.

Q. Do you have any subspecialty within the practice unique within your group?

A. I still am having trouble. What do you mean by subspecialty?

Q. Any subspecialty in any way. Do you limit yourself in the practice of ear, nose and throat?

A. No, at this point I don't. Actually I limit myself in that I don't do ear surgery besides the placement of tympanostomy tubes. I limit my surgery, but besides that I do not limit it.

Q. Do you serve in any committee functions on medical staffs in any way?

A. Yes.

Q. Where do you serve?

A. I'm the chief of ENT at Hillcrest Hospital.

Q. For what period of time have you held that position?

A. I believe it will be two years. Going on two years.

Q. Doctor, can you describe for me the nature of your business entity here whether it is a corporation or what type of entity it is'?

A. It's a corporation.

Q. Are you a stockholder?

A. Yes.

Q. Are all of the physicians stockholders here?
A. No.
Q. How many are there?
A. How many shareholders?
Q. Stockholders, shareholders.
A. Five at present.
Q. For what period of time have you been a shareholder?
A. I'm in my third year as a shareholder.
Q. At the time of this incident in 1989 were you a shareholder to your knowledge?
A. No.
Q. Do you have any independent recollection of Allan Boyd?
A. No. I should say -- No, I don't. At one point I thought I may have recalled the incident, and only with a picture of him could I say. The name and the chart do not help me recall anything.
Q. Separate and apart from the written record that we have here before us do you have any independent recollection concerning his treatment, examination, or any of this?
A. No.
Q. All right. When did Allan Boyd come under your care, if you know?
A. I don't know from the chart. November 22, 1989.

Q. Okay. And how do you know that?
A. Because on the chart it says date of office visit November 22, 1989.
Q. That is the time the chart was first created?
A. That, I don't know. I believe so. That is the time that the patient appeared to me with his chart.
Q. I've asked you to produce all of your office records pertaining to this patient. Have you looked for any prior records there might have been other than this patient file?
A. In regards to this patient?
Q. Yes.
A. Yes.
Q. This is all you have been able to locate?
A. Yes.
Q. When he came to see you on November 22, 1989 what was the reason for presenting here in your office?
A. Again, I have to rely on the chart.
Q. If you would.
A. He presented with a lesion on the tongue that had been there for two months. It was occasionally painful and had not changed in size.
Q. And that's the history that you gained from him at that time?
A. Yes.

Q. Did you at that point in time learn how he had come to be under your care?
A. In the cover sheet which you just received we tried to find out how he was referred to us.
Q. What did you find?
A. He didn't say.
Q. Okay. Here we have on what's been marked for identification purposes as Bert Brown Deposition Exhibit 1 a page concerning your examination, correct? You have to answer verbally for the record.
A. Yes.
Q. Here we have some handwriting. Is all the handwriting on this form in your handwriting?
A. Yes.
Q. If we look in the upper right hand --
A. No, it's not. This is not my handwriting, (indicating).
Q. If you can identify what you are pointing to?
A. In the left-hand side of the page.
Q. We have a stamp in the left-hand margin?
A. The writing within that is not my writing.
Q. Here we have under, Referred by?
A. That's not my writing. Anything at the top of the page before the history where it says, History

and physical, all of that writing is not my writing.

Q. When a patient presents in your office or when a patient presented in your office in 1989 and a record was created who would create the initial page of the record?

A. The initial page would be given to the patient to fill out the information.

Q. All right. They would generally prepare that in their handwriting?

A. Yes.

Q. Does your office do anything to create a patient record other than this initial face sheet?

A. No. That, and the sheet that I write my history and physical on with the information on that.

Q. Other than the initial face sheet that's created in the patient's handwritten form you don't create a billing sheet or an initial face sheet within your office concerning that patient?

A. Well, upon leaving there is a face sheet where billing information is filled out.

Q. For billing purposes?

A. Yes.

Q. But tnere is no other sheer which coiiects data concerning how patients are referred, billing procedures? You don't Xerox a copy of their

hospitalization card or anything of that nature and collect data?

A. At that point I don't know if they did copy the card or not. I'm not sure.

Q. All right. We have what's been marked for identification purposes as Bert Brown Deposition Exhibit 1. Can you describe what this form is called within your office?

A. That was our history and physical form.

Q. And is any portion of that prepared prior to your examination of the patient?

A. The stamp at the top on the left-hand side is placed before I --

Q. Before you actually see the patient?

A. Before I actually see the patient.

Q. We have some typewritten information on the top of the form. Is there a clerk or other person here who prepares that?

A. Yes.

Q. Do they prepare that before you actually see the patient?

A. Yes.

Q. Here we have certain informarion on Brown Exhibit 1 which is typewritten and pertains to Allan Boyd. We have some handwritten notation. Can you tell me who

actually would have made those?
A. That would be the nurse who placed the patient into the room.
Q. Are you able to tell from the handwriting who that would have been in your practice in 1989?
A. No.
Q. I take it you are able to tell from this sheet that Allan Boyd, in fact, came to see you on the date that is indicated?
A. Yes.
Q. The sheet was prepared within your office?
A. Yes.
Q. And it would generally accurately depict what occurred here within the office, correct?
A. Yes.
Q. But You have no independent recollection concerning actually seeing this patient or the events that transpired other than the written records that we have before us on these five pages. Is that fair?
A. I don't understand that.
Q. Okay. Other than what we have here before us on these five pages you have no independent recollection concerning this patient?
A. Yes.
Q. That's fair. Now, you got a history from this

gentleman when he came in, and he indicated apparently to someone that he had been referred by his wife's mother; is that correct?

A. Yes.

Q. We know that because it's written on the sheet?

A. Yes.

Q. You do not know who actually wrote that on the sheet?

A. The nurse did.

Q. Did you ever learn that Allan Boyd had had a mother-in-law who had been treated by Dr. O'Brien?

A. No.

Q. You do have a partner or a shareholder in your group Dr. O'Brien, do you not?

A. Yeah.

Q. Okay. You have no recollection concerning any conversation concerning this gentleman's mother-in-law or her treatment for oral cancer; is that correct?

A. That's correct.

Q. That's correct. Okay. Now, after you obtained a history what did you do with regard to this gentleman?

A. Well, again, going from the record, I did a physical examination, and at that time a lesion was

identified on the tongue and I excised it.

Q. All right. Are you able to tell anything as vou sit here today concerning the appearance of the lesion or location of the lesion that was on the tongue?

A. The appearance of the lesion was a white plaque with a questionable ulcer. The location was on the tongue. That's all I can answer to.

Q. You don't know where on the tongue it was located? There is no diagram or anythinq for us to recreate where that lesion was located?

A. I know, given the fact I did a biopsy in the office, it was on the anterior portion of the tongue.

Q. How do you know that, Doctor'?

A. Because I would not biopsy the posterior portion of the tongue in the office. I cannot excise that.

Q. All right. Now, with regard to your general practice you would not have excised that here in the office?

A. Yes.

Q. I assume from the record that the excision occurred during the first visit when he first presented in your office. Is that accurate?

A. Yes.

Q. You describe the lesion as white plaque lesion. Can

you describe it more particularly than that?

A. I can only rely on the note. It's a white plaque.

Q. From the note does that indicate anything to you? I understand that it was a white plaque, but anythinq more?

A. No. The note indicates as written.

Q. What office was this gentleman examined in?

A. The Marymount office.

Q. I take it from your notes that the primary reason he presented in your office was this white lesion, correct?

A. Yes.

Q. That was his original complaint and the reason that he presented here?

A. Yes.

Q. We know from your note that it was a white plaque lesion. Are there various white plaqued lesions which car, occur within the mouth?

A. Many lesions can look like a white plaque. A white plaque is purely a descriptive term.

Q. What do you mean by white plaque? How does it describe lesion?

A. Normal mucosa is pink. It was an area of white surrounding the normal pink mucosa.

Q. Are you able to tell from the note the size of the

lesion when you excised it?

A. No.

Q. Were sutures placed?

A. Yes.

Q. At the excision?

A. (Indicating).

Q. Does that indicate anything to you concerning size?

A. If I can go further, we have --

Q. If you would?

A. -- we have a pathology report that states the size of the lesion. That was the size.

Q. My concern is it appears on your billing report there is one estimate of the size of the lesion?

A. That's correct. In other words, on the billing report the lesion was between one and two centimeters.

Q. Is that in your handwriting?

A. That is not my handwriting.

Q. How would that occur and how would it be placed on that billing report?

A. The nurse working with me on the billing report would ask me what size.

Q. And you would have responded that it was one to two centimeters?

A. That is actually the size of the defect created by

the excision.

Q. Describe for me how you differentiate between the size of the defect and the size of the lesion? What do you mean by that?

A. When you excise a lesion you take an area of normal mucosa around the lesion and vou are then left with a bigger defect than the actual lesion size.

Q. Why is that?

A. Well, to excise a lesion, which was done, you try to remove it completely.

Q. And when we talk about trying to remove it completely I assume you try not to cut the lesion but try to provide some margin --

A. Yes.

Q. -- surrounding the lesion when you remove it?

A. Right.

Q. Are you able to tell from the record why you excised this lesion?

A. It was a white plaque. It always is in the back of one's mind the thing you must rule out in any sort of white plaque is a cancer, and it would be excised as a plaque that would not heal to examine under the microscope.

Q. Would it be your practice to excise all white lesions from the mouth?

A. No, not initially.

Q. All right. What was it about this lesion, if vou know, that would have caused you to excise it on the first visit?

A. Well, again, having no recollection predisposing of looking at the report, I did not feel at my initial assessment of this this was an inflammatory lesion.

Q. Are you able to tell how you concluded that?

A. Because I wrote in my impression questionable Candida, which is yeast infection, inflammation. That is what I was thinking at that time. The reason I would excise under those circumstances would be patient anxiety.

Q. Now, do I understand from your office notes that Candida and the inflammation are consistent? You are not trying to distinguish between the two, but Candida and inflammation were present?

A. Well, the inflammation is an irritation mucosa. It can be caused by many things. Candida is one source that often causes a white plaque. So I felt, yes, it could have been there was a Candida infection that caused the inflammation.

Q. As I understand your testimony, however, the reason that you excised the lesion was there was a potential for malignancy and it was to rule out that

potential; is that correct?

A. Well, let me say on a first visit if I felt that this was inflammation I would have normally tried some medication first and seen the patient in a brief two weeks usually. If it were a patient that was -- he has had this for two months, was very anxious, just wanted it off, was worried it was a cancer, and if he asked me can you say a hundred percent it is not a cancer, even though you think that it may not be from its appearance, I'd say no. So if the patient were anxious and wanted it off, for the patient's sake I would have taken it off initially.

Q. All right. Let me see if I can recap the testimony so that I understand it and restate it. The observations that you have recorded on your record and what you are reviewing with us today present no cause for you to conclude imnediately that the lesion would have been cancerous and, initially, upon this presentation you felt that the lesion was benign, due to Candida and inflammation, but the fact that you excised that on the first visit causes you to believe that you would only have done that because of the anxiety of the patient and to satisfy the concerns that that patient would have had about

the possibility of cancer; is that correct?
A. Yes.
Q. In other words, it doesn't hurt to cut it off if the patient is worried about it being cancer and it provides him with some piece of mind?
A. And it's been there two months and hasn't gone away.
Q. It's not bad practice to cut it off?
A. No.
Q. Conservative practice would have permitted you, based upon what you were reading here, to follow it closely and with a follow-up of perhaps two weeks?
A. Yes.
Q. When you examined this lesion you considered at that time and had a provisional or working diagnosis of a benign lesion. Is that fair?
A. Yes.
Q. You excised it, and you told the patient to follow up in one week, correct?
A. Yes.
Q. And that was because, essentially, the pathology report, getting the report back on that lesion, would take approximately one week; would it not?
A. Yes, but that's not the only reason he should come back in a week.
What was the reason that you had him follow-up in

one week?

A. Number one, to get the pathology report. Number two, to discuss the pathology report in person with him and, number three, to see how the wound was hea1ing.

Q. All right.

Q. When you excise a lesion, such as you did in this case, can you describe for us procedurally how you go about it and what you did?

A. I would take a knife and form what we call an ellipse around the lesion, and in the course of dissecting it you get a feel for where the lesion is, how deep the lesion goes. You're palpating it as you work it so you get a feel for what the lesion exactly is or get a feel for what it clinically is. So you take margins all around the sides, a deep margin, and close the wound up.

Q. All right. And you take margins all around the sides and the deep margin. Why?

A. I'm excising a lesion.

Q. I understand. Is there a reason that you actually provide that margin surrounding the lesion?

A. To try to remove the lesion completely.

Q. And why is it important to remove the lesion completely?

A. Well, when you are doing a biopsy if it is a small lesion you are trying to eliminate it.

Q. The reason for excising this lesion was to perform a biopsy, was it not?

A. Yes.

Q. In other words, to have it pathologically reviewed so you could know what the actual cause of the problem was?

A. And to eliminate the lesion for the patient to eliminate the problem that it was causing.

Q. In general, when you take a biopsy here at the Marymount office where does the specimen go and what is the procedure for having it analyzed?

A. The pathology department at the hospital.

Q. And, procedurally, how does it go? What is done here?

A. It is placed informally with a fixative and taken to *the* pathology department.

Q. It is placed informally by your office'?

A. Yes.

Q. Is there a request form that goes along with it?

A. Yes.

Q. Is rhat a patnoiogy department request form?

A. Yes.

Q. Is that form then subsequently returned to your

office?

A. No.

Q. Does your office retain a copy of that?

A. No.

Q. I assume the request form contains some instructions for the pathology department; is that correct?

A. It may or may not. I don't know.

Q. Well, what is your general practice? Do you generally provide -- Let me complete the question. Do you generally provide some directions in providing that specimen to the pathology department?

A. The form states clinical diagnosis and operative procedure, and those two areas are filled out.

Q. In providing that specimen to the pathology department are you asking a specific question concerning the specimen or are you asking for a general analysis and response?

A. It depends on the biopsy and what the clinical suspicions are. There is no set answer for that.

Q. I notice on the billing form that was prepared by your office that's been marked for identification purposes as Deposition Exhibit 3, is that the billing form that came from your office?

A. That's an office billing form, yes.

Q. Okay. It was prepared here in your office?

A. Yes.

Q. By someone in accordance with your instruction, correct?

A. Right.

Q. If we look at these two forms, and I'm looking at Exhibit 1 and Exhibit 3, we see that Allan Boyd was in your office on the 22nd of November, 1989?

A. Yes.

Q. At the point in time when he was released from your office your impression was that he was suffering from an inflammation and Candida; is that correct?

A. I thought that was one possibility.

Q. All right. Was this a working diagnosis at that point in time?

A. It was, but it wasn't firm. That is why there is a question mark.

Q. Of course. And the pathology report was needed to more carefully diagnose the condition. But that was your working diagnosis or impression at the time?

A. Yes, yes.

Q. By that I mean at the point in time when Allan Boyd walked out of your office you had the impression that this was a benign 'lesion but that it was necessary just to eliminate the possibility that it was cancerous. Is that fair?

A. Yes.
Q. All right. You prescribed some medication for him, did you not?
A. Yes.
Q. What did you prescribe?
A. Mycelex.
Q. And what is the purpose for Mycelex?
A. That is an anti-yeast medicine.
Q. It is a topical --
A. It is a lozenge that you dissolve in your mouth.
Q. That was for the treatment of what you thought at that time was Candida; is that correct?
A. Yes.
Q. You left instructions that Allan Boyd was to follow up in one week. And that is your handwriting, correct?
A. Yes.
Q. FU one week?
A. Yes.
Q. By that was Allan Boyd to contact your office by telephone?
A. No, he was to see me again in one week.
Q. Was an appointment scheduled on the 22nd of November, 1989 for him to see you in one week?
A. I cannot tell that from the records.

Q. Do you have a calendar or is there a record of such appointment?

A. We don't have the records from the time period after this.

Q. What does that mean?

A. We don't have records of my patient appointments for the month of December.

Q. Of 1989?

A. Yes.

Q. Can you tell me why you don't have those records?

A. No.

Q. No? You have them for prior to that and after, but you don't have them for December of '89?

A. (Indicating).

Q So I assume from your testimony you've actually checked to see if an appointment was made and if it was broken, and you are unable to conclude from the written record just what had happened. Is that fair?

A. Can I ask my lawyer one question?

Q. Yes, of course.

MR. MURPHY: Step out just for a minute.

(Discussion was had off the record.)

(Reporter read back previous question.)

A. No.
Q. Go ahead and explain.
A. I did, needless to say when this all occurred, I extensively went through the record to see what happened.
Q. Of course.
A. Those records were missing. And I've gone through it multiple times myself personally after having other people try. What I did find on the chart for other people who were seen in that week or whatever is if someone made an appointment the following week, as I asked him to do, and didn't show up there would be an N/S written on the chart. On his chart no N/S is written.
Q. Let me understand then. See if I can make it clear for the record. Generally you have some calendars or other records of appointments that are made in the office for 1989 and other years, correct?
A. (Indicating).
Q. You have to answer verbally for her.
A. Yes.
Q. And you have gone back to try to determine whether Allan Boyd had an appointment in December of 1989, and for some reason unknown to us today those records have been lost --

A. Yes.
Q. -- concerning the calendar?
A. The appointment, yes.
Q. But you were, when this happened, able to look at other charts concerning the treatment of patients that were seen in or about this time, correct?
A. Yes.
Q. And by that I mean we have here five pages that would make up this patient's chart. You have similar records pertaining to other patients that were seen in the week of mid-November 1989, correct?
A. Yes.
Q. And where an appointment was made at that time and the person failed to appear, the chart was marked in some way?
A. Yes.
Q. Okay. How was the chart marked and by whom, if you know?
A. The charts -- When a patient had an appointment at that time the charts were collected either that morning or the day before the appointment. They would be kept up at the front. When the patient came for an appointment he would be given his chart or the nurse would take his chart and put him in a room. If at the end of that day if an appointment

was supposed to be scheduled, the chart was out waiting for the patient who did not show up, one of the nurses would open the chart and mark on that day, write N/S indicating he did not show up and follow as arranged.

Q. From your general practice as verified from other charts you were able to conclude that this patient did not fail to appear for a scheduled appointment approximately a week after November 22, 1989? Is that your conclusion?

A. Could you repeat the question?

Q. Yes. From the fact that there is no N/S on this chart, you are able to conclude that the patient Allan Boyd did not fail to appear for a scheduled appointment at or about this time?

A. It seems, yes, that he did -- No follow-up appointment was made.

Q. And you are able to conclude that because there is no record of a €allow-up appointment in your file --

A. Right.

Q. -- and there is no N/S on his chart?

A. Right.

Q. Okay. Are you able to conclude from your chart in any way or from any records that the result of the pathology examination was ever indicated to Allan

Boyd?

A. No.

Q. Are you able to conclude in your chart that it was not communicated to Allan Boyd --

A. No.

Q. -- in your opinion?

A. No.

Q. We just can't tell from the written record. Is that fair?

A. Yes,

Q. From the pathology report which has been marked for identification purposes as Brown Deposition Exhibit 4, I see under the pre-op diagnosis and the post-op diagnosis certain tvpewritten language, correct?

A. (Indicating).

Q. This is typewritten language that would have been placed there in the pathology department here at Marvmount, correct?

A. Yes.

Q. There is the pre-op and the post-op diagnosis white plaque tongue - rule out Candida. Would that have been taken from instructions given by you to the pathology department?

A. I cannot say that for sure. I have to believe, though, they cannot have that without my

information so I guess the answer is yes.

Q. Okay. We conclude yes because it's logical if they had that information they must have gotten it from you in some way, correct?

A. Yes.

Q. Just in general terms, when a specimen is taken from your office, placed in a fixing agent, and conveyed to the pathology department here how long does it take for you to receive a report concerning that examination?

A. Within a week.

Q. When you receive a report what is the normal way in which you receive it?

A. It's placed in a mailbox at the hospital.

Q. A written report such as this is placed in the mailbox?

A. This actual report.

Q. Are there any findings that would be conveyed to you prior to receipt of that written form?

A. In this case?

Q. In general.

A. At times if there's a question or at a time a pathologist is looking at a slide they have questions they may call you before they would have written the report.

Q. Do you know if that occurred in this case?
A. Yes.
Q. You know that from the notation on the chart of the 28th?
A. Well, yes. There's a note on 11-28-89 that states the pathology Hyperkeratosis, mild dysplasia.
Q. Is that notation written in your handwriting?
A. That's my handwriting.
Q. You have no independent recollection concerning that telephone conversation, do you?
A. We have a note that Dr. Alonso, the pathologist who typed this report, called on that day.
Q. And that note is where?

MR. MURPHY: I've got a copy of it. Just a telephone message sheet.

Q. (BY MR. YOUNG) Is that message sheet something that was taken from Dr. Alonso's records or a hospital record?
A. No, that is from our message sheet.
Q. Message sheet being a form here in your office?
A. A book with telephone messages.
Q. Carbonized form?
A. Yes.
Q. Are there any other written notations of any sort other than this and the five pages that we have

here before us that provide any information concerning Allan Boyd to your knowledge?

A. No.

MR. MURPHY: Before I give this to you, this is out of a book, a carbon copy of telephone messages. I'm going to have somebody cut off these other patients just on the same sheet.

MR. YOUNG: That's fine. Why don't we get that now and I'll continue to ask questions while that's being done.

(Brown Deposition Exhibits 5 and 6 marked for identification)

Q. (BY MR. YOUNG) Doctor, showing you what's been marked for identification purposes as Brown Exhibit 5, this is the intake sheet we've been referring to as we've gone through the deposition?

A. Yes.

Q. Showing you what's been marked for identification purposes as Brown Deposition Exhibit 6, that is the telephone notation concerning Dr. Alonso's call, correct?

A. Yes.

Q. Before we get into the receipt of that call and what was actually said, as I understand your testimony

generally you send a specimen off to the pathology department here at Marymount and you receive a written typed report, an official report, of the reading at your mailbox at the hospital; is that correct?

A. Yes.

Q. If there is any question or any problem, there can be a direct contact by the pathologist?

A. Yes.

Q. What occasions would call for direct contact by the pathologist?

A. When they have a question, when they look at a specimen, something looks unusual to them, doesn't fit in with the clinical history they have received.

Q. I take it then they would contact you for information received by vou in the clinical examination that led to the biopsy; is that correct?

A. Yes, additionally.

Q. That is additional information they need?

A. Yes.

Q. They are not there seeing the patient and, so, perhaps there is something they need to be able to place in proper context what they are seeing under the microscope?

A. Or something that can help them clarify things, yes.

Q. What I am trying to understand, what other information could help them clarify a pathology slide?

A. It depends on the actual biopsy, where it came from. Maybe an example would be a biopsy from here, but there is a piece of tissue that looked like it came from somewhere else --

Q. I see.

A. -- they would call and say why -- where did you take this? Is there any reason, you know, why it might look like this?

Q. The pathology department would not contact you for assistance in reading a slide, however, would they?

A. No.

Q. You don't read your own slides?

A. No.

Q. Okay. And you do not look at the specimen yourself under the microscope?

A. I do at times. But I rely on the pathologist's report generally.

Q. On what occasions would vou look at the slide yourself?

A. In the case of an unusual pathology.

Q. In consultation with the pathologist?

A. It is not so much in consultation as so just to see

what it looks like. For my own purposes. They're not consulting me. Or in the case where I received a biopsy report that was not consistent with my clinical impression, I might call them and want to look at the slide with them.

Q. All right. We have before us what has been marked for identification purposes as Exhibit 6, and it indicates that Dr. Alonso contacted you and was unable to reach you to discuss this case on November 28, 1989, correct? That's what that slip indicates? In other words, she called but didn't reach you and you got a message?

A. Yes.

Q. And I assume it is your general practice to return that type telephone call on that day?

A. Yes.

Q. And the message indicates that she called regarding Boyd, **Allan**, correct?

A. Yes.

Q. Are you able to draw any conclusions as a result of the contents of this telephone message?

A. Well, coupling this message with my note on Exhibit 1 dated 11-28-89.

Q. You are able to conclude, in fact, you did return her phone call?

A. We talked, and she gave me this preliminary diagnosis.

Q. What was the preliminary diagnosis that she gave you?

A. Hyperkeratosis, mild dysplasia.

Q. What does that verbal report indicate to you?

A. (Indicating). The pathology as stated.

Q. Hyperkeratosis and mild dysplasia. But for the purpose of using this record at another time to explain what hyperkeratosis and mild dysplasia is, can you tell me what is meant by that?

A. Keratosis is a debris. As the skin or mucous membranes grow they shed debris, and keratosis is that debris on top of the tissue. Mild dysplasia is there is a certain appearance of cells within the mucous membrane. Dysplasia suggests some abnormal looking cells, but mild dysplasia is a benign process,

Q. All right. I assume then from the verbal report that you received from Dr. Alonso on November 28, 1989 that you concluded that this was, in fact, a benign lesion which had been excised, correct?

A. Yes.

Q. You were satisfied as a result of that verbal report that you received that there was no reason for

further concern with regard to the condition and treatment of Allan Boyd; is that correct?

A. Not completely.

Q. How would you clarify?

A. He had an excision done of a lesion. He needed additional follow-up to evaluate how it heals.

Q. For the excision, the healing of the normal tissue?

A. Yes. And this is -- Again, this is a preliminary report. So one reason I have patients come in a week later, I prefer the final report.

Q. As we sit here today do you -- are you able to draw any conclusion as to why Dr. Alonso would have contacted you by telephone to inform you that this was a benign condition?

A. Again, this is conjecture based on the record, because I have no recollection myself, but I sent a form down, at least from what we see on Exhibit 4, that says white plaque tongue - rule out Candida. In her actual pathology report she talks about a virus. So I can conjecture she wanted to discuss that with me if I thought -- if I thought there was a possibility of a virus causing this.

Q. As opposed to Candida?

A. Or in conjunction with it.

Q. Do you have any independent recollection of that

telephone conversation with Dr. Alonso?

A. No.

Q. Is Dr. Alonso a physician with whom you've worked in the past?

A. Yes.

Q. For what period of time had you worked with her prior to November of 1989, if you know?

A. Since I have been out -- since I started with Cleveland Ear, Nose and Throat which was August of '88.

Q. Do you have a good working relationship with her?

A. Yes.

Q. Have you been able to rely on her judgment in the past?

A. Yes.

Q. Were there occasions in November of 1989 known to you where she had failed to properly treat a slide on a tissue specimen that you'd rent off to that department?

A. No.

FAR. MALLERNEE: Objection.

Q. (BY MR. YOUNG) Have there been such occasions since November of '89?

MR. MURPHY: Objection.

FAR. MALLERNEE: Objection.

MR. MURPHY: You can answer. The objection is made for the record. Later on the judge can decide whether the question is appropriate or not for the case.

A. No.

Q. All right. Doctor, when you examined Allan Boyd on November 22, 1989 you found evidence of white plaque tongue and a questionable ulcer, correct?

A. Yes.

Q. I assume that when you examined him you performed a differential diagnosis. Is that fair?

A. Yes.

Q. In other words, there were many conditions that might have caused or many causes for the white plaque tongue that could have existed. Ts that fair?

A. Yes.

Q. What conditions did you consider when you examined him?

A. Well, you're dealing -- your looking at two things. Is it inflammatory condition or is it a growth? If it is a growth, is it a benign growth or cancerous growth? And then there's many things that can cause all of that. So to put it -- You look in those broad categories, and the thing you want to always

rule out is the cancer.

Q. If we divide it into two possibilities and we talk about inflammatory versus a growth or cancerous growth, the inflammatory condition is one which will -- is not life threatening, would you agree?

A. Yes. But inflammation can occur with cancer too.

Q. Yes. They can coexist, but it is the cancerous condition which actually presents some danger of loss of life, correct?

A. Yes.

Q. And in performing the differential diagnosis it is important to rule out the most serious conditions and that's why you did the biopsy, correct?

A. Yes.

Q. Why would the pathology department have received a request, Rule out Candida as opposed to rule out cancer?

A. The request was sent to give them what my impression was. They know any time they get a biopsy from the mouth they want to rule out cancer.

Q. When I look at the pathology department's characterization of the request it says, Rule out Candida. in fact, what you had was a working impression at that time that it was Candida but the pathologist would have understood the request was

made in order to rule out the more serious condition of cancer, correct?

A. Yes.

Q. As a result of your general working arrangement with them that would have been the understanding between the two of you?

A. Yes.

Q. You send off a specimen in order to rule out that life-threatening condition?

A. Yes.

Q. What information do you have to get back from the pathology department in order to draw a proper conclusion or diagnosis as to the condition?

A. I don't understand that question.

Q. Well, you send the specimen of€ to them and you ask them for advice concerning what their interpretation is. What do you expect to receive?

A. I expect tc receive a report on what the microscopic evaluation of lesion showed.

Q. A definitive diagnosis?

A. Yes.

Q. And if you don't get a definitive diagnosis I assume you expect to receive any qualification of a definitive diagnosis?

A. Yes.

Q. By that I mean if they can't tell you definitely what they have and they have some problem interpreting it, you want to know that?

A. Yes.

Q. Has it been their past practice to advise you of such difficulty if they had difficulty in treating a specimen?

A. Yes.

Q. It had been your past practice prior to November 22, 1989; is that correct?

A. Yes.

Q. When you received this verbal advice essentially it was advice that this was a benign condition, correct?

A. Yes.

Q. Was there any qualification to your knowledge concerning difficulty reading the slides, difficulty making an interpretation, or difficulty in being able to rule out cancer here?

A. No.

Q. If there had been such a qualification would that have been a relevant finding you would have entered in the record?

A. Yes.

Q. I assume that you have some system here for

follow-up to make sure that when you make a request for a pathology examination you, in fact, receive it within a given period of time. Is that accurate?

A. That's one of the reasons I have a patient come back in a week.

Q. So that the patient will be here and that will jog the response?

A. Yes.

Q. Do you have any written system, a particular system, a computerized system, anything that makes sure when you send a specimen off to the pathology department it doesn't get lost?

A. Not that I am aware of.

Q. So that the only check that you have on proper receipt of a report to your knowledge is the fact that the patient reappears, and that jogs your memory concerning the fact that you have a specimen out there?

A. Yes.

Q. Okay. Can you tell me when you actually received the written pathology report in this case?

A. No.

Q. The pathology report indicates that I believe it was read on the 24th. Is that accurate?

A. I'm not sure what this notation means.

Q. There is a reference to November 24, 1989?
A. Yes.
Q. You don't yourself know what that means?
A. Right.
Q. There is a reference at the bottom to November 29, 1989. Do you know that to be the day on which it was typed?
A. I can only tell from the record. I think when you see that that means that is when it was typed.
Q. You yourself do not know in your practice?
A. NO.
Q. And you have no personal knowledge concerning when the written record would have been received through your mailbox into vour office?
A. No.
Q. And I believe your testimony is that you have no way of knowing whether, in fact, the result of the pathology report was ever communicated *to* Allan Boyd?
A. Yes.
Q. Correct?
A. Yes.
Q. Are there occasions on which you have someone in your office communicate verbally to a patient the result of a pathology examination, pathology report?

A. I don't.
Q. You do not?
A. No.
Q. Are there occasions in your practice when that has occurred?
A. It could in the case of a benign report I believe.
Q. By that I mean where you believe at the time of the treatment of the patient it is not necessary to follow up for the medical condition, and you have a benign report, there are occasions when someone in your office will contact the patient by telephone?
A. That question -- I don't understand that question.
Q. All right. You've said in your opinion you wanted to see Allan Boyd because you had surgically removed a lesion from his mouth and you would want to follow up medically to see that it was healing well?
A. And to discuss the pathology.
Q. And to discuss the pathology?
A. Face to face.
Q. Right. You believe that to be so?
A. I believe what to be so?
Q. What. you've just said. You wanted to see him for two reasons. That being medical follow-up on the surgeon --
A. That is my standard of care.

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A. Yes.
Q. You don't yourself know what that means?
A. Right.
Q. There is a reference at the bottom to November 29, 1989. Do you know that to be the day on which it was typed?
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A. That questien -- I don't understand that question.
Q. All right. You've said in your opinion you wanted to see Allan Boyd because you had surgically removed a lesion from his mouth and you would want to follow up medically to see that it was healing well?
A. And to discuss the pathology.
Q. And to discuss the pathology?
A. Face to face.
Q. Right. You believe that to be so?
A. I believe what to be so?
Q. What you've just said. You wanted to see him for two reasons. That being medical follow-up on the surgeon --
A. That is my standard of care.

Q. My question is, are there occasions when you don't need to follow up with the patient for treatment of the open sore and you receive a benign report where someone in the office will contact the person by telephone?

A. No.

Q. That has not happened in your practice to your knowledge?

A. Yes.

Q. Yes, it has not happened, correct?

A. Yes.

Q. Showing you what's been marked for identification purposes as Brown Deposition Exhibit 4, this is the official pathology report, is it not?

A. Yes.

Q. You've had the occasion to read it a number of times?

A. Yes.

Q. In your opinion is this written report consistent with the verbal report that you received on November 28th?

A. Yes.

Q. We see a grass description of the tissue specimen. And the gross description contains measurements made by the pathologist, correct?

A. Yes.
Q. When you report on your billing record the size of the lesion, that is an approximation which you give to a clerk here?
A. Yes.
Q. For billing purposes, correct?
A. Yes.
Q. The accurate measurement of the specimen, however, would be contained in this gross description having actually been measured, correct?
A. Yes.
Q. And when you approximate the lesion for billing purposes, that was actually the size of the defect that was approximated? That being the defect left after removal of the lesion?
A. Yes.
Q. Do you have any reason to believe that the gross description of this lesion and the measurement contained therein is inaccurate?
A. No.
Q. I'd like you to go over the microscopic description if you would and describe for me the medical terms contained here. It reads, paragraph, The biopsy shows a hyperplastic epithelium. What is meant by that?

A. Well, I'm not a pathologist.
Q. Right. But in terms of your interpretation?
A. Hyperplastic epithelium would mean an increase in the number of cells.
Q. All right. Supported by a connective tissue core that shows moderate chronic inflammation and fibrosis?
A. Inflammation is an irritation. In the case of pathology it usually means there are white blood cells which migrate to the area indicating inflammation. Fibrosis is a response to inflammation. Scar tissue.
Q. The hyperplastic epithelium shows elongated and bulbous -- Is it rete?
A. Rete.
Q. -- rete ridges with isolated dyskeratoses. What is dyskeratoses?
A. That, I am not -- The way I characterized it dyskeratoses, parakeratosis and hyperkeratosis are changes of the cells at the surface of the lesion. In the course of them we spoke earlier about desquamation.
Q. The deep margin of the lesion is fairiv weii defined and an occasional base of a ridge appears atypical and hyperchromatic. What does that mean to you?

A. I'm not sure what she's getting at. The atypical I'm not sure. It could be a cell, but it's not saying it is a cell. The hyperchromatic is just a staining character. So I'm not sure what that means. But I don't know what she means by atypical.

Q. Skipping down it says the findings are very suggestive of a viral infection. What does that indicate to you?

A. Yes, it suggests a viral infection caused the lesion.

Q. Now, correct me if I am wrong, but I assume that you take this specimen and send it off to the pathology department because vou want an expert in microscopic examination of cells to give you an opinion concerning whether it is cancerous, correct?

A. Yes.

Q. And when you receive the report back you expect this report to clearly state whether there's cancer shown on the slide or in the specimen, correct?

A. Yes.

Q. All right. Here we have following the microscopic examination a diagnosis which has been set forth by Dr. Alonso, correct?

A. Yes.

Q. And the conclusion is moderate papillary hyperplasia

with hyperkeratosis, focal mild atypia and chronic inflammation, from tongue. Now, is there anything in that diagnosis which gave you cause for concern concerning Allan Boyd's condition in November of 1989?

A. This is a benign report.

Q. By that do you mean that from this report you were able to eliminate the possibility that the lesion was cancerous?

A. Yes.

Q. If this specimen had indicated well-differentiated squamous cell carcinoma how would you expect that to be reported?

A. Well-differentiated squamous cell carcinoma.

Q. If you, in your general practice, examine a patient and suspect carcinoma, do you make arrangements for a visit, follow-up visit, upon release of that patient? Do you understand the question?

A. No.

Q. I assume that in your history here with this group you have examined patients where you strongly suspected they were suffering from a cancerous condition?

A. Yes.

Q. You took a biopsy and you sent it off to the

pathology department?

A. Correct. Yes.

Q. And how would you generally make arrangements fox follow-up of that patient?

A. In one week.

Q. And would the appointment be made as they left your office?

A. I give the patient the chart, I show him where the reception desk is, they have been told they want to be seen in one week and it is written in the chart. So I believe the appointment is being made.

Q. And if the appointment is not made does your office follow up and see that it is made in some way?

A. Well, at that time they tell the patient to make the appointment. There would be no reason for the office not to make it. So if the patient states I will call back, we do not call him back, we ask him to make the appointment at that time.

Q. Is that true even when a patient whom you strongly suspect has a cancerous condition is released? And by that I mean if they don't follow up you don't follow up?

A. No. Well, in your own mind that kind of jogs something. If I see a patient I really believe has a cancer and I do a biopsy, number one, we do get

the report. If it is a cancer, we're going to check into it.

Q. In other words, what I an looking for is when you see a patient that you suspect has cancer, you certainly are more attentive or more careful in the follow-up than if you suspect it is a benign condition, are you not?

A. Well, that's a difficult question to answer. When I do a biopsy I request follow-up in one week. I tell them I want to see them in one week whether I think it is benign or cancerous. Yes, when I believe it is a cancer I tell the patient that, And I would also believe that would encourage the patient to keep a close follow.

Q. When you tell the patient you believe they have cancer they are certainly quick to follow up, are they not?

A. I would think so.

Q. And, in fact, if you receive a report, a pathology report, which says they have cancer, and they've not contacted your office, you would make a point of contacting that patient, would you not?

A. Yes.

Q. In other words, if a person has cancer they're not easily lost to follow up, are they?

A. No.
Q. You make sure your office in some way gets in touch with them?
A. Yes.
Q. If they have a benign condition and they don't reappear in your office, you are less concerned?
A. Yes.
Q. All right. In the examination of white lesion of the mouth to your knowledge are there such things as precancerous lesions?
A. Yes.
Q. What would indicate a precancerous condition?
A. I don't understand that question.
Q. Are there conditions of the mouth which are benign but which indicate that a person is more susceptible to cancer or likely to develop cancer as a result of the benign lesion'!
A. Yes.

MR. MURPHY: Could you read that question back?

Q. (BY MR. YOUNG) Let me rephrase it because it was a little convaluted. I talked about precancerous lesions. Again, in your practice are there conditions known as precancerous conditions?
A. Yes.

Q. Are you able to characterize them or define them?
A. Precancerous lesions are lesions that are believed to potentially lead to cancer.
Q. Is there a medical term for the type of lesion we're talking about?
A. No one medical term. They're called precancerous lesions. There are findings in the pathology that make one feel they are precancerous.
Q. What findings would indicate to you that a lesion could be precancerous? Pathological findings.
A. What's called severe dysplasia. That is where all the cells within the mucosa are abnormal. That is, well correlated to be suspicious for a precancerous lesion.
Q. All right. Are there other pathological indications other than severe dysplasia that would indicate a precancerous condition'?
A. That is the main thing when you are talking about precancerous lesion. In other words, before it is a cancer. Having the severe dysplasia is something that you want to keep a close eye on.
Q. And the pathological finding, the report, would indicate severe dysplasia? Those words wouid occur?
A. Right.
Q. Doctor, do you have any knowledge as to when you

next encountered Allan Boyd in any manner or had had knowledge concerning him?

A. No.

Q. At some point in time you received a letter from Ed Galaska advising that he had been retained concerning Allan Boyd, correct?

A. (Indicating).

Q. Would that have been the next time this would have occurred to you, this matter, in any way?

A. Yes.

Q. From November 22, 1989 until today have you had the opportunity to discuss this matter with any other physicians?

A. Oh, with my partners.

Q. All right.

A. Yes.

Q. Anyone other than your partners?

A. Other physicians?

Q. Other physicians.

A. My father.

Q. He is a physician?

A. Yes.

Q. What is hi., name?

A. Marvin Brown.

Q. Marvin Brown. Anyone else?

A. I don't believe so.
Q. Have you had the occasion to discuss the matter at any point in time since November 28, 1989 with Dr. Alonso or any member of the pathology department?
A. Besides this contact --
Q. This contact?
A. -- on 11-28-89?
Q. You are pointing to the chart?
A. No.
Q. So from November 28, 1989 until today you have not discussed the matter with Allan Boyd with her?
A. I should say when I received a note from Ed Galaska I was asked by Dr. Garewal. He said he received a note, did I receive one, and I said yes, and that was all that was discussed.
Q. I assume that is a member of the pathology department here?
A. He is the chief of the pathology department.
Q. You have not had any other conversation with any member of the pathology department concerning this matter or any other physician other than those partners of yours or your father?
A. Yes.
Q. That's correct?
A. That's correct.

Q. You have discussed this matter or have you ever discussed the matter with Dr. Parsanko?
A. No.
Q. In your discussion of the matter with the physicians in your office have you had the occasion to review any tissue samples or slides?
A. No.
Q. You have had the occasion, of course, to review it with Mr. Murphy your attorney?
A. Slides or tissue samples?
Q. Well, this matter. You have reviewed this matter with Mr. Murphy?
A. Yes.
Q. In reviewing with Mr. Murphy have you ever reviewed it with him and discussed the facts of the case?
MR. MURPHY: Note an objection. I don't think that's proper questioning.
MR. YOUNG: I'll get to the proper question.
Q. (BY MR. YOUNG) You have discussed the matter with Mr. Murphy?
A. The case?
Q. Yes.
A. Yes.
Q. In discussing it with Mr. Murphy have you ever

discussed it with him when others were present?
A. No.
Q. By that I mean Mr. Jackson, or Mr. Farchione, or anyone of that nature?
A. No.
Q. Have you ever discussed the matter with Mr. Jackson?
A. No.
Q. Mr. Farchione?
A. No.
Q. To your knowledge, as you sit here today, is the pathology report before you that's been marked for identification purposes as Exhibit No. 4 accurate?
A. Yes.
Q. You have no reason to dispute it?
A. Based -- The report itself. I have received files on other reports of these slides.
Q. Okay. Now, what other files or other reports have you received concerninq these slides?
A. I have the additional chart information on Allan Boyd.
Q. That being for his subsequent treatment after you saw him?
A. Yes.
Q. What information have you had the opportunity to review concerning Allan Boyd at any time other than

that that we have described here?

A. I have reviewed his chart.

Q. That being which chart?

A. The care he received after my care.

Q. Do you know what chart that was?

A. Well, I have reviewed his hospital stay and hospital course, and I have seen the dentist record.

Q. Any other records?

A. I did see the deposition of his wife.

Q. Anything else?

A. I believe that's it.

Q. You've taken a look at the record of Dr. Parsanko?

A. Yes.

Q. And those records, I believe, refer to a lesion of the tongue'?

A. A lesion of tongue is mentioned.

Q. And do you have an opinion concerning whether the iesion to which Dr. Parsanko refers is the lesion or the area which vou examined on November 22, 1989?

A. I cannot tell from that record.

Q. All right. You have no reason to confirm or dispute that, correct, based on what you have seen?

A. Yes, yes.

Q. You've taken a look at the records pertaining to Allan Boyd after November 22, 1989 and once his

cancerous condition was diagnosed, correct?

A. Yes.

Q. Have you ever been able to draw any conclusion after review of your record?

A. Conclusion as far as what?

Q. As far as whether the condition that he was suffering from resulted from the lesion that you examined on November 22, 1989?

A. Was the lymph nodes in the neck related to that?

Q. Correct.

A. My conclusion would be yes.

Q. In other words, it appears from the records that you've examined that Allan Boyd was, in fact, suffering from squamous cell carcinoma on November 22, 1989 when you examined him. Is that fair?

A. No, I can't say that.

Q. Are you able to say that he was no??

A. No.

Q. Are you able to draw any conclusion concerning the condition that you examined on November 22, 1989 from the subsequent records that you read?

A. Repeat the question.

Q. You've taken a look at the records. Let me give a little history here, and then I'll ask the question.

The only thing you have before you and the only recollection that you have concerning your involvement in this case is the written record of your chart here concerning Allan Boyd, correct?

A. Yes.

Q. And you have a report, pathology report, verbal and written, which indicates that he was suffering from a benign lesion on November 22, 1989, correct?

A. Yes.

Q. You suspected a henign condition at the time that you examined him, and the pathology report confirms that for you?

A. Yes.

Q. You had been concerned it might be a cancerous condition, a cancerous lesion, that you examined, and *so* you sought the pathology department's advice concerning the microscopic evaluation of the lesion?

A. That's not completely true the way it is worded.

Q. Maybe it is an overstatement. It was possible it was a carcinoma *so* you want an evaluation by the pathology department --

A. If I can clarify?

Q. Go ahead, yes.

A. Any time you do a biopsy, as we noted earlier, you want to rule out the serious condition from the

life-threatening one. Even given a clinical impression you always send it off to pathology and you always do want to make sure it is not a cancer, yes.

Q. In fact, that is why you do the biopsy, to make sure it isn't cancer?

A. Right.

Q. In this case we believe it was done because the patient was concerned that it might be cancer and to ease his frame of mind rather than a periodic follow-up. Rut there was the possibility in your mind on November 22, 1989 that it could be cancer and that's why you did the biopsy?

A. Yes.

Q. All right. Now, you have had the opportunity to review the records concerning Allan Boyd's treatment after he left here in November of 1989?

A. Yes.

Q. You've also had the opportunity to review the pathology interpretation of the cancerous condition from which he was suffering at the time of his treatment?

A. Yes.

Q. Has your examination of those records caused you to conclude that Allan Boyd was suffering from squamous

cell carcinoma of the tongue on November 22, 1989?

A. It has led me to be concerned that that is the case.

Q. All I'm trying to do is understand your opinion. You are unable to confirm or deny that that is the case at this point in time based on what you have reviewed?

A. Well, I would like to clarify. We have this report, (indicating).

Q. This being?

A. On the biopsy slides.

Q. This being Exhibit 4?

A. We have a report from a pathologist who also evaluated these slide, and that pathologist said suspicious for squamous cell carcinoma. He had the same slides to look at. So there is a concern that this biopsy was carcinoma.

Q. Had you received a pathology report following your examination on November 22, 1989 which said essentially suspicious for squamous cell carcinoma what would you have done?

A. I would have taken him to the operating room and done a wider excision of the area.

Q. Why?

A. Because suspicious for carcinoma, this was an excisional biopsy of what I felt was a benign

lesion. We have a report saying suspicious €or carcinoma. I'm concerned there could be an area that's definitely carcinoma in there. T would re-excise the area making sure I get an even additional margin around it and an additional deeper margin to be sure that is or is not cancer.

Q. When we talk about margin we're talking about area which is cut out surrounding what is a cancerous condition or suspected cancerous condition, correct?

A. Yes.

Q. What we're doing is eliminating all of the tissue and taking some healthy tissue just to make sure we have all of the diseased tissue to make sure it doesn't --

A. You try to remove the diseased tissue completely.

Q. In doing so you have to ensure there is sufficient margin surrounding the lesion?

A. Yes.

Q. When you take a specimen or you remove a lesion from the mouth do you expect the pathologist to address the issue of the margin in the pathology report if a cancerous or possibly cancerous condition is found?

A. Yes.

Q. Describe €or me what you mean by that.

A. When you take a cancerous or precancerous condition

off you try to take an area of normal tissue around it to be sure the region is removed completely. So when the pathologist looks at the specimen they will see the lesion and should be able to see an area of normal tissue removed completely around the lesion to ascertain that the lesion has been removed completely.

Q. And if the diseased tissue or abnormal -- the atypical tissue runs to the edge of the specimen is that reported by the pathologist generally to you?

A. Yes, it should be.

Q. In what manner and why?

A. It is reported the diseased process is either at the margin or close to the margin.

Q. And that way you know it is necessary to return to the operating room and to take additional tissue if, in fact, it goes to the edge of the specimen, correct?

A. Depending on what the pathology is, yes.

Q. If you have inadequate margin you make sure you have adequate margin to ensure the health of the patient?

A. In the case of cancers.

Q. To your knowledge other than the interpretation of the slides that's contained in the records of the subsequent treatment of Allan Boyd has any physician

addressed or read these slides?

A. Resides the other expert?

Q. Other than treating physicians.

A. Well, the -- this slide was read by an outside pathologist at The Cleveland Clinic. Other than him?

Q. And it was read by another pathologist in the treatment of Allan Boyd. But other than those people to your knowledge --

A. No.

Q. -- you've not worked in connection with anv expert witness or any other person in having these slides read?

A. No.

Q. You've described for me the fact that if a patient has a cancerous condition there's going to be more careful follow-up than if you have a benign report, correct?

A. Yes.

Q. Would that also be true if you have a precancerous pathology report?

A. Yes.

Q. By that I mean if the pathology report indicates to you a condition which may be precancerous, your department would be careful to make sure they

followed up and they received the proper treatment, correct?

A. Yes.

Q. Other than the viral inflammations that you described for me are there other conditions that cause white lesion of the mouth?

A. Many.

Q. Can you describe them for me'?

A. There can be local irritation from a tooth, or from chewing, or something like that. We mentioned the viruses. There could be a Candida infection that can cause a white plaque. Smoking itself leads to white plaques, any sort of friction in an area, again, that is related to something. The mouth can cause white plaques, glass blowers can get white plaques.

Q. If you have a white plaque condition and it is, as you've suggested, appearing to be a benign condition -- Let me withdraw that and ask it this way. If you have a white plaque lesion of the tongue and there appears to be a cause, whether it be local irritation, smoking, chewing tobacco, something of this sort, you've described the fact that conservatively you can follow up over a period of perhaps two weeks. Is that fair?

A. Hard to say the exact time period. You can follow for a brief period with some treatment to see what happens, yes.

Q. When we talk about treatment are we talking medication?

A. Medication.

Q. And the removal of the cause of irritation, if that is obvious?

A. Yes.

Q. In other words, if we have a sharp tooth or a problem that we are trying to treat conservatively, we would remove the cause or apparent cause of the irritation and see if the inflammation clears?

A. Yes.

Q. Follow up over a short period of time?

A. Yes?

Q. To your knowledge when you examined Allan Boyd was there any apparent cause for the irritation or inflammation in his mouth?

A. Not rhat I can tell from this record.

Q. The follow-up period to determine whether removal of the cause of irritation corrects the condition would be a short period, would it not? By that I mean a matter of weeks as opposed to a matter of months?

A. I would say so.
Q. We find a reference in Dr. Parsanko's records to a lesion of the tongue or a condition of the tongue which he examined, and a reference to the patient he has been told it's benign. Have you read those records and that notation?
A. Yes.
Q. That notation I believe is in May of '90, correct?
A. Yes.
Q. Would that five-month period of time or six months, from November of '89 to May of '90, be an abnormal period of time to wait to see if something cleared after removal of the cause of the aggravation, the source of the irritation?
A. Yes. You mean to do something and see him six months later?
Q. Right.
A. Yes.
Q. In other words, if you're going to follow up on a patient to determine whether something is benign and whether to treat it conservatively you don't wait six months generally, correct?
A. Yes.

MR. MURPHY: Just note an objection.

I'm looking at Dr. Parsanko's records and

you can infer the patient was told it was benign but it doesn't cay that. It says patient all okay. Going back to that earlier question I would like let the record to reflect that.

MR. YOUNG: I stand corrected. I didn't have the record before me when I asked the question.

Q. (BY MR. YOUNG) Doctor, let me ask you some general questions concerning terms and conditions that I have encountered in trying to read about white lesion of the mouth, and if I get beyond your area of expertise I want you to stop me and say that's not my area, I'm not a pathologist, and I don't deal with that sort of thing. But I would like to understand, if I can, the question of keratotic versus nonkeratotic lesions. Keratosis I think you described as the -- Redefine it for me, if you would?

A. Again, I am not a pathologist. My understanding is as the membrane evolves it pushes the cells off and keratosis is the debris left from the cells. Normally you don't have keratosis in normal mucous membranes.

Q. Is it important in the examination of white lesions

of the mouth to differentiate between keratotic and nonkeratotic lesions?

A. I don't understand that question.

Q. All right. In other words, in your examination is it important for you to determine whether a lesion is keratotic or not?

A. That's a pathological term so you can't do that in a clinical exam.

Q. In your treatment of these lesions do you differentiate between the hvperkeratosis simplex versus hyperkeratosis complex or is that a pathological issue?

A. Those are pathological issues.

Q. In the terms of white lesion of the mouth, do you use the term dyskeratosis?

A. No.

Q. Leukoplakia?

A. Leukoplakia means white plaque. That's a clinical term.

Q. Does it have anv further definition other than white plaque?

A. No.

Q. So leukoplakia would refer to any white plaque tongue?

A. Yes.

Q. In terms of treatment of Candida, is it treated simply by medication?
A. Yes.
Q. And carcinoma is treated by excising the lesion?
A. Well, there's different modalities for treating carcinoma.
Q. In terms of your expertise certainly you examine lesions of the tongue to provide a diagnosis, correct?
A. Yes.
Q. Do you get involved in the treatment of cancerous lesions of the tongue?
A. Yes.
Q. Is there a limitation that you place on yourself in the treatment of cancerous lesions of the tongue?
A. Meaning?
Q. Is there any limitation? Is there anything you won't do in the treatment of cancer of the tongue?
A. I don't understand that question.
Q. You've described for me the fact that if you have cancer of the tongue it's surgically removed, correct?
A. No.
Q. NO?
A. There are many treatment modalities for cancer of

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the tongue so it depends on where the tumor is, how big the tumor is which modality you pick.

Q. What treatments are familiar for treatment of cancer of the tongue?

A. Surgery, radiation therapy or chemotherapy,

Q. Do you become involved in radiation therapy and chemotherapy of cancer of the tongue?

A. I would be involved in referring the patient to a radiation oncologist or a hematologist oncologist.

Q. Surgically You would take that responsibility?

A. I would do the surgery, yes.

Q. Did you have the opportunity in the examination of Allan Boyd on November 22, 1989 to examine more than the interior of his mouth?

A. Could you repeat the question, please?

Q. Yes. In your general practice -- I understand there's not a great deal here on the written record before us, but in your general practice when presented with this condition would you have examined, for instance, the lymph nodes of the neck or anything else?

A. Yes.

Q. What would your general procedure have provided? What would you have done on November 22, 1989 in the examination of Allan Boyd?

A. I would have examined the ears, the mouth, the neck and the larynx.

Q. Were there any relevant findings in performing that examination on November 22, 1989 other than the findings concerning the lesion of the tongue?

A. Since I did not write them, I don't believe so.

Q. All right. And if you found something abnormal, or there had been a relative finding, it would have been your practice to record it?

A. Yes.

Q. Is there anything concerning the size of the lesion that was removed by you on November 22, 1989 that indicates to you how it would have been treated had you received a pathology report which indicated that it was well-differentiated squamous cell carcinoma?

A. Yes.

Q. What?

A. The size of this lesion was a small lesion, I know from the fact that I excised it it was also not a deep lesion, so that would indicate to me I would have recommended surgery.

Q. All right. Had it been a deep lesion I would assume he would have been hospitalized and the surgery would have been performed there?

A. Any additional surgery would have been performed in

the hospital.

Q. In your opinion had the well-differentiated squamous cell carcinoma have been reported concerning this lesion what additional surgery would have been necessary?

A. I would have taken the patient to the operating room, I would have reevaluated all the areas within the mouth, done what's called a panendoscopy, even though we looked already, looked with the patient asleep to be sure there's nothing else, and then I would have excised the area of previous excision and closed it primarily.

Q. And that would have been to ensure that all of the diseased or atypical cells have been removed and only healthy tissue remained in the tongue?

A. Right.

Q. Do you have any reason to believe that that surgery would not have been successful and that he would nat have been cured as a result of that treatment?

A. Well, cancer is still cancer, you know. You can do all the things and cancer can still recur. There is no guarantee no matter what was done the cancer would not come back. But clearly if this was a cancer or were a cancer he would have had a better chance having it completely excised.

Q. We can only evaluate these things based on probabilities. And, of course, it's possible even with the best of care that it would have recured, but is there anything which is indicated to you by the record that causes you to believe that he could not have been successfully cured through additional surgery and removal of the atypical cells?

A. Cure rates for the size of this lesion, not having a complete evaluation of it, which is lacking, just based on what we have, are anywhere between 70 and 90 percent.

Q. Based on the information that You have reviewed, that being the record pertaining to the subsequent treatment of Allan Boyd and the pathological and pathology analysis and report that you referred to earlier, do you an opinion as to whether -- Withdraw it. Withdraw it.

MR. YOUNG: I don't think I have anything further. Let me take a minute and look at the notes. Take a break if you like.

Thanks, Doctor. That's all.

(Discussion was had off the record.)

MR. YOUNG: Let's go back on the record just to make a notation that John

Jackson on behalf of Dr. Alonso failed to appear this afternoon.

MR. MALLERNEE: I'm here for John.

MR. YOUNG: Joe Farchione on behalf of Dr. Parsanko failed to appear. He had notice, and I'm sure there has been some problem that caused him not to appear. I have no objection to his right to cross-examine at a later date with proper note and sufficient notice prior to trial.

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(Deposition concluded at 4:15 p.m.)

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I have read the foregoing transcript of my deposition taken on Thursday, July 22, 1993 from page 1 to page 88 and note the following corrections:

PAGE:	LINE:	CORRECTION:	REASON:

_____

BERT M. BROWN, M.D.

_____

Date

THE STATE OF OHIO,)
) SS: CERTIFICATE
COUNTY OF CUYAHOGA.)

I, Lisa Hrovat, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that BERT M. BROWN, M.D. was by me, before the giving of his deposition, first duly sworn to testify the truth, the whole truth and nothing but the truth; that the deposition as above set forth was reduced to writing by me by means of Stenotype and was subsequently transcribed into typewriting by means of computer-aided transcription under my direction: that said deposition was taken at the time and place aforesaid pursuant to notice and agreement of counsel; and that I am not a relative or attorney of either party or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I hereunto set my hand and seal of office at Cleveland, Ohio, this 38th day of July, 1993.

Lisa Hrovat

Lisa Hrovat, RPR, Notary Public
Within and for the State of Ohio
444 Terminal Tower
Cleveland, Ohio 44113

My Commission Expires: January 17, 1997.