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Last Name	KAISI
First Name	DA NADIA
Specialty	Pathologist
Party	Plaintiff <input checked="" type="checkbox"/> D
Date (format =99/99/9999)	10/28/03
Type of Document	Articles <input checked="" type="checkbox"/> Depo <input type="checkbox"/>
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<p>Page 1</p> <p>1 IN THE COURT OF COMMON PLEAS 2 OF CUYAHOGA COUNTY, OHIO 3 ----- 4 WILLIAM J. GILL, III, Executor 5 of the Estate of 6 DANIEL P. GILL, deceased, 7 Plaintiff, 8 vs Case No. 457639 9 Judge Russo 10 11 ROGER A. MANSNERUS, M.D., 12 et al., 13 Defendants. 14 ----- 15 DEPOSITION OF NADIA KAISI, M.D. 16 TUESDAY, OCTOBER 28, 2003 17 ----- 18 Deposition of NADIA KAISI, M.D., a Witness 19 herein, called by counsel on behalf of the 20 Plaintiff for examination under the statute, 21 taken before me, Vivian L. Gordon, a Registered 22 Diplomate Reporter and Notary Public in and for 23 the State of Ohio, pursuant to agreement of 24 counsel, at the offices of Parma Community 25 General Hospital, 7007 Powers Avenue, Parma, Ohio, commencing at 1:30 o'clock p.m. on the day and date above set forth. -----</p>	<p>Page 3</p> <p>1 ----- 2 (Thereupon, KAISI Deposition 3 Exhibits 1 and 2 were marked for 4 purposes of identification.) 5 ----- 6 7 NADIA KAISI, M.D., a witness herein, called 8 for examination, as provided by the Ohio Rules 9 of Civil Procedure, being by me first duly 10 sworn, as hereinafter certified, was deposed and 11 said as follows: 12 EXAMINATION OF NADIA KAISI, M.D. 13 BY MR. MISHKIND: 14 Q. Would you please state your name for 15 the record. 16 A. Nadia Kaisi, also known as Nadia 17 Al-Kaisi, A-L-K-A-I-S-I. 18 Q. Do you prefer to be referred to as 19 Dr. Kaisi or Dr. Al-Kaisi? 20 A. Kaisi is fine. 21 Q. Dr. Kaisi? 22 A. Right. 23 Q. You are a pathologist; is that 24 correct? 25 A. Yes.</p>
<p>Page 2</p> <p>1 APPEARANCES: 2 On behalf of the Plaintiff 3 Becker & Mishkind 4 HOWARD D. MISHKIND, ESQ. 5 Skylight Office Tower Suite 660 6 1220 W. 2nd Street 7 Cleveland, Ohio 44113 8 241-2600 9 10 On behalf of the Defendant 11 Reminger & Reminger 12 ROBERT D. WARNER, ESQ. 13 1400 Midland Building 14 Cleveland, Ohio 44115 15 687-1311 16 17 18 ----- 19 20 21 22 23 24 25</p>	<p>Page 4</p> <p>1 Q. You have been identified as an expert 2 on behalf of Dr. Mansnerus and that's why I am 3 here to talk with you today. You understand 4 that, don't you? 5 A. Yes. 6 Q. Have you had your deposition taken 7 before? 8 A. Yes. 9 Q. Tell me how many times. 10 A. Probably 12, 15 times. 11 Q. So you generally know the routine in 12 terms of I'm going to be asking you questions 13 about your background and questions about your 14 opinions that you hold in this case. Do you 15 understand that? 16 A. Yes. 17 Q. Even though you have had your 18 deposition taken 12 to 15 times before, you and 19 I have never met; correct? 20 A. Right. 21 Q. Let me just give you a couple 22 precautions so that we can try to move the 23 deposition along as smoothly as possible. 24 I'll wait until you are done with an 25 answer before I move on to the next question.</p>

Page 5

1 Also, wait until I am done with my question
2 before you start answering it so that we aren't
3 overlapping each other, okay?
4 A. Okay.
5 Q. Occasionally Mr. Warner may object to
6 a question. The court reporter will take the
7 objection down, but that doesn't mean that you
8 then won't proceed to answer the question. But
9 if he objects to a question, wait until he
10 finishes his objection and then go ahead and
11 answer the question, okay?
12 A. Okay.
13 Q. If you don't understand my question,
14 tell me that you don't understand. I'll try to
15 rephrase it or I'll have Vivian read it back to
16 you. Is that fair, as well?
17 A. Yes.
18 Q. I have had marked as an exhibit
19 Plaintiff's Exhibit 2 with your name on it and
20 I'm going to hand this to you.
21 Is this, in fact, the report that you
22 authored to Mr. Warner in connection with your
23 opinions in this case?
24 A. Yes.
25 Q. Is this the only report that you have

Page 7

1 report on my computer, on my PC. These are the
2 notes that I have made.
3 Q. That was going to be my next question
4 as to whether or not the report, which is
5 Exhibit 2, whether that was typed by yourself or
6 whether you had someone else do it for you?
7 A. I usually type my reports.
8 Q. And in this case, did you prepare the
9 report yourself?
10 A. Yes.
11 Q. So as you reviewed the case, you
12 prepared your report. Was it a work in progress
13 or did you review the entire case and then
14 prepare the report?
15 A. I think I reviewed all the documents
16 that I refer to in my report and then typed the
17 report.
18 Q. Can you tell me from looking at your
19 report when it was that you prepared this
20 report?
21 A. I just noticed that the date was
22 missing here, so --
23 MR. WARNER: Objection. There is a
24 date at the bottom.
25 A. January 9th, 2003.

Page 6

1 authored in this case?
2 A. Yes.
3 Q. In looking through the material that
4 you have with you today, I do not see any notes
5 written --
6 (Telephone interruption.)
7 Q. In looking through your file or the
8 material that you have with you, I do not see
9 any written notes or any typed notes. Was my
10 perusal of your file accurate in terms of there
11 not being any notes?
12 A. That's correct.
13 (Telephone interruption.)
14 Q. Let's try that one more time. Am I
15 correct in my statement that there aren't any
16 written or typed notes in the file?
17 A. That's correct.
18 Q. Did you at the time that you reviewed
19 the case make any notes?
20 A. No, I don't believe so.
21 Q. When you say you don't believe so,
22 just in fairness to you, I want to make certain
23 that your answer is unequivocal in terms of I
24 didn't make any notes.
25 A. I did not make notes. I typed the

Page 8

1 Q. Do you know what that January 9, 2003
2 represents?
3 A. Probably a fax. I usually fax my
4 reports and then follow up with a signed copy in
5 the mail. So it's probably the day I faxed it
6 to Mr. Warner's office.
7 Q. And again, understand, this is my
8 only opportunity to talk to you before you
9 testify. I just want to make certain that, is
10 it your testimony that that stamp on the bottom
11 of the report in the lower left-hand corner was
12 placed by you as opposed to perhaps someone at
13 Mr. Warner's office?
14 A. I did not place that stamp.
15 Q. Do you know who placed that stamp?
16 A. No.
17 Q. And there is nowhere on this report
18 indicating the date that it was faxed, if, in
19 fact, it was faxed to Mr. Warner; correct?
20 A. That's correct. Unless this is the
21 faxed stamp, you know, when you fax that report,
22 when you fax a paper, then it usually prints on
23 the report.
24 Q. You are guessing that that's the fax
25 in the lower left-hand corner, aren't you?

2 (Pages 5 to 8)

Page 9

1 A. Yes.
2 Q. In fact, you don't know what that
3 date of January 9, 2003 represents; true?
4 A. That's true.
5 Q. And as you look at this report,
6 recognizing that there is no date on this
7 report, are you able to tell me when this report
8 was prepared?
9 A. I can from looking at the records, if
10 you want me to go into these letters that
11 Mr. Warner had sent me.
12 Q. Well, let me ask you this. You
13 received some material from Mr. Warner before
14 preparing this report; correct?
15 A. Yes.
16 Q. And the material that you received
17 from Mr. Warner before preparing this report
18 came with a cover letter; true?
19 A. Yes.
20 Q. And that cover letter was dated what?
21 A. December 19th, 2002.
22 Q. So can we agree that you didn't
23 prepare your report before December 19th, 2002?
24 A. Yes.
25 Q. Is the material that you reviewed for

Page 11

1 sending it to Mr. Warner, it appears as if you
2 received some additional material; true?
3 A. Yes.
4 Q. Did any of that additional material
5 from the standpoint of your opinions in this
6 case have any significance?
7 A. As to my report and my opinions that
8 I expressed in my report?
9 Q. Yes.
10 A. I don't think so.
11 Q. And just for the record, is it fair
12 to say that the material that you received after
13 preparing your report, that the material that
14 you received were depositions?
15 A. Yes.
16 Q. And it appears as if you received
17 Dr. Levitan's deposition?
18 A. That's true.
19 Q. It appears as if you have received --
20 why don't you tell me which depositions you
21 received. Maybe it would be easier.
22 A. Dr. Levitan's deposition,
23 Dr. Sutherland's deposition, and Dr. Steele's
24 deposition.
25 Q. Did you read each of those

Page 10

1 purposes of your report referenced in your
2 undated report, which is Exhibit 2?
3 A. Yes. I think the first letter I
4 received from Mr. Warner was December 9th, which
5 accompanied the slides, the glass slides.
6 Q. Okay.
7 A. And that's what I usually do is I
8 review the slides before I review any of the
9 medical records.
10 And then the second cover letter was
11 dated December 19th from Mr. Warner which
12 accompanied the medical records and the reports,
13 the expert witness reports, which I reviewed
14 after that, and my report was sometime after the
15 review of the medical records.
16 Q. But suffice it to say, you don't know
17 exactly when you prepared your report; correct?
18 A. That's correct.
19 Q. Do you normally put a date on your
20 reports?
21 A. Yes.
22 Q. In this case, is it fair to say that
23 you just don't know why the date was omitted?
24 A. I think it was an oversight.
25 Q. After preparing this report and

Page 12

1 depositions from cover to cover?
2 A. No, I did not read them from cover to
3 cover.
4 Q. Did you read them sufficiently enough
5 that you are familiar with what those doctors
6 said in their depositions?
7 A. Yes, I think so.
8 Q. But you made no notes; true?
9 A. That's true.
10 Q. When is the last time you reviewed
11 this material prior to us getting together
12 today?
13 A. I think it was at the time I received
14 the depositions.
15 Q. Other than the depositions that you
16 have identified and the material that is
17 referenced in Exhibit 2, which includes the
18 slides, have you reviewed any other material in
19 connection with this case, ma'am?
20 A. No.
21 Q. As you sit here right now, do you
22 anticipate reviewing any other material prior to
23 testifying that you believe to be relevant or
24 material to the opinions that you intend to
25 provide in this case?

3 (Pages 9 to 12)

<p>Page 13</p> <p>1 A. Not unless Mr. Warner provides me 2 with additional material. 3 Q. As you sit here right now, do you 4 have any understanding that Mr. Warner is 5 intending to provide you with any additional 6 material? 7 A. No. 8 Q. In looking at your report, it appears 9 as if you do not intend to provide opinions with 10 regard to Dr. Mansnerus' care of Mr. Gill; is 11 that true? 12 A. That's correct. 13 Q. So you won't be taking the stand and 14 saying that you have an opinion that 15 Dr. Mansnerus complied with the standard of 16 care; true? 17 A. That's true. 18 Q. Your focus is with regard to the 19 issue of staging of the lung cancer and 20 providing potential opinions as relate to any 21 alteration in the outcome of this case; is that 22 a fair statement? 23 A. Yes. 24 Q. And obviously we are going to talk 25 about those opinions shortly.</p>	<p>Page 15</p> <p>1 Q. Tell me the names of the other two 2 full time. 3 A. Edward Cottle, C-O-T-T-L-E, and 4 Angelina Bautista, B-A-U-T-I-S-T-A. These are 5 the two full-time pathologists. 6 Q. And the other one that is short. 7 A. Caroline Steinetz, S-T-E-I-N-E-T-Z. 8 Q. Do all three and a half of you work 9 exclusively at Parma? 10 A. No. The three of us work exclusively 11 at Parma, but Dr. Steinetz works at other 12 hospitals, as well; mostly Marymount and Parma. 13 Sometimes at UH, as well. 14 Q. You are not board certified in 15 internal medicine; true? 16 A. True. 17 Q. You are not board certified in 18 oncology; correct? 19 A. Correct. 20 Q. You don't hold yourself out as an 21 expert in the area of oncology; correct? 22 A. As it relates to pathology. Part of 23 pathology is related to oncology, but not as a 24 medical oncologist, no. 25 Q. So you are looking at slides or other</p>
<p>Page 14</p> <p>1 Exhibit 1 is your CV; is that true? 2 A. Yes. 3 Q. I want to ask you just a few 4 background questions and then some specifics 5 about your CV for a few minutes. 6 We are here at Parma Hospital today. 7 What is your position here at the hospital? 8 A. I'm an associate pathologist. 9 Q. Whom are you employed by? 10 A. Cottle Pathology Services, Inc. 11 Q. How long have you been employed by 12 that group? 13 A. A little over three years. 14 Q. How many other pathologists are there 15 in that group? 16 A. We are a total of three and a half; 17 three full time and one part time. 18 Q. I was going to ask you how the fourth 19 one became a half person. 20 A. She is a little short. Just kidding. 21 Q. Tell me, including yourself, there 22 are three full time or including yourself there 23 are four? 24 A. Including myself there are three full 25 time.</p>	<p>Page 16</p> <p>1 specimens from the standpoint of evaluating 2 staging and assisting potentially with treatment 3 modalities as opposed to actually treating 4 cancer patients? 5 A. Well, I do not see cancer patients 6 routinely, if that's your question. 7 Q. When is the last time that you had 8 any hands-on involvement in terms of treating a 9 patient that had a suspicion of lung cancer? 10 A. Actually seeing the patient and 11 examining him physically? 12 Q. Yes. 13 A. When I was a resident. 14 Q. That would have been how long ago? 15 A. That was 1986-87. 16 Q. And I take it also that you don't 17 hold yourself out as an expert in the area of 18 radiology or radiological interpretation? 19 A. Well, I do have, of course I do have 20 knowledge of radiology as it relates to 21 pathology and how it correlates with the 22 pathology, but I am not an expert in radiology. 23 Q. Your education in terms of medical 24 school took place where? 25 A. In Bagdad Medical School, Bagdad,</p>

Page 17

1 Iraq.
2 Q. And that's where you were born; true?
3 A. Yes.
4 MR. MISHKIND: Off the record.
5 (Discussion off the record.)
6 Q. Before your affiliation with the
7 pathology group that you mentioned, where did
8 you practice?
9 A. University Hospitals of Cleveland.
10 Q. And how many years did you practice
11 there?
12 A. From 1986 to July 2000.
13 Q. What was your position at UH?
14 A. The first year I was there from 1986
15 to 1987 I did a fellowship in surgical pathology
16 and cytopathology. Then I became a staff
17 pathologist and held various administrative
18 positions, like the director of histology,
19 director of cytology, as outlined in my CV.
20 Q. What exactly is cytology?
21 A. Histology?
22 Q. Cytology.
23 A. Cytology is the study of the cells.
24 Q. And histology is study of blood?
25 A. Of the tissue.

Page 19

1 types, yes.
2 Q. So when one looks under a microscope,
3 one can look for the type of configuration of
4 the cell in terms of trying to define whether or
5 not it's a squamous cell carcinoma or one of the
6 other nonsmall cell carcinomas; correct?
7 A. There are several criteria that we
8 look at and take into consideration to try to
9 classify the tumor and to classify the nonsmall
10 cell cancer into the different subcategories,
11 like squamous cell carcinoma, adenocarcinoma,
12 merkel undifferentiated carcinoma,
13 neuroendocrine carcinomas and otherwise.
14 Q. Did Mr. Gill have squamous cell
15 carcinoma?
16 A. I think there was two types of
17 differentiation, or maybe even three. There was
18 a component that was poorly differentiated
19 nonsmall cell; i.e., the tumor cells did not
20 express any specific differentiation. There
21 were four slides that had squamous
22 differentiation and there were four slides that
23 had that glandular or adenocarcinoma
24 differentiation.
25 Q. So as we look through the medical

Page 18

1 Q. It's no mystery that we are talking
2 about nonsmall cell lung cancer in this case;
3 correct?
4 A. What do you mean it's no mystery?
5 Q. Well, Mr. Gill had, when it was
6 diagnosed, he had a diagnosis in terms of the
7 primary tumor falling within the category of
8 nonsmall cell carcinoma; true?
9 A. Well, if you are asking me if I agree
10 from reviewing the slides on Mr. Gill that he
11 had nonsmall cell lung cancer, the answer is
12 yes, I do.
13 Q. There are different categories of
14 lung cancer; correct?
15 A. Yes.
16 Q. Those that would fall outside of the
17 area of nonsmall cell are grouped in what title,
18 what category?
19 A. The ones that fall outside the
20 nonsmall cell?
21 Q. Yes.
22 A. Are the small cells.
23 Q. And within the nonsmall cell there
24 are various types of nonsmall cell; correct?
25 A. Yes, there are various histologic

Page 20

1 records, we may see different references to the
2 descriptive terms of his nonsmall cell
3 carcinoma?
4 A. That's correct.
5 Q. I think at one point I see it
6 referred to as adenosquamous carcinoma, which is
7 sort of a combination of adenocarcinoma and
8 squamous cell carcinoma?
9 A. That's correct.
10 Q. And that would be different from
11 poorly differentiated nonsmall cell carcinoma;
12 true?
13 A. Not necessarily. Poorly
14 differentiated nonsmall cell carcinomas can have
15 signs of either adeno or squamous
16 differentiation. So the poorly differentiated
17 aspect of it is another characterization of the
18 tumor. So adenosquamous carcinomas and nonsmall
19 cell lung cancers can be poorly differentiated
20 or well differentiated or moderately well
21 differentiated.
22 Q. We will talk more about that in a
23 little bit. But just to sort of talk in general
24 about what we know the ultimate diagnosis on
25 Mr. Gill to be, I want to focus in on your CV

5 (Pages 17 to 20)

Page 21

1 and ask you whether there are any lectures that
2 you have given of the 17 that are referenced
3 that would be relevant to the issue of staging
4 or diagnosis of nonsmall cell carcinoma?

5 A. Can I take a look at my CV?

6 MR. MISHKIND: Rob, I think you may
7 have the same, just to make it easy for her.

8 Q. For the record, it's on page five.

9 And if you have the same version, the invited
10 guest lectures on page five and six total 17.

11 A. I don't see anything related to the
12 lung in these lectures, but the lectures that I
13 do give related to the diagnosis of lung cancer
14 is in the invited seminars and workshops which
15 are mostly at our national meetings, the
16 American Society of Clinical Pathologists
17 national meetings.

18 Q. What page would that be on your CV?

19 A. Well, it starts, the lung lectures
20 start on page 11. I think the fourth item,
21 pulmonary cytology workshop, there are several
22 of them in different years, different locations.

23 Q. Now, the one that I am focusing in
24 on, the first pulmonary cytology workshop that
25 has a parenthesis, three category, one CME hours

Page 23

1 A. I have all of the abstracts and the
2 material that I was giving to the participants.
3 The kodachromes that I used for the
4 presentation, I have it, but it's not -- it's
5 part of my kodachrome collection that I use to
6 lecture at the medical school and at University
7 Hospitals, so it's not one. I usually mix and
8 match, depending on the subject and the
9 audience.

10 Q. In terms of the printed material,
11 though, that you gave back in 1994 -- and it
12 looks like you continued to do that periodically
13 over the years -- did that printed material
14 change at all or was it pretty much the same
15 from year to year?

16 A. I may have updated the references,
17 but the basic material is pretty much the same.

18 Q. So you would have a file that would
19 have your printed material that you presented to
20 the American Society of Clinical Pathologists;
21 true?

22 A. Yes.

23 Q. And that would have some relevance to
24 the issues that we are talking about in this
25 case?

Page 22

1 and that was at the American Society of Clinical
2 Pathologists, the national meeting in Seattle in
3 April of 1994, was that a presentation that you
4 were one of a number of presenters?

5 A. Well, this was solely my
6 presentation.

7 Q. Did you provide any written material
8 or slide presentations, power point or anything
9 of that nature?

10 A. Yes. There is an abstract that we
11 provide to the participants at the time of the
12 meeting. There is a set of kodachromes and case
13 histories that we provide to the participants
14 prior to the meeting, and during the meeting
15 there are a set of kodachrome slides.

16 At that time I did not use the power
17 point presentation, so they were 35 millimeter
18 transparencies.

19 Q. If someone like Howard Mishkind
20 wanted to acquire a copy of the material that
21 was disseminated at that presentation, what
22 would I have to do?

23 A. You can ask me.

24 Q. It's something that you have in your
25 possession?

Page 24

1 A. Mostly in the area of the diagnosis
2 of lung cancer, yes.

3 Q. If you would be so kind as to provide
4 copies of the printed material, not necessarily
5 the slides, but the printed material to
6 Mr. Warner, and I'll make a request on the
7 record that Mr. Warner provide me with a copy of
8 that.

9 A. Okay.

10 Q. Doctor, it looks like the last time
11 that you presented at the cytology workshop was
12 1998; is that true?

13 A. 1999. Which is on page 12.

14 Q. My CV that was faxed to me actually
15 ended on page 11. So you have got a page 12.

16 A. I'm sorry.

17 Q. It's not your fault.

18 MR. MISHKIND: Rob, what I would like
19 to do is --

20 MR. WARNER: We can get you copies.

21 MR. MISHKIND: Just for the record,
22 my CV ended at page 11 and the original has 12
23 pages.

24 MR. WARNER: When we leave, we will
25 go down to the copy center.

6 (Pages 21 to 24)

Page 25

1 MR. MISHKIND: And we will just
2 substitute page 12 to Exhibit 1.
3 Q. Doctor, besides the invited workshops
4 or seminars, if I look back through your CV,
5 there is a number of abstracts. There are a
6 number of peer reviewed articles and educational
7 publications in your bibliography. Do any of
8 them have any relevance to the topic of nonsmall
9 cell lung cancer?
10 A. Well, some of them have relevance to
11 the diagnosis of lung cancer in general, even
12 though the specific tumors that are described or
13 reported were neuroendocrine carcinoma or
14 carcinoid tumors, but they do enter into the
15 category of lung cancers.
16 Q. Would the references be voluminous or
17 could you very quickly look through and tell me
18 number 10 or number 11 would have something
19 touching on the topic of lung cancer?
20 A. Sure. Many of the lectures that I
21 gave at University Hospitals of Cleveland do
22 relate to lung cancer; again mostly in the
23 diagnosis aspect of it.
24 And these are not listed separately
25 as such, but they are under the teaching

Page 26

1 responsibilities at University Hospitals of
2 Cleveland which is on page five of the
3 educational publications. On page seven, number
4 four, it relates to pulmonary blastoma, which is
5 a different type of lung tumor than the one we
6 are discussing today.
7 Under the peer reviewed articles on
8 page seven, there is number two, bronchial
9 carcinoid tumor.
10 Number 14 on page eight. I think
11 that's it.
12 Q. On the last page of your CV that I
13 didn't have until a moment ago, there is a book
14 chapter that you wrote?
15 A. Yes.
16 Q. Does that have anything to do with
17 lung cancer?
18 A. No. It was on GYN cytology. I was
19 asked to write a book on pulmonary cytology but
20 I declined.
21 Q. Why is that?
22 A. Because at the time I did not think I
23 could devote the time necessary to write a book.
24 Q. Do you have an area within pathology
25 that you consider to be your specialty or

Page 27

1 subspecialty?
2 A. By training and certification I am a
3 board anatomic and clinical pathologist. My
4 specialty areas are surgical pathology and
5 cytopathology and my areas of interest or
6 expertise in these subspecialties is breast
7 pathology and lung pathology. I still do look
8 at all the general surgical pathology.
9 Q. How did you develop an interest in
10 the area of lung and breast pathology?
11 A. Well, these are very common tumors
12 and lesions and pathologic material that we are
13 provided with to interpret. I was at UH at the
14 time that the breast center was founded and
15 started and I developed my interest that way.
16 Lung pathology, I was assigned to be
17 the lung pathology expert at UH by one of our
18 directors. And for several years I was in charge
19 of reviewing all the lung pathology material for
20 conferences and be the person to answer
21 questions of the physicians, pulmonologists.
22 A few years actually before I left
23 UH, when it got to be too much, the breast part
24 of it was very demanding and I did transfer the
25 responsibility gradually to one of our younger

Page 28

1 more junior pathologists there at UH.
2 Q. Who was it at UH that had asked you
3 to head up the lung pathology?
4 A. Dr. Katherine DeShriver.
5 Q. Is Dr. DeShriver still at UH?
6 A. No.
7 Q. Where is she at now?
8 A. I don't know.
9 Q. When you are looking at lung or
10 breast pathology, you are normally looking at
11 surgical specimens; true?
12 A. Yes.
13 Q. And in looking at surgical specimens,
14 you are providing some input to the clinician as
15 to what the patient's prognosis is based upon
16 the cell structure and other findings that you
17 make on that surgical specimen; correct?
18 A. Yes.
19 Q. So you may assist in terms of
20 staging, in particular with lung cancer, staging
21 what the stage is of the lung cancer so that a
22 clinical decision can be made as to what type of
23 adjunctive treatment may be appropriate for that
24 patient; true?
25 A. Yes.

7 (Pages 25 to 28)

<p style="text-align: right;">Page 29</p> <p>1 Q. And also having some prognostic 2 indicators as to how long the patient 3 statistically may live; correct? 4 A. Yes. These are findings that are 5 related to the staging, basically, and the 6 histologic type of the tumor. 7 Q. You are not typically asked to 8 provide an opinion as to when the patient 9 progressed from Stage 1 to Stage 2 to Stage 3 to 10 Stage 4, are you? 11 A. You mean in my daily practice of 12 pathology -- 13 Q. Yes. 14 A. -- at Parma Hospital? Not as a 15 written report, but as discussions in tumor 16 conferences on specific patients. 17 Q. But on a day-to-day basis, when you 18 provide an opinion that someone is Stage 4, 19 nonsmall cell poorly differentiated 20 adenosquamous cell carcinoma or whatever the 21 configuration is, your concern is more of giving 22 that information to the clinician as opposed to 23 determining when that patient progressed from 24 Stage 3 to Stage 4; true? 25 A. That's true.</p>	<p style="text-align: right;">Page 31</p> <p>1 negligence cases. 2 Q. Sure. You understand in this case, 3 there are allegations that Dr. Mansnerus did not 4 comply with the standard of care. You 5 understand that? 6 A. Right. 7 Q. You are not here to provide a defense 8 for Dr. Mansnerus as to whether he did or didn't 9 meet the standard of care; correct? 10 A. That's correct. 11 Q. But this case involves issues of 12 medical negligence where there is a plaintiff 13 and a defendant. 14 A. Yes. 15 Q. And Dr. Mansnerus is the defendant. 16 In that context, have you testified in a 17 courtroom where there were allegations of 18 malpractice on the part of a physician? 19 A. Yes. 20 Q. Of the four to five times that you 21 have testified, how many times have you 22 testified in court in that capacity? 23 A. Either once or twice. 24 Q. The other times that you have 25 testified in a courtroom, what was the capacity</p>
<p style="text-align: right;">Page 30</p> <p>1 Q. Before I move away entirely from your 2 CV, is there anything else in your CV by way of 3 presentations, lectures, book chapters, invited 4 presentations that touch on the topic of lung 5 cancer, other than what we have talked about? 6 A. I don't think so. 7 Q. I'm going to focus your attention now 8 on your medical/legal experience and ask you 9 some questions about that, okay? 10 A. Okay. 11 Q. You said that you have testified 12 12 to 15 times; true? 13 A. Depositions taken. 14 Q. Depositions. 15 A. Approximately. 16 Q. Have you ever testified in a 17 courtroom? 18 A. Yes. 19 Q. How many times? 20 A. Four or five times. 21 Q. Have you ever testified in a 22 courtroom as an expert witness in a medical 23 negligence case? 24 A. You mean medical/legal case? I don't 25 really understand what you are saying, medical</p>	<p style="text-align: right;">Page 32</p> <p>1 of your appearance? 2 A. Mostly determining the stage of the 3 tumor and the rate of progression of the tumor. 4 Q. Were any of these times that you 5 testified in court, were they criminal cases or 6 were they all civil cases? 7 A. I think they were all civil cases. 8 Q. The other three times that you have 9 testified in court were not malpractice cases or 10 what you may refer to as medical/legal cases? 11 A. I'm sorry, say it again. 12 Q. Sure. Let me make it easier for you 13 so that we are speaking the same language. I'll 14 come at it from a different direction. 15 The four to five times that you have 16 testified in the courtroom, how many of those 17 times that you have testified in the courtroom 18 have you been retained by the attorney 19 representing a hospital or a doctor? 20 A. All of them. 21 Q. Can you explain to me when I asked 22 you about the four to five times why you 23 separated out one to two times that you were 24 testifying in a malpractice case as opposed to 25 the entire four to five times of testifying?</p>

Page 33

1 A. Well, the one time that I do remember
2 the details was regarding the interpretation of
3 PAP smears by a lab. And as is obvious from my
4 answer, I can't really remember the other case.
5 But I know that there are two other cases that
6 did not involve the interpretation of pathologic
7 material and I can't remember whether there
8 is -- it's probably not five, it's probably just
9 four cases, more like four.
10 Q. But even though there may not have
11 been an issue of interpretation of the
12 pathological material, were all of these cases
13 medical/legal cases?
14 A. Yes.
15 Q. And all of the cases you had been
16 retained by a defense attorney to come in and
17 testify; true?
18 A. Yes.
19 Q. When is the last time you testified
20 in a courtroom, either in Cleveland or anywhere
21 else?
22 A. About a year ago.
23 Q. Was that here in Cleveland?
24 A. Yes.
25 Q. Do you remember what firm, what law

Page 35

1 you want on the list?
2 Q. If you have the name of the attorney,
3 the name of the case. These are matters that
4 you have already testified on, so it wouldn't be
5 an issue of disclosing something that you
6 haven't been identified in. If you have given
7 depositions or you have testified in court, then
8 we don't have to worry about somebody saying
9 that you were a confidential consultant, okay?
10 A. Okay.
11 Q. When are you scheduled next to
12 testify in a courtroom?
13 A. In November.
14 Q. And that would again be for?
15 A. I think it's the Gill case.
16 MR. WARNER: This case is continued.
17 THE WITNESS: So the November 20th
18 date is off?
19 MR. WARNER: Is off. Cancel it on
20 your calendar.
21 (Discussion off the record.)
22 Q. Putting aside the Gill case, do you
23 know when you are next set to testify?
24 A. I am not scheduled.
25 Q. The 12 to 15 times that you have

Page 34

1 firm had retained you to testify?
2 A. No.
3 Q. Do you remember the subject matter of
4 that case that was one year ago?
5 A. Yes. It was a breast cancer patient.
6 Q. Did the breast cancer patient die?
7 A. No. She was alive at the time of
8 trial.
9 Q. And was your opinion essentially that
10 an earlier diagnosis would probably not have led
11 to a different outcome?
12 A. Yes.
13 Q. You don't remember the name of the
14 law firm?
15 A. No.
16 Q. Do you keep any records of your
17 medical/legal cases?
18 A. Yes.
19 Q. That's something that you would have
20 on your computer?
21 A. Yes.
22 Q. I'm going to request that you provide
23 me with a list of the medical/legal cases that
24 you have been involved in.
25 A. Sure. What kind of information do

Page 36

1 given depositions, have all of those cases been
2 where you have been retained as an expert by a
3 party in litigation?
4 A. Well, one time I was a defendant.
5 Q. Have you been a defendant on more
6 than one occasion?
7 A. No.
8 Q. How long ago was that, ma'am?
9 A. I was a fellow at University
10 Hospitals, so it was in 1987.
11 Q. How did that case wind up?
12 A. This was a famous case, the Moskovitz
13 case.
14 Q. Yes, I recognize the name.
15 A. At the time I was a resident at
16 Mt. Sinai Hospital when the alleged malpractice
17 occurred, and I was a resident involved in the
18 frozen section, but not in the actual
19 interpretation of any of the tissue.
20 So I was named and when it was found
21 out that I had nothing to do with actually
22 interpreting any of the pathology material, my
23 name was dropped in the case.
24 Q. Chuck Kampinski is the one that took
25 your deposition?

Page 37

1 A. Yes.
2 Q. Let's put aside that experience.
3 Other than that experience where you were named,
4 you have been able to avoid the unfortunate
5 experience of being named as a defendant at any
6 other time in your career?
7 A. Well, I don't know if I was able to
8 avoid it, but thank God, I have not been named.
9 Q. Avoiding it or otherwise, you haven't
10 been named?
11 A. No.
12 Q. The other times that you have given
13 deposition testimony, I want to talk about
14 those. They have been in situations where you
15 have been retained as an expert witness; is that
16 true?
17 A. Yes.
18 Q. I take it all of them have had to do
19 with pathology issues?
20 A. Mostly pathology issues. Sometimes
21 it was related to the proximate cause of death.
22 Q. Have you ever testified in deposition
23 in a nonsmall cell lung cancer case?
24 A. I don't remember so.
25 Q. Of the 11 to 14 times, excluding the

Page 39

1 including Mr. Warner, on medical malpractice
2 cases?
3 A. You mean by Reminger & Reminger?
4 Q. Yes.
5 A. Yes.
6 Q. Mr. Warner, how many times has he
7 asked you and you have agreed to serve as an
8 expert on behalf of one of his doctors?
9 A. Four or five times.
10 Q. Would this be the fifth or the sixth
11 or would this be -- would that all be
12 encompassing with the Gill case?
13 A. That's probably additional. But
14 that's not an accurate number.
15 Q. These are your best estimates?
16 A. Yes.
17 Q. So that if we added Gill, your best
18 estimate would be this is now the fifth or sixth
19 time that you have been an expert for
20 Mr. Warner?
21 A. Probably.
22 Q. What about other lawyers at
23 Reminger & Reminger?
24 A. I have reviewed maybe a couple other
25 cases for some other Reminger & Reminger

Page 38

1 one time that you were a defendant, how many of
2 those cases where you were serving as an expert,
3 either on proximate cause of death or dealing
4 with pathology issues, were you testifying at
5 the request of an attorney representing a doctor
6 or a hospital?
7 A. I think all of these cases.
8 Q. So is it fair to say that your
9 testifying experience in terms of depositions,
10 as well as courtroom testimony, has been 100
11 percent at the request of an attorney
12 representing either a doctor or a hospital?
13 A. As far as giving depositions and
14 court testimony, yes.
15 Q. How many cases a year are presented
16 to you, new cases for you to take a look at by
17 an attorney like Mr. Warner or some other
18 lawyer?
19 A. Four to six cases a year.
20 Q. And while we are talking about
21 Mr. Warner, I presume you know that he is with
22 the law firm of Reminger & Reminger; correct?
23 A. Yes.
24 Q. Have you had occasion to serve as an
25 expert at the request of other attorneys,

Page 40

1 lawyers.
2 Q. Do you remember the name of any of
3 the attorneys?
4 A. Mr. Malone is one of them.
5 Q. How many cases have you reviewed for
6 Jim Malone?
7 A. One.
8 Q. Any other lawyers that names come to
9 mind?
10 A. There is a woman lawyer that I can't
11 remember her name.
12 Q. Marilena?
13 A. No. Sue.
14 Q. Sue Seacrist?
15 A. Sue Seacrist, yes.
16 Q. How many cases have you reviewed for
17 Ms. Seacrist?
18 A. One.
19 Q. Any other attorneys that you have
20 worked with at Reminger & Reminger?
21 A. Not that I can remember.
22 Q. Of the five to six cases for
23 Mr. Warner, including the Gill case, how many of
24 them have you given deposition testimony in?
25 A. Three or four, probably. I can't

10 (Pages 37 to 40)

Page 41

1 remember exactly because these depositions
2 always get cancelled and I don't keep a record
3 of which ones exactly went through.
4 Q. Just like the cancellation of
5 Dr. Botham that Mr. Warner's family matter
6 caused today; right?
7 A. Right.
8 Q. None of those cases were nonsmall
9 cell lung cancer cases?
10 A. I don't think so.
11 Q. Were any of them lung cancer cases?
12 A. I don't think so.
13 Q. Of the four to six cases per year
14 that you review, how long has that been the
15 range of cases, new cases that you look at? How
16 many years has that been?
17 A. I think I started about ten years
18 ago, but I only did like maybe one or two cases
19 a year. I was very busy when I was at UH. I
20 already had a very hectic schedule there, so I
21 think there were less cases per year.
22 Overall, and I'm not talking about
23 the depositions, but all cases that I would
24 review, which many times do not go to
25 depositions or testimony, there is probably 25,

Page 42

1 around 25 cases.
2 Q. That you have reviewed over the ten
3 years?
4 A. Yes.
5 Q. So the amount is actually increasing
6 as of the current year; is that correct?
7 A. No, not really. It's been steady for
8 the past few years. For the past three or four
9 years it's been steady.
10 Q. So early on in that ten year spectrum
11 there might have been one case a year?
12 A. Yes.
13 Q. Of the 25 cases that you have
14 reviewed, some of them have gone to deposition;
15 true?
16 A. Yes.
17 Q. We have talked about that.
18 A. Yes.
19 Q. Some of them have gone to trial?
20 A. Yes.
21 Q. Of the total 25 that you have
22 reviewed, tell me how many have been on behalf
23 of an attorney representing the plaintiff as
24 opposed to an attorney representing the defense?
25 A. Maybe four or five plaintiff cases.

Page 43

1 Q. Were any of them in the State of
2 Ohio?
3 A. Yes.
4 Q. Were any of them in the Cleveland
5 area?
6 A. Yes.
7 Q. Did any of those cases that you
8 reviewed in the Cleveland area -- actually I
9 just figured out my own answer but I'll ask it
10 any way -- did any of those lead to deposition
11 testimony?
12 A. I don't remember, so, no.
13 Q. Do you remember the names of any of
14 the plaintiff's lawyers that you reviewed cases
15 for?
16 A. At least two of them were for
17 Nurenberg, Plevin, whatever.
18 Q. I get the gist. Do you remember
19 which lawyer from that firm?
20 A. There were two different ones. Tom
21 Mester and the other guy.
22 Q. Harley Gordon?
23 A. Gordon.
24 (Discussion off the record.)
25 Q. Any other plaintiff's firms that you

Page 44

1 recall other than Nurenberg, Plevin?
2 A. I don't really remember the names of
3 the firms, but as I said, there were probably
4 three other cases that I have reviewed.
5 Q. For plaintiff's attorneys in the
6 Cleveland area?
7 A. Yes.
8 Q. Have you reviewed any cases outside
9 of the Cleveland area?
10 A. Yes. I think some of the cases, or
11 at least one of the cases was in Youngstown.
12 There were a couple of cases in the Akron-Canton
13 area. There was some cases for a law firm in
14 Atlanta, Georgia, but the case was actually
15 tried in Akron-Canton. And one maybe in
16 Columbus that never went to deposition, but just
17 a review.
18 Q. Do you know how your name was
19 obtained by any of those attorneys, like, for
20 example, the Atlanta, Georgia, attorney?
21 A. It's either referrals from lawyers or
22 usually the law firms call University Hospital
23 and ask for a pathologist to review a certain
24 case and my name is given to them.
25 Q. Have you ever been on any type of a

11 (Pages 41 to 44)

Page 45

1 list where your name has been made available as
2 an expert to attorneys?
3 A. No.
4 Q. Have you ever advertised?
5 A. No.
6 Q. I take it you have never had your
7 privileges suspended or revoked or called into
8 question?
9 A. That's correct.
10 Q. In your report, doctor, the last
11 paragraph, it says based upon the above review
12 to a reasonable degree of medical probability, I
13 believe that if it was possible to diagnose
14 Mr. Gill's lung tumor in January or February of
15 2000 -- and then the sentence goes on. I want
16 to stop at that point because that's what I want
17 to focus in on.
18 Do you intend to testify at trial
19 that it was not possible to diagnose Mr. Gill's
20 lung cancer in January or February of 2000?
21 A. No.
22 Q. Do you agree or have a basis to agree
23 that the diagnosis in December of 1999 that was
24 made by Dr. Mansnerus of pneumonia was or was
25 not accurate?

Page 46

1 A. I don't intend to render an opinion
2 on this issue.
3 Q. Thank you. Was there any evidence in
4 January -- strike that.
5 You have enough of a time line in
6 your mind in terms of when Mr. Gill was seen by
7 Dr. Mansnerus to appreciate the temporal
8 relationship of all of what developed; true?
9 A. Yes.
10 Q. Do you know how long Mr. Gill had
11 been a patient of Dr. Mansnerus?
12 A. I can't recall that. I know that the
13 first time that he was seen in relationship to
14 this illness was in December, the beginning of
15 December of 1999.
16 Q. Do you remember how many times he was
17 seen in December?
18 A. Twice. December 9th and 30th.
19 Q. And before those two dates in
20 December, had he been a patient for any extended
21 period of time with Dr. Mansnerus?
22 A. I can't remember.
23 Q. Can you tell me from your review how
24 many times Mr. Gill had been seen by
25 Dr. Mansnerus, if at all, during 1999 prior to

Page 47

1 December 9, 1999?
2 A. No. I think I mentioned I can't
3 remember.
4 MR. WARNER: Note my objection. Do
5 you want her to look at the records? Just from
6 her memory?
7 Q. Doctor, based upon your review in
8 this case, is there any evidence in January or
9 February that Mr. Gill had metastatic lung
10 cancer?
11 A. What kind of evidence?
12 Q. Any evidence that was discovered or
13 revealed from a clinical standpoint or any
14 diagnostic studies that were done that would
15 cause you to be able to say that Mr. Gill had
16 metastatic lung cancer in January or February?
17 A. You mean in retrospect now that we
18 know what we know about Mr. Gill or at the time
19 in January or February of 2000 based on his
20 clinical presentation and his signs and symptoms
21 and x-ray findings?
22 Q. Based upon the latter statement
23 rather than the former statement.
24 A. So in January or February of 2000,
25 basically in December, his presentation was

Page 48

1 respiratory symptoms and numbness in the left
2 arm and neck at the time. Now, in retrospect?
3 Q. No, no. At that time.
4 A. If I was a physician that was seeing
5 the patient, is that what you are asking me? If
6 I was a physician seeing the patient in January
7 or February of 2000 whether I would suspect that
8 he had mets at the time? Is that what you are
9 asking me?
10 Q. You are kind of close, but before you
11 answer it -- and you are doing exactly the right
12 thing. I'm not asking you retrospectively. We
13 may talk about that in a moment based upon the
14 slides that you looked at, which are at the time
15 of the diagnosis, but what I'm asking you is
16 from your review of this case.
17 You have already told me that he
18 appeared twice in December to see Dr. Mansnerus
19 and then we know that there are certain events
20 that went on in the early part of 2000 leading
21 up to his diagnosis.
22 What I'm asking you is from what you
23 have in black and white, medical records,
24 diagnostic studies, examinations, is there any
25 evidence that you have as an expert looking at

12 (Pages 45 to 48)

Page 49

1 the case that causes you to be able to say that
2 in January or February of 2000, that there was
3 evidence clinically that Mr. Gill had metastatic
4 disease or metastatic lung cancer?
5 MR. WARNER: Objection. Asked and
6 answered. You can answer again.
7 A. You are asking me to answer this
8 question based on all the records I have now?
9 Q. Yes.
10 A. Or based on the records that were
11 available in January or February of 2000?
12 Q. The records that were available in
13 January or February of 2000, and December of
14 '99.
15 A. If I am reviewing a case of a patient
16 that presented with respiratory symptoms,
17 basically symptoms of pneumonia and numbness,
18 would I suspect that the patient had -- I mean,
19 obviously there was no definite diagnosis of
20 cancer in Mr. Gill, so it's unlikely that
21 someone would think of metastatic disease if
22 there is no previous diagnosis or known history
23 of cancer in a patient. Any of these symptoms
24 can be related to either primary or metastatic
25 disease.

Page 50

1 Q. So in other words, in order to be
2 able to say definitely that there was evidence
3 that in January or February he had metastatic
4 disease, you wouldn't have needed to see
5 diagnostic studies to be able to say that the
6 patient had metastatic disease in January or
7 February; true?
8 MR. WARNER: Objection. Go ahead.
9 A. Before someone concludes, before a
10 physician concludes that a patient has
11 metastatic disease, obviously we need more than
12 the patient's signs and symptoms that he
13 presents with. Or you know, even though there
14 was a chest x-ray that was done in December
15 1999, that was read as an infiltrate and
16 according to the report was not suggestive of
17 cancer, at that time I had no reason to suspect
18 that Mr. Gill had metastatic disease at that
19 time.
20 Q. Okay.
21 A. But my opinion can change, of course,
22 with additional diagnostic studies and data.
23 Q. Which at that time were not done;
24 correct?
25 A. They were not available. You are

Page 51

1 asking me as to me reviewing records of Mr. Gill
2 in January and February, they were not available
3 to me at that time.
4 Q. And additional studies were not done
5 in January or February to rule out or confirm
6 the existence of metastatic lung cancer; true?
7 MR. WARNER: Objection. Go ahead.
8 A. I don't know which ones you are
9 referring to, but a chest x-ray can be taken or
10 can be ordered for that purpose.
11 Q. Is a chest x-ray usually used as
12 diagnostic of lung cancer?
13 MR. WARNER: Objection.
14 A. A chest x-ray can review evidence of
15 lung cancer.
16 Q. Even though you are not an oncologist
17 and you have indicated what your specialty is,
18 do doctors typically treat a patient for lung
19 cancer solely based upon the presentation on a
20 chest x-ray?
21 MR. WARNER: Objection.
22 A. Not usually, but the chest x-ray is
23 kind of the first test that is the least
24 invasive test that is done, and depending on the
25 findings, it may lead to further tests.

Page 52

1 If you are asking about the gold
2 standard, obviously it's the pathology
3 examination of tissue or cells to document the
4 nature of the tumor or the mass or lesion, if
5 found on chest x-ray.
6 Q. There was no biopsy or pathology
7 obtained in January or February to define the
8 status of any tumor that Mr. Gill had at that
9 time; true?
10 A. That's true.
11 Q. Any evidence from your review of the
12 records, from clinical exam or description by
13 any of the doctors that Mr. Gill had any nodal
14 involvement in January or February of 2000?
15 A. I can't remember specifically any of
16 the doctors' comments in the records, but I
17 think at the time of presentation in December,
18 the beginning of December, the patient did have
19 numbness in the arm and neck and these can be
20 signs of lymph node involvement at the time.
21 Q. Does Dr. Mansnerus in the description
22 that he has in the records, does he give any
23 indication from what you can see, either from
24 his deposition or from his records, that the
25 findings in early November in the neck were

13 (Pages 49 to 52)

Page 53

1 suggestive of nodal involvement?
2 MR. WARNER: Note my objection. Go
3 ahead.
4 A. Now, you are asking me about what
5 Dr. Mansnerus, what he thought or what he
6 commented on at the time that he saw the patient
7 on December 9th; is that correct?
8 Q. Correct.
9 A. I don't think there was mention of
10 metastatic disease in his notes of December or
11 early December when he saw Mr. Gill. I don't
12 think there was mention of metastatic disease.
13 The main differential diagnosis was pneumonia
14 versus bronchitis or influenza.
15 Q. And your testimony is that this was
16 at the beginning of the month or the end of the
17 month?
18 A. I think this was at the beginning, if
19 I recall correctly, the beginning -- I think
20 December 9th, the first time he saw him in
21 relationship to this illness.
22 MR. WARNER: Note my objection. You
23 are allowed to look at records, but go ahead, he
24 wants you to do it from memory.
25 MR. MISHKIND: No, I don't.

Page 54

1 Q. You are more than welcome to look at
2 any records that you want to, doctor.
3 A. Well, let me verify then what I just
4 stated.
5 Q. Sure.
6 A. There is no mention in the December
7 9th, 1999 notes of Dr. Mansnerus, there is no
8 mention of metastatic disease or nodal disease
9 at that time.
10 Q. December 9th?
11 A. December 9th.
12 Q. And would the same apply in terms of
13 any reference to or evidence of nodal
14 involvement at the end of December when
15 Dr. Mansnerus saw him, as well?
16 A. I don't see evidence of mention of
17 nodal disease on December 30th, 1999.
18 Q. In January when he returned, the
19 early part of January, do you know from your
20 review in this case why it was that Mr. Gill
21 returned only a week after having had the
22 diagnosis of pneumonia?
23 A. You are asking me why did Mr. Gill
24 return to Dr. Mansnerus in January of 2000?
25 Q. That's what I am asking. Right.

Page 55

1 A. I guess it was, the main cause is
2 lingering cough. I am referring to the notes
3 from January of 2000, January 6th.
4 Q. Do you know whether this was a
5 scheduled follow up or whether the patient
6 returned for some other reason on January 6th?
7 A. I don't know. It's not obvious here
8 whether it was scheduled or whether he just
9 returned, the patient returned because he wanted
10 to see the doctor again.
11 Q. On that January 6th visit, doctor, is
12 there any evidence of nodal involvement that
13 Dr. Mansnerus describes?
14 A. No, there is no mention of nodal
15 involvement.
16 Q. Any evidence in January, any evidence
17 suggestive of a metastatic disease in January
18 when Dr. Mansnerus saw the patient?
19 MR. WARNER: Objection.
20 A. I'm sorry, repeat it.
21 Q. Any evidence when Dr. Mansnerus saw
22 him in January of any metastatic disease?
23 MR. WARNER: Same objection.
24 A. To Dr. Mansnerus or to me?
25 Q. To Dr. Mansnerus.

Page 56

1 A. It's not obvious from his records
2 that he saw any signs of metastatic disease.
3 Q. As I understand it, in looking at
4 lung cancer, that the size of the tumor at the
5 time of diagnosis is of some significance;
6 correct?
7 A. Yes.
8 Q. And correct me if I am wrong, but a
9 tumor that is less than three centimeters is
10 considered to be a T1; is that correct?
11 A. Well, that's not the only criteria
12 for a T1 tumor.
13 Q. What else?
14 A. A tumor of any size that has invaded
15 adjacent structures, the associated pneumonitis,
16 and there are several other features, then the
17 tumor can be classified as T4.
18 Q. Generally speaking -- and you are
19 familiar, are you not, with the AJCC Cancer
20 Staging Handbook?
21 A. Yes.
22 Q. And I am holding this up. Let's see,
23 what edition is this one?
24 The one that I have is the 5th
25 edition. But this is considered to be a

14 (Pages 53 to 56)

Page 57

1 generally accepted or reliable source in the
2 area of cancer staging, is it not?
3 MR. WARNER: Objection.
4 A. The AJCC Cancer Staging manual is a
5 reliable source for clinicians to stage lung
6 cancer, but I don't know about the 5th edition,
7 because we have upgraded more than a year ago to
8 the 6th edition and I can't really remember the
9 exact differences in the lung.

10 There are some organs where there are
11 major differences, but I can't remember the
12 lung.

13 Q. So what I would have to do is compare
14 the 5th and the 6th edition as it relates to
15 lung to see whether there have been any changes
16 in the cancer staging; correct?

17 A. Right.

18 Q. But generally speaking, subject to,
19 perhaps, some changes in the 6th edition -- and
20 in fact, if we were looking at the 6th edition,
21 it's a generally reliable source of information
22 when it comes to staging of lung cancer; true?

23 A. Well, let me put it this way. It is
24 the protocol that we use to pathologically stage
25 lung cancer.

Page 59

1 And I can't remember the specifics,
2 because we have a list and I usually refer to it
3 every time I do staging of lung cancer.

4 Q. You have sort of a cheat sheet that
5 you have right in front of you?

6 A. It's not a cheat sheet, but it's
7 actually for completeness so we remember all the
8 details.

9 Q. Is it fair to say that when the tumor
10 gets to be above three centimeters, regardless
11 of whether or not there is atelectasis or
12 whether or not there is any spread, just in and
13 of itself, a tumor greater than three
14 centimeters is at the very least a T2?

15 A. Yes.

16 Q. And if a tumor is less than three
17 centimeters and there is no atelectasis, there
18 is no spread of the tumor, and there is no nodal
19 involvement, generally speaking, that would be a
20 T1-NO; correct?

21 A. If all the lymph nodes are negative
22 pathologically and clinically, obviously, and if
23 the tumor is less than three centimeters and
24 none of the other criteria as stated in the AJCC
25 manual that upstages a tumor, then it would be a

Page 58

1 Q. You can't ask for anything more than
2 that.

3 In terms of cancer staging, when one
4 refers to a T1 lung cancer, generally speaking,
5 that's a tumor that's less than three
6 centimeters; correct?

7 A. As I mentioned before, not
8 necessarily. Because it depends on the other
9 features or criteria. If it's a tumor that is
10 less than three centimeters, but it's invading
11 the mediastinum or invading the pleura or chest
12 wall, then it's a T4 lesion, regardless.

13 Q. You are absolutely correct. Absent
14 any invasion or extending into the pleura or
15 into the chest wall, or any of the hilar regions
16 or anything of that nature, just a tumor less
17 than three centimeters that does not go outside
18 of the lung, that generally is considered to be
19 T1; correct?

20 A. I think there are other criteria,
21 which is the presence of atelectasis, the
22 presence of obstructive pneumonitis, the
23 presence of pleura effusions that can upgrade
24 the T stage of the tumor, again, regardless of
25 the size.

Page 60

1 T1 tumor.

2 Q. Are you qualified as a pathologist to
3 testify as to what the prognosis is for a
4 patient diagnosed with nonsmall cell lung cancer
5 that's diagnosed at a Stage 1, being a tumor
6 less than three centimeters and no spread, no
7 atelectasis, nothing outside of what you would
8 expect for less than three centimeters, no nodal
9 involvement, and no other evidence of
10 metastasis, clearly by definition a Stage 1, are
11 you qualified to provide an opinion as to what
12 the prognosis is for survival of a Stage 1
13 nonsmall cell lung cancer?

14 A. Regardless of the treatment or with
15 the treatment?

16 Q. Well, good question. With the
17 treatment.

18 A. I usually refer -- again, this is
19 some data in the AJCC manual that refers to the
20 prognosis of the different stages of breast
21 cancer -- I'm sorry, of lung cancer.

22 Q. I knew what you meant.

23 A. But, of course, the literature is
24 full of studies of different subsets and
25 different treatment protocols that can influence

15 (Pages 57 to 60)

Page 61

1 that. So is there any one single person or
2 medical expert that is qualified to comment on
3 these prognoses and the five-year survival, I
4 think all medical specialists that are involved
5 in assessing lung cancers are qualified to some
6 extent in rendering their opinion.
7 Q. And you certainly consider reliable
8 the cancer staging information, the AJCC Cancer
9 Staging information in terms of treatment and
10 prognosis for a Stage 1 nonsmall cell lung
11 cancer; true?
12 A. Well, really there is no treatment
13 recommendations or guidelines in the AJCC
14 manual. And the part that is nice about their
15 survival data is it's usually their large
16 studies. But after a couple of years, a few
17 years, they become kind of old and we have to
18 consider newer data.
19 Q. What is your opinion as to the likely
20 five-year survival for a nonsmall cell lung
21 cancer patient diagnosed in a Stage 1 clinically
22 and pathologically that receives the appropriate
23 regimen of treatment?
24 A. Well, again, it varies, depending on
25 if it's only surgical excision, whether the

Page 63

1 statistics in terms of all comers in Stage 1
2 nonsmall cell lung cancer, that statistically
3 the five-year survival is in the 60 to 80
4 percent range, would you quarrel with that
5 statistic?
6 MR. WARNER: Objection.
7 A. No.
8 Q. And in fact, is that generally your
9 understanding in terms of all comers in Stage 1;
10 that it's generally for five-year survival 60 to
11 80 percent?
12 A. Well, as I said, there are a lot of
13 other factors, so I don't really want to give an
14 exact percentage unless we are talking about a
15 specific group of patients and specific
16 histology and specific type of treatment.
17 Q. You have seen that statistic, though,
18 in terms of Stage 1 nonsmall cell lung cancer,
19 the survival rate has been reported in certain
20 studies to be in the 60 to 80 percent range;
21 correct?
22 A. I think I probably have seen it. I
23 don't recall specifically, but probably I have.
24 Q. Are there any resources, doctor, that
25 you believe to be reasonably reliable or

Page 62

1 tumor was excised entirely, and whether the
2 patient had any chemotherapy.
3 There are other factors, intrinsic
4 factors to the tumor itself, which includes the
5 exact type of the tumor and the grade of the
6 tumor, whether it's a low grade or a high grade
7 histologically, that can influence the
8 prognosis. But the prognosis of Stage 1 lung
9 cancers, in general, is better than prognosis of
10 the higher stages.
11 Q. Sure. And in fact, in the Stage 1,
12 there is sort of a range in terms of prognostic
13 factors, are there not? It's not just X percent
14 of patients survive five years; correct?
15 A. Exactly. So that means that there
16 are certain patients -- if you take 100 patients
17 with Stage 1 nonsmall cell lung cancer, out of
18 these 100, some of them are going to survive
19 five years or longer and some of them are going
20 to die, even though they are the same pathologic
21 and clinical stage. Some of them are going to
22 die for reasons that we may know, some of them
23 we may not know, or we may not know all of them.
24 Q. What I want to do is just understand
25 your knowledge. If I said to you that the

Page 64

1 authoritative that support any of the opinions
2 that you hold in this case?
3 A. I don't consider any one source of
4 medical information as authoritative. I look at
5 everything critically and there are some papers
6 and articles published by very famous physicians
7 that have a lot of deficiencies, so I look at
8 every article or every data critically and try
9 to get the best out of each one of them.
10 Q. Did you do any medical research at
11 all in preparation for this case?
12 A. Not specifically for this case, but I
13 have my collection of medical literature, and
14 every now and then I go back and look at certain
15 issues when it comes to, when it concerns one of
16 our patients.
17 Q. What I want to understand is when you
18 take the stand, not in November, but the end of
19 April, in this case, do you intend to testify
20 that a certain journal article or a section of a
21 certain journal article as it relates to
22 nonsmall cell lung cancer, staging and
23 prognosis, is, in your opinion, to be generally
24 reliable or authoritative?
25 A. I don't think I am going to quote a

16 (Pages 61 to 64)

Page 65

1 specific journal as being authoritative.
2 Q. Or a section of a particular journal?
3 A. I don't think so.
4 Q. Okay.
5 A. I may refer to a certain article, you
6 know, if something comes up or I come across it
7 from now until then, but I don't have anything
8 in mind now that I can tell you.
9 Q. Well, that's a fair statement. And
10 certainly if there is something that you deem to
11 be authoritative or generally reliable that you
12 plan on from an evidentiary standpoint, and more
13 for the lawyers to deal with than the doctors,
14 but if you find something you plan on
15 acknowledging as being generally reliable or
16 authoritative, the purpose of my deposition
17 today is to find out what knowledge you have on
18 the case that we thought was going to trial in
19 two weeks. If you develop some thought process
20 on something that's reliable, I certainly will
21 note my objection to anything beyond today's
22 deposition, but I would at the very least ask
23 that you notify Mr. Warner so that I would have
24 an opportunity potentially as necessary to
25 reconvene the deposition or to file the

Page 67

1 less than that.
2 Q. How about Dr. Rozman?
3 A. I don't know Dr. Rozman.
4 Q. Dr. Botham?
5 A. I know Dr. Botham.
6 Q. How do you know Dr. Botham?
7 A. He is one of the cardiovascular
8 surgeons here at Parma Hospital.
9 Q. How often do you interact with
10 Dr. Botham?
11 A. Very little. He works mostly at
12 Hillcrest Hospital.
13 Q. How long have you known Dr. Botham?
14 A. Since I started working here at Parma
15 Hospital three years ago.
16 Q. Have you ever talked with Dr. Botham,
17 Dr. Levitan about this case?
18 A. No.
19 Q. Do you know Dr. Steele,
20 Dr. Sutherland or Dr. Bass?
21 A. No.
22 Q. One of the most important questions
23 that I forgot to ask you early on is how much
24 are you charging me for this deposition today?
25 A. \$400 an hour.

Page 66

1 appropriate motion with the court. Okay?
2 A. Okay. I will.
3 Q. Thank you. By the way, do you know
4 Dr. Mansnerus?
5 A. No.
6 Q. There are several other experts in
7 this case. Dr. Levitan. Do you know Dr.
8 Levitan?
9 A. Yes.
10 Q. How do you know him?
11 A. I knew him from when I was working at
12 University Hospitals.
13 Q. Was it just sort of a passing
14 familiarity with him or did you have occasion --
15 A. It was a professional relationship.
16 We talked about cases, cancer patients that he
17 is involved with that I have been involved with.
18 Q. Is it fair to say that you had fairly
19 regular contact with Dr. Levitan when you were
20 at UH?
21 A. I don't know what regular means.
22 Q. Either do I. Was it more than once a
23 week that you had contact with him?
24 A. No. It was less than that. Probably
25 more like once every one or two months or even

Page 68

1 Q. How much do you charge per hour for
2 reviewing of records and slides?
3 A. \$300 an hour for reviews.
4 Q. How much do you charge to testify at
5 trial?
6 A. \$400 an hour.
7 Q. Do you know how many hours you have
8 put in on this case thus far?
9 A. I can't remember. I have not
10 reviewed the bills or the statements, but it's
11 probably not more than four or five hours.
12 That's a guesstimate.
13 Q. You have your report in front of you.
14 Other than there being the omission of the date
15 on the report, are there any other corrections
16 or modifications that you feel need to be made
17 to that report to make it entirely accurate?
18 A. I don't think so.
19 Q. And does that report contain all of
20 the opinions that you hold in this case?
21 A. Yes.
22 Q. Doctor, can we agree that it's always
23 best to diagnose lung cancer as early as
24 possible?
25 MR. WARNER: Objection.

17 (Pages 65 to 68)

Page 69

1 A. As a general statement, it's good to
2 identify any cancer at an early stage,
3 preferably at the noninvasive stage, if
4 possible.
5 Q. And noninvasive would be where there
6 isn't any evidence of clinically significant
7 metastasis?
8 A. No. Invasion refers to, in a field
9 of tumors, usually they start at the stage that
10 we call in situ. For squamous cell carcinomas
11 they start within the epithelium linings, the
12 airways or skin or other parts of the body. The
13 in situ stage they are limited to that
14 epithelium.
15 When they invade beyond the
16 epithelium into the surrounding tissue and
17 stoma, then that's the stage when they become
18 potentially, when they potentially have the
19 ability to spread and metastasize. Before that
20 they do not.
21 So before that, it's basically
22 curable if you can diagnose a tumor at that
23 stage.
24 Q. So at the point where it hasn't
25 invaded the epithelium --

Page 71

1 there are some factors that we don't know yet.
2 Q. How many cells does it take once the
3 tumor gets beyond the epithelium to create a
4 metastatic phenomenon?
5 A. Well, I don't think anyone knows how
6 many cells it takes. And it's really not a
7 function of the number of cells, it's rather a
8 function of the type of cells and their biologic
9 behavior and their biologic differences that
10 contributes more to their ability to
11 metastasize, rather than the actual number of
12 cells or the size of the mass of the cells or
13 the mass of the tumor.
14 Q. Are most patients that are diagnosed
15 with nonsmall cell lung cancer at a Stage 1
16 surgical candidates?
17 MR. WARNER: Objection.
18 A. I don't know the exact percentages of
19 these patients that are surgical candidates.
20 Q. Do you know whether there is a
21 greater than 50 percent phenomenon where
22 patients that are diagnosed at Stage 1 are
23 surgical candidates, assuming there aren't any
24 other comorbidities, that affect the ability to
25 operate?

Page 70

1 A. Beyond the epithelium. The
2 epithelium is the lining, so that's where the
3 tumor usually starts.
4 Q. Originates?
5 A. Yes, either in the squamous
6 epithelium or the glandular epithelium. But
7 once it invades beyond the epithelium to the
8 stoma surrounding the tumor where usually the
9 lymphatics and the blood vessels are located,
10 that's when the tumor has the potential to
11 spread beyond that location and metastasize.
12 Q. Do all nonsmall cell cancers that
13 invade beyond the epithelium metastasize?
14 A. Not necessarily, but they do have the
15 potential to metastasize.
16 Q. How do we know which ones will from
17 an epidemiological standpoint metastasize and
18 which ones will not metastasize, or don't we
19 know?
20 A. Well, that's the million dollar
21 question.
22 Q. Okay.
23 A. There are some factors that we do
24 know contribute to faster and earlier spread of
25 the tumor of the nonsmall cell lung cancers and

Page 72

1 A. Well, in general, the earlier the
2 stage of the tumor, the more likely that it
3 would be clinically resectable.
4 Q. Assuming Mr. Gill's cancer had been
5 diagnosed at a stage where it was Stage 1 and he
6 was clinically resectable, hypothetically,
7 because of what you see by way of the molecular
8 structure and what you see on the slides, would
9 he have required chemotherapy and radiation as
10 an adjunctive therapy to surgery?
11 A. I think I would leave that question
12 to the medical oncologists.
13 Q. Fair enough.
14 A. That's what they do for a living.
15 Q. Fair enough. I just want to find out
16 what the limitations are of your knowledge.
17 When Mr. Gill was diagnosed, what
18 stage was he?
19 A. Stage 4.
20 Q. And what is it that we see in this
21 case that constitutes sufficient clinical or
22 pathological evidence to say that he was Stage 4
23 when he was diagnosed?
24 A. He had metastatic disease into the
25 bones and into the mediastinum, neck and

18 (Pages 69 to 72)

Page 73

1 contralateral, I think contralateral mediastinum
2 or hilar nodes and multiple nodules on the same
3 side.

4 Q. I was trying to mark down. He had
5 metastatic disease of the bone, the mediastinum,
6 the hilar nodes and --

7 A. The neck and contralateral hilar
8 nodes and multiple nodules on the same side of
9 the tumor.

10 Q. And at the time that he was
11 diagnosed, what was the size of the tumor, the
12 primary tumor?

13 A. According to CT report?

14 Q. Yes.

15 A. I think it was described as four
16 times 4.5 centimeters.

17 Q. Are you able to tell me to a
18 reasonable degree of medical probability what
19 the size of the tumor was back in January or
20 February?

21 A. I think so..

22 Q. On what basis?

23 A. Based on the knowledge that we know
24 about the tumor growth and the tumor doubling
25 time that is usually done in a more experimental

Page 75

1 treatment, it's very important to identify the
2 cell type so that the best treatment can be
3 given?

4 A. Yes. Not only for treatment
5 purposes, but for prognostic purposes, as well.

6 Q. In terms of nonsmall cell lung
7 cancer, what percentage does that make up of all
8 lung cancer cases?

9 A. I think it's more than the nonsmall
10 cell lung cancer, in general. I would say
11 one-third is nonsmall cell and then if you lump
12 all the non-small cells together, it's
13 two-thirds or more, maybe.

14 Q. Where does squamous cell, the
15 squamous cell -- strike that.

16 I can just refer to nonsmall cell
17 rather than elongating my sentence.

18 A. Okay.

19 Q. In terms of the origination of
20 squamous cell when you are dealing with lung
21 cancer, where is the most common site where it
22 originates?

23 A. Usually it's central or closer to the
24 larger bronchi, and the cell of origin is
25 thought to be metaplastic squamous epithelium

Page 74

1 in vitro type of environment, as well as some of
2 the clinical studies that have been performed
3 following patients with lung tumors over several
4 month intervals.

5 Q. I think you told me earlier that he
6 had different types of, different cell types in
7 his nonsmall cell; correct?

8 A. Different types of differentiation
9 within the same tumor.

10 Q. The squamous cell, the
11 adenocarcinoma, and then they were poorly
12 differentiated. Is that an accurate statement?

13 A. Yes.

14 Q. The progression rate for squamous
15 cell carcinoma, can you tell me about that?

16 First, when I use the term
17 progression rate, is that a medical term?

18 A. No.

19 Q. It isn't?

20 A. No. Well, it's a vague term. I
21 don't know what you really are referring to by
22 using that term.

23 Q. Would you agree with this statement?
24 Because of the different types of lung cancers
25 and different ways that they may respond to

Page 76

1 from the lining epithelium of the bronchi, which
2 are the airways that bring the air into the
3 lungs.

4 Q. When you are dealing with squamous
5 cell carcinoma, does it stay within the large
6 bronchi or in that area frequently for extended
7 periods of time without spreading?

8 A. You mean at the in situ stage, the
9 noninvasive stage?

10 Q. Yes.

11 A. We don't really know much about the
12 in situ stage, how long it stays there because
13 it's frequently not diagnosed because it's
14 asymptomatic.

15 We frequently see the in situ stage
16 in connection with the invasive tumor of the
17 periphery or some of the other bronchi adjacent
18 to the tumor. So the answer to your question is
19 that we do not know how long it stays as a
20 noninvasive stage, but probably for years.

21 Q. Would you agree that with squamous
22 cell cancers that usually start in the large
23 bronchi, that without spreading outside of that
24 area, that typically they stay for longer
25 periods than other types of lung cancers?

19 (Pages 73 to 76)

Page 77

1 MR. WARNER: Objection.
2 A. What do you mean they stay for a long
3 period?
4 Q. Without spreading.
5 A. Without spreading, without
6 metastasizing outside?
7 Q. Yes.
8 A. Well, first of all, even though most
9 nonsmall cell lung, or most squamous cell
10 carcinomas, not all nonsmall cell cancers, but
11 most squamous cell carcinomas arise proximal in
12 the major tracheobronchial tree branches. There
13 is certainly a category of peripheral squamous
14 cell carcinoma that arises peripheral in the
15 lung. It's a well documented entity.
16 Second of all is that it depends on
17 the degree of differentiation of the squamous
18 cell carcinoma. The well differentiated ones
19 usually grow slower, invade mostly into the
20 lumen of the tracheobronchial tree and causes
21 obstruction and obstructive pneumonia and
22 atelectasis, and by the time they are
23 discovered, they are usually large tumors.
24 However, the poorly differentiated
25 squamous cell carcinomas, when they are

Page 78

1 discovered, they can also be large tumors, but
2 they may be peripheral, as well, the poorly
3 differentiated squamous cell carcinomas.
4 They can, depending on their biologic
5 potential, they may be associated at the time of
6 diagnosis, they may already have metastasized to
7 either the local lymph nodes or to distant
8 sites.
9 Q. In this case, do you have an opinion
10 as to where this squamous cell carcinoma
11 originated?
12 A. You mean which of the bronchial tree?
13 Q. Yes.
14 A. Not without referring to the CT scan.
15 And I don't think -- even the CT scan does not
16 have, most of the time cannot tell exactly where
17 the tumor started.
18 In this case, the tumor is not a pure
19 squamous cell carcinoma; in fact, an
20 adenosquamous or a tumor with both squamous and
21 glandular differentiation, and many times these
22 tumors arise more peripheral than the pure
23 squamous cell carcinomas. But they do usually
24 arise from the lining of either the
25 tracheobronchial tree or the more distal

Page 79

1 alveolar spaces.
2 Q. Can you say in this case, given the
3 cell structure that we have and the combination
4 of the squamous cell, as well as the
5 adenocarcinoma, where the cancer originated in
6 Dan Gill's case?
7 A. As I said, it most likely originated
8 from the lining of either the tracheobronchial
9 tree or the more distal airways. But exactly to
10 pinpoint where it started, the exact point, I
11 don't think I can do that.
12 Q. Can you tell me to a probability when
13 his adenosquamous cell carcinoma metastasized?
14 A. His tumor was a high grade tumor,
15 which means that it's biologically a more
16 aggressive tumor. These tumors usually
17 metastasize earlier in the course of the disease
18 than the lower grade tumors, which are the well
19 differentiated nonsmall cell carcinomas.
20 When did this tumor exactly
21 metastasize, I can't tell you an exact date that
22 this tumor metastasized.
23 MR. WARNER: Doctor, are you done
24 with the answer?
25 A. Well, I have an opinion as to the

Page 80

1 approximate time period as to when, you know, a
2 general range of time where the tumor probably
3 metastasized.
4 Q. Before you give me that answer, tell
5 me what you're basing that statement on as to
6 the general range as to when it metastasized in
7 Mr. Gill?
8 A. On two factors, mostly, which is --
9 well, make it three factors: The size of the
10 tumor at the time of diagnosis in August 2000.
11 The histologic grade, which is a high grade.
12 These tumors usually metastasize earlier. And
13 the clinical information at the time of
14 presentation in December where the patient,
15 Mr. Gill, presented with numbness in the left
16 arm and the neck, and these are in retrospect.
17 Now, you asked me before if I had
18 seen the patient or assessed or reviewed the
19 case in January of 2000, whether I would think
20 that the patient had mets, and I said no,
21 because the patient did not have cancer. Now
22 that I know that Mr. Gill has had cancer and I
23 know the features of his lung cancer, now I can
24 say that he probably did have mets at the time
25 of presentation and probably a long time before

20 (Pages 77 to 80)

Page 81

1 that.
2 Q. Let me ask you a couple questions
3 about that. First, as of December, it's your
4 opinion that on December 9th and December 30th
5 that when he was seen by Dr. Mansnerus, knowing
6 everything that you know -- and I think you used
7 the term retrospectively -- what you are saying
8 to me is that Mr. Gill had cancer when he was
9 seen by the doctor on those two occasions;
10 correct?
11 A. I'm sorry, say it again.
12 Q. Sure. Based upon everything that you
13 know looking at this case, and then
14 retrospectively going back to the symptoms that
15 he had in December, it's your opinion that most
16 likely Mr. Gill had metastatic lung cancer in
17 December of 1999; true?
18 A. That's correct.
19 Q. Are you able to tell me at what stage
20 the metastasis existed in December of 1999?
21 A. You mean where exactly it was, the
22 metastasis?
23 Q. Yes.
24 A. It was probably in the neck and
25 probably in the mediastinum, from the symptoms.

Page 82

1 Q. No bone involvement from the
2 symptoms; correct?
3 A. Not that I can tell from the medical
4 records. That doesn't exclude that he did not
5 have bone mets at the time, but according to the
6 medical records, I can't say that he had bone
7 mets at the time.
8 Q. Can you tell me based upon your
9 expertise in this area what size the tumor was
10 back in December of 1999?
11 A. It was probably a few millimeters
12 smaller than it was at the time of diagnosis in
13 August.
14 Q. And what do you base that on?
15 A. Based on my experience and the
16 knowledge that we know about lung cancers and
17 their growth rates.
18 Q. You have seen a lot of articles on
19 doubling times in lung cancer; correct?
20 A. Yes.
21 Q. And you have also seen that there is
22 a lot of debate, even amongst oncologists or
23 pathologists in terms of the efficacy or the
24 appropriateness of using doubling times;
25 correct?

Page 83

1 A. Yes.
2 Q. Where do you fall in that spectrum?
3 MR. WARNER: Objection. Go ahead.
4 A. Well, there is a lot of controversy,
5 because doubling time -- well, first of all, I
6 like to refer to it as doubling volume because
7 it's really the time that it takes the tumor to
8 double the volume of the tumor.
9 But these usually refer to the tumors
10 in the ideal situations where the tumor has
11 grown in vitro in a culture type of environment,
12 provided all the nutrients of all the ideal
13 conditions and not taking into account the tumor
14 necrosis that sometimes exceeds the rate of
15 tumor growth, not taking into account the
16 intrinsic factors such as the blood supply and
17 other factors that we do not know about that
18 contributes to the tumor growth, not taking into
19 account the host response or immunologic system
20 that sometimes can arrest tumor cells, also not
21 taking into account changes in the growth rate
22 of the tumor, we are assuming that it's --
23 Q. Exponential?
24 A. -- exponential, but it's not
25 necessarily that.

Page 84

1 So therefore, you know, with all of
2 these pitfalls and the tumor doubling time or
3 tumor doubling volume time, it is only a general
4 guideline. And what it tells us is that it
5 really takes a very, very long time for tumors
6 to divide in the ideal situations until they
7 double and until they become actually visible on
8 x-ray or clinically on some other sites, by
9 palpation and so forth.
10 But it does correlate, however, with
11 our observations, our clinical observations on
12 many patients that for one reason or another
13 have an abnormal x-ray or an abnormal clinical
14 result, a mass in the case of tumors, such as
15 lung or nodes and things like that, that takes a
16 very, very long time to change and grow in size
17 from the base of the radiologic examinations and
18 serial radiologic examinations.
19 Q. You mentioned that this was a high
20 grade tumor?
21 A. Yes.
22 Q. High grade tumors of this type, in
23 your experience, and based upon your knowledge
24 and training, metastasize early in the disease
25 or earlier in the disease than lower grade?

21 (Pages 81 to 84)

<p>Page 85</p> <p>1 A. Usually, yes. 2 Q. Can you state in this case, based 3 upon your review of the pathology slides, that 4 Mr. Gill's tumor did metastasize early in the 5 disease? 6 A. I cannot only based on the histologic 7 rate of the tumor that it's a high grade, but as 8 I mentioned based on the size as well as the 9 grade as well as the clinical signs and symptoms 10 that he presented with, I have an opinion that 11 it's very likely and it's probable that the 12 patient, that Mr. Gill had metastasis at the 13 time of presentation, and as I said, probably a 14 long time before that. 15 Q. Okay. 16 A. Whether you are asking me early in 17 the disease, I don't know what early in the 18 disease means. 19 Q. I pretty much understand that you are 20 saying that as of December your opinion in this 21 case and what you intend to testify to at trial 22 is that he had metastatic lung cancer in 23 December when he was seen by Dr. Mansnerus; 24 true? 25 A. Yes, most likely.</p>	<p>Page 87</p> <p>1 cancer, lung cancer -- that was the primary 2 tumor; correct? 3 A. Yes. 4 Q. That he had lung cancer going back to 5 either 1995 or 1997, roughly speaking? 6 A. Yes. 7 Q. And when along that spectrum, if we 8 take 1995 to 1997, given the tumor type that he 9 had, when in your opinion did this high grade 10 tumor first metastasize? At what interval from 11 '95 up to 2000? 12 A. I don't really know exactly when. I 13 can't tell, but again, from the clinical signs 14 and symptoms, when he presented with the neck, 15 the symptoms in the neck and the left arm, he 16 probably had the met at that time. How long 17 it's been there, I don't know. I can't tell. 18 Q. You would just be speculating to give 19 me an opinion as to how long before December he 20 had had metastatic disease; is that a fair 21 statement? 22 A. Yes. 23 Q. Don't squamous cell carcinomas 24 normally spread late as opposed to early? 25 A. It depends on a lot of factors.</p>
<p>Page 86</p> <p>1 Q. And do you intend to testify that 2 most likely it was Stage 4 metastatic lung 3 cancer or are you not of that opinion as of 4 December? 5 A. Yes, I think it was Stage 4 at that 6 time. 7 Q. When did he first develop the lung 8 cancer? How many years before, given everything 9 that you know, looking at the slides, knowing 10 what stage he was at when he was diagnosed? 11 A. Probably a few years, but I can't 12 really specify it any further than that. 13 Q. All right. One person's few may be 14 another person's not so few, so I am going to 15 press you just a little bit as best I can. 16 When you say few, are you talking two 17 or three or are you talking five or six? Give 18 me your best estimate. 19 A. The way I use few is three to five. 20 Q. And in the spectrum of the three to 21 five years before, is it three to five years 22 before 1999 that he developed the cancer? 23 A. Before the diagnosis of the cancer in 24 August of 2000. 25 Q. So it's your opinion that he had</p>	<p>Page 88</p> <p>1 Q. What is it about -- 2 A. If you are asking -- 3 Q. Go ahead. 4 A. -- If squamous cell carcinomas 5 metastasize later in the stage of the disease 6 than small cell cancers, the answer is yes. If 7 you are asking whether there is a difference 8 between the spread rate of squamous cell 9 carcinomas versus adenocarcinomas, not that 10 significant a difference. 11 If you are asking in general, 12 squamous cell carcinomas anywhere in the body 13 versus lungs, then actually that depends on 14 their differentiation, the degree of 15 differentiation. 16 Q. What I'm talking about is in lung 17 cancer cases, squamous cell lung cancer patients 18 that also have adenocarcinoma components and are 19 poorly differentiated -- because I don't want to 20 exclude any of the variables that we have in 21 this case -- are you aware of medical literature 22 that indicates that the spread of that type of 23 lung cancer is usually late as opposed to early 24 in the life span of the cancer? 25 A. As opposed to what other tumors? Are</p>

Page 89

1 we comparing the squamous cell carcinoma, the
2 high grade with what type of tumor?

3 Q. With small cell.

4 A. Yes, I answered that. Small cell
5 cancers spread earlier in the course of the
6 disease than squamous cell carcinomas. Usually,
7 many times they actually present with metastatic
8 disease in other organs.

9 Q. So that if you had to develop a lung
10 cancer, statistically, all things being equal,
11 you have a better chance of survival if you have
12 a nonsmall cell as opposed to a small cell
13 carcinoma; true?

14 MR. WARNER: Objection.

15 A. Well, there are a lot of other
16 variables. The most important is really the
17 stage of the disease and the responsiveness to
18 whether there is available chemotherapy for
19 small cell cancer. Sometimes they disappear
20 with chemotherapy, so there are lots of
21 variables.

22 Q. Does adenocarcinoma, nonsmall cell
23 adenocarcinoma spread quicker and earlier than
24 squamous cell, nonsmall cell or are they
25 pretty --

Page 91

1 biologic behavior and the biologic features of
2 the tumor. So high grade tumors are those
3 tumors that have very bizarre nuclei.

4 Usually they have and employ DNA
5 contents and these are the tumors that behave
6 bad and spread fast and more lethal than the
7 tumors that are low grade. And these are the
8 tumors, the high grade tumors are those tumors
9 that can metastasize and metastasize earlier
10 than the low grade tumors.

11 Q. Do you use the term, when you are
12 talking about a high grade or a low grade -- and
13 we will put aside the use of the term poorly
14 differentiated and try to get a little more
15 scientific.

16 But when you use the term high
17 grade with a lung cancer, do you ever use the
18 term that a high grade lung cancer has from its
19 inception a bad personality? Have you ever
20 heard that term used?

21 A. Yes. And that's exactly what the
22 biologic behavior of the tumor refers to is that
23 this tumor is determined to be bad, regardless
24 of its size, regardless of the treatment.

25 Q. But still can you cite me to any

Page 90

1 A. It depends really mostly on the
2 degree of differentiation.

3 Q. In poorly differentiated. Do they
4 both spread at about the same juncture or do you
5 normally see adeno spread earlier than squamous
6 cell?

7 A. Well, I want to say that the poorly
8 differentiated, even though I use that term also
9 and I am a pathologist, is really a vague term
10 and it's very misleading because it's based on a
11 very old concept of the resemblance of the tumor
12 to the tissue of origin.

13 So in the case of squamous cell
14 carcinoma, based on the well differentiated
15 tumor, is that the tumors that they resemble,
16 benign squamous epithelium, the poorly
17 differentiated are those that do not resemble
18 the normal squamous epithelium. But it's really
19 vague and inconsistently used by pathologists,
20 let alone other medical specialists.

21 Q. Let alone lawyers, as well?

22 A. Let alone lawyers, yes.

23 The better term and the better
24 criteria to use is the high grade versus the low
25 grade, which really correlates more to the

Page 92

1 statistics that even in a high grade nonsmall
2 cell lung cancer case, if one is fortunate
3 enough to be diagnosed early in the stage, Stage
4 1, and all of the criteria are met from the
5 standpoint of it being high grade but yet you
6 were in the right place at the right time, can
7 you cite me to any literature that would suggest
8 that those patients still more often than not
9 die and don't make it to a five-year survival?

10 A. I can't cite the literature now, but
11 I know that it is present. There is literature
12 that correlates the survival, the survival of
13 patients with high grade tumors versus survival
14 of patients with low grade tumors, if we compare
15 apples to apples, same stage, same size,
16 basically same time, same stage at the time of
17 diagnosis and same treatment versus those that
18 are low grade.

19 Q. So I want to make sure I understand.
20 In Mr. Gill's case, hypothetically, if he had
21 been diagnosed at Stage 1 with the high grade
22 nonsmall cell components that we know that he
23 had, regardless of when that time period was
24 that he was at Stage 1, do you have an opinion
25 as to what his probable survival would have

23 (Pages 89 to 92)

Page 93

1 been, his five-year survival, if he was
2 fortunate enough to have been diagnosed at Stage
3 1?

4 MR. WARNER: Objection. Go ahead.

5 A. I can't tell you exactly what his
6 prognosis specifically would be. It would be
7 better than his prognosis at the stage that he
8 was diagnosed in, which was Stage 4.

9 However, many of these -- that's the
10 reason why we don't have a lot of these tumors
11 that are high grades that are diagnosed at an
12 early stage, because most of them are diagnosed
13 at a later stage.

14 Q. But you are aware, are you not, from
15 the literature and from your training of studies
16 that have talked about high grade nonsmall cell
17 carcinomas that are diagnosed at a Stage 1 in
18 terms of the prognosis for that patient?

19 A. As I said, yes, there are definitely
20 some patients that are diagnosed with an earlier
21 stage high grade nonsmall cell cancers and the
22 survival and the prognosis of these patients is
23 in general better than similar tumors that are
24 diagnosed at Stage 4.

25 Q. Can you tell me what the statistics

Page 95

1 reasons that I already mentioned, which is the
2 size of the tumor at the time of diagnosis in
3 August of 2000, the histologic type and the high
4 grade of the biologic type of the tumor, as well
5 as the clinical information about the presence
6 of the symptoms related to the metastatic sites
7 in December of 1999.

8 Q. You acknowledge nonetheless that
9 while you don't believe that the size of the
10 tumor would have been significantly smaller, you
11 do acknowledge that the tumor would have likely
12 been back in January smaller than it was in
13 July; true?

14 MR. WARNER: Objection. Asked and
15 answered. Go ahead.

16 A. It probably was a few millimeters
17 smaller, but not to the extent of changing the
18 stage.

19 Q. And I understand your opinion. But I
20 just want to get a general agreement, that even
21 though in your opinion it would have only been
22 millimeters, you would agree at least that in
23 January, comparing the size of the tumor, not
24 the stage, but the size of the tumor, versus the
25 size of the tumor in July, that we would have

Page 94

1 show for a high grade Stage 1 survivor?

2 A. I can't really remember the number.
3 I can look it up for you, but I can't just throw
4 a number at you today.

5 Q. As you sit here right now, you are
6 not able to tell me whether or not it's greater
7 than 50 percent survival or less than 50 percent
8 survival, high grade Stage 1?

9 A. That's correct.

10 Q. Now, we have been talking around a
11 lot of the pathology in an indirect manner, but
12 what I would like to do is I would like you to
13 tell me what it is that you saw on the
14 microscopic slides other than what you have
15 already told me that causes you to say that if
16 it was possible to diagnose Mr. Gill in January
17 or February of 2000 that the outcome would not
18 have been any different than it was when it was
19 diagnosed in July.

20 And you don't have to repeat that
21 which you have told me, but I would like you to
22 tell me everything else that perhaps you haven't
23 told me that is pathologically significant.

24 A. I don't think there is -- I can't
25 think of any other reason in addition to those

Page 96

1 been looking at a smaller tumor in January than
2 the tumor in July; true?

3 A. As I said, probably it would have
4 been a few millimeters smaller, but not
5 clinically significant --

6 Q. Okay.

7 A. -- in terms of altering the staging,
8 whether it's the clinical group staging or the
9 pathologic staging of the tumor.

10 Q. And again, I understand and I
11 qualified my question by saying we are not
12 dealing with staging or the clinical factors.
13 But as a general principle, if you look back, if
14 you had diagnosed the cancer back in January, we
15 can agree that even though it may not have been
16 clinically significant and even though it may
17 not have changed the staging, in your opinion,
18 the tumor would have probably been smaller even
19 if only by millimeters than what we saw in July;
20 true?

21 A. Probably.

22 Q. When you put those slides under your
23 microscope, which I presume is what you did --

24 A. Yes.

25 Q. -- you didn't hold it up to a light.

24 (Pages 93 to 96)

Page 97

1 When you looked at the cell structure, did you
2 see cubes or column shaped cells?
3 A. Well, the cells -- and again I have
4 not reviewed the slides since I reviewed them
5 for the purpose of issuing the report. But I
6 basically agreed with the outside report. And
7 again, I am talking about these tumors in
8 general. I cannot recall specifics.
9 If you want me to give you more
10 specific information, I have to review the
11 slides and tell you exactly what I see.
12 Q. You don't have a microscope in your
13 purse with you today?
14 A. No. Sorry.
15 Q. So when I refer to cubes or column
16 shaped, is that something that typically is used
17 to describe the molecular structure in
18 adenocarcinoma?
19 A. Well, I think what you are trying to
20 say is cuboidal or columnar cells.
21 Q. You said it better than I did.
22 A. And these are descriptive terms that
23 we use to describe the shape of the cell, not
24 the molecular structure of the cell. It's just
25 really the shape, how they look to our eyes.

Page 99

1 would treat the patient based on our assessment
2 of the pathologic material. So if we say it's
3 small cell carcinoma, the patient usually gets
4 referred to an oncologist for further studies
5 just as an extent of the disease. If we say
6 squamous cell carcinoma or nonsmall cell
7 carcinoma, then the patient either gets more
8 diagnostic tests to assess a stage or goes to
9 surgery and so forth.
10 So what we say, yeah, we do provide,
11 the pathologists do provide essential
12 information for the clinician to manage the
13 patient, but I'm not going to tell the surgeon
14 to go ahead and resect the tumor. That's a
15 decision that he or she has to make for
16 themselves.
17 Q. Do you know whether this tumor back
18 in January would have been less bulky in size
19 than it was at the time of diagnosis in July?
20 A. Do you mean bulky -- by bulky you
21 mean smaller or larger? You are referring to
22 the size?
23 Q. Is the term bulky a medical term?
24 A. Well, it's a term that is really,
25 it's more descriptive and it's not used in lung

Page 98

1 And again, in general, they refer to
2 tumor types. Columnar cells usually are seen in
3 adenocarcinomas, while polygonal cells are seen
4 in squamous cell carcinoma. But there is a lot
5 of overlapping and a lot of subjectivity in
6 characterizing these cells as such.
7 Q. So one pathologist looking at the
8 cells and describing them, another pathologist
9 looking at the same cells may describe them in a
10 different way?
11 A. Yes. In general.
12 Q. As a pathologist here at the hospital
13 or back over at UH, when you would look at
14 slides, would they typically be after surgical
15 resection or would it be after an initial
16 biopsy, perhaps at the time of a bronchoscopy?
17 A. Usually, in most cases it is either
18 bronchoscopic biopsy or needle guided or fine
19 needle aspiration and then the resection comes
20 and that's when we look at the entire tumor.
21 Q. Do you provide any input to the
22 surgeon at the time of either needle guided or
23 bronchoscopy biopsy or any of the other
24 modalities as to how to proceed with treatment?
25 A. Well, the surgeon and the physician

Page 100

1 cancer, let's say. It's usually used in, for
2 example, tumors in the peritoneum, where there
3 is a lot of tumor.
4 Q. So really from the standpoint of lung
5 cancer, you wouldn't expect one to be using the
6 term bulky when describing the mass; correct?
7 A. Well, as I said, you know, people use
8 different terms and some of them more accurately
9 describe the tumor, some do not. I won't be
10 surprised if I see that description in some of
11 the medical or op reports.
12 Q. Is it your opinion that Mr. Gill in
13 December of '99 had bronchogenic carcinoma?
14 A. Yes.
15 Q. Again, do you have an opinion as to
16 when Mr. Gill developed the bony metastasis in
17 this case?
18 A. Not specific to the time point, but
19 probably the same time frame as when he
20 developed the neck metastasis.
21 Q. So we are talking -- so you are
22 thinking that he had bony metastasis in
23 December?
24 A. Or before that, yes.
25 Q. And went all this time until May or

25 (Pages 97 to 100)

<p>Page 101</p> <p>1 so when he had pain in the femur?</p> <p>2 A. Well, the patient had other symptoms</p> <p>3 that may or may not have been related to his</p> <p>4 bone mets; fatigue and malaise. And we all</p> <p>5 have -- I have back pain, if you don't any way.</p> <p>6 Q. Lawyers never have back pain.</p> <p>7 A. Lawyers are perfect.</p> <p>8 Q. Doctor, I think I am done. I just</p> <p>9 want to make sure that we have covered the</p> <p>10 opinions that you hold in this case and also</p> <p>11 that you have told me the areas within which you</p> <p>12 do not feel qualified to render opinions.</p> <p>13 Have I given you an opportunity</p> <p>14 during the course of this deposition to explain</p> <p>15 the bases for your opinions?</p> <p>16 A. I think so.</p> <p>17 Q. I haven't cut you off or limited you</p> <p>18 in any way, have I?</p> <p>19 A. I don't think so.</p> <p>20 MR. MISHKIND: I thank you very much.</p> <p>21 I have nothing further.</p> <p>22 Do you want the doctor to read the</p> <p>23 transcript?</p> <p>24 MR. WARNER: I will leave it up to</p> <p>25 you. Do you want to read?</p>	<p>Page 103</p> <p>1 CERTIFICATE</p> <p>2</p> <p>3 State of Ohio,</p> <p>4 SS:</p> <p>5 County of Cuyahoga.</p> <p>6</p> <p>7</p> <p>8 I, Vivian L. Gordon, a Notary Public within</p> <p>9 and for the State of Ohio, duly commissioned and</p> <p>10 qualified, do hereby certify that the within</p> <p>11 named NADIA KAISI, M.D. was by me first duly</p> <p>12 sworn to testify to the truth, the whole truth</p> <p>13 and nothing but the truth in the cause</p> <p>14 aforesaid; that the testimony as above set forth</p> <p>15 was by me reduced to stenotypy, afterwards</p> <p>16 transcribed, and that the foregoing is a true</p> <p>17 and correct transcription of the testimony.</p> <p>18</p> <p>19 I do further certify that this deposition</p> <p>20 was taken at the time and place specified and</p> <p>21 was completed without adjournment; that I am not</p> <p>22 a relative or attorney for either party or</p> <p>23 otherwise interested in the event of this</p> <p>24 action. I am not, nor is the court reporting</p> <p>25 firm with which I am affiliated, under a</p> <p>contract as defined in Civil Rule 28(D).</p> <p>IN WITNESS WHEREOF, I have hereunto set my</p> <p>hand and affixed my seal of office at Cleveland,</p> <p>Ohio, on this 3rd day of November, 2003.</p> <p><i>Vivian L. Gordon</i></p> <p>Vivian L. Gordon, Notary Public</p> <p>Within and for the State of Ohio</p> <p>My commission expires June 8, 2004.</p> <p>-----</p>
<p>Page 102</p> <p>1 THE WITNESS: I'll defer to you.</p> <p>2 MR. WARNER: I will trust her</p> <p>3 abilities. You can waive.</p> <p>4 -----</p> <p>5 (Deposition concluded at 4:10 p.m.)</p> <p>6 (Signature waived.)</p> <p>7</p> <p>8</p> <p>9</p> <p>10</p> <p>11</p> <p>12</p> <p>13</p> <p>14</p> <p>15</p> <p>16</p> <p>17</p> <p>18</p> <p>19</p> <p>20</p> <p>21</p> <p>22</p> <p>23</p> <p>24</p> <p>25</p>	<p>Page 104</p> <p>1 INDEX</p> <p>2 EXAMINATION OF NADIA KAISI, M.D.</p> <p>3 BY MR. MISHKIND: 3:13</p> <p>4 EXHIBITS</p> <p>5 Exhibits 1 and 2 were marked..... 3:3</p> <p>6</p> <p>7</p> <p>8</p> <p>9</p> <p>10</p> <p>11</p> <p>12</p> <p>13</p> <p>14</p> <p>15</p> <p>16</p> <p>17</p> <p>18</p> <p>19</p> <p>20</p> <p>21</p> <p>22</p> <p>23</p> <p>24</p> <p>25</p>

<p>A</p> <p>abilities 102:3</p> <p>ability 69:19 71:10 71:24</p> <p>able 9:7 37:4,7 47:15 49:1 50:2,5 73:17 81:19 94:6</p> <p>abnormal 84:13,13</p> <p>about 4:13,13 13:25 14:5 18:2 20:22 20:24 23:24 30:5 30:9 32:22 33:22 35:8 37:13 38:20 39:22 41:17,22 42:17 47:18 48:13 52:1 53:4 57:6 61:14 63:14 66:16 67:2,17 73:24 74:15 76:11 81:3 82:16 83:17 88:1 88:16 90:4 91:12 93:16 95:5 97:7</p> <p>above 1:24 45:11 59:10 103:11</p> <p>Absent 58:13</p> <p>absolutely 58:13</p> <p>abstract 22:10</p> <p>abstracts 23:1 25:5</p> <p>accepted 57:1</p> <p>accompanied 10:5 10:12</p> <p>according 50:16 73:13 82:5</p> <p>account 83:13,15 83:19,21</p> <p>accurate 6:10 39:14 45:25 68:17 74:12</p> <p>accurately 100:8</p> <p>acknowledge 95:8 95:11</p> <p>acknowledging 65:15</p> <p>acquire 22:20</p> <p>across 65:6</p> <p>action 103:16</p> <p>actual 36:18 71:11</p> <p>actually 16:3,10 24:14 27:22 36:21 42:5 43:8 44:14 59:7 84:7 88:13 89:7</p> <p>added 39:17</p> <p>addition 94:25</p>	<p>additional 11:2,4 13:2,5 39:13 50:22 51:4</p> <p>adeno 20:15 90:5</p> <p>adenocarcinoma 19:11,23 20:7 74:11 79:5 88:18 89:22,23 97:18</p> <p>adenocarcinomas 88:9 98:3</p> <p>adenosquamous 20:6,18 29:20 78:20 79:13</p> <p>adjacent 56:15 76:17</p> <p>adjournment 103:14</p> <p>adjunctive 28:23 72:10</p> <p>administrative 17:17</p> <p>advertised 45:4</p> <p>affect 71:24</p> <p>affiliated 103:16</p> <p>affiliation 17:6</p> <p>affixed 103:18</p> <p>aforesaid 103:11</p> <p>after 10:14,14,25 11:12 54:21 61:16 98:14,15</p> <p>afterwards 103:11</p> <p>again 8:7 25:22 32:11 35:14 49:6 55:10 58:24 60:18 61:24 81:11 87:13 96:10 97:3,7 98:1 100:15</p> <p>aggressive 79:16</p> <p>ago 16:14 26:13 33:22 34:4 36:8 41:18 57:7 67:15</p> <p>agree 9:22 18:9 45:22,22 68:22 74:23 76:21 95:22 96:15</p> <p>agreed 39:7 97:6</p> <p>agreement 1:20 95:20</p> <p>ahead 5:10 50:8 51:7 53:3,23 83:3 88:3 93:4 95:15 99:14</p> <p>air 76:2</p>	<p>airways 69:12 76:2 79:9</p> <p>AJCC 56:19 57:4 59:24 60:19 61:8 61:13</p> <p>Akron-Canton 44:12,15</p> <p>al 1:9</p> <p>alive 34:7</p> <p>allegations 31:3,17</p> <p>alleged 36:16</p> <p>allowed 53:23</p> <p>alone 90:20,21,22</p> <p>along 4:23 87:7</p> <p>already 35:4 41:20 48:17 78:6 94:15 95:1</p> <p>alteration 13:21</p> <p>altering 96:7</p> <p>alveolar 79:1</p> <p>always 41:2 68:22</p> <p>Al-Kaisi 3:17,19</p> <p>American 21:16 22:1 23:20</p> <p>amongst 82:22</p> <p>amount 42:5</p> <p>anatomic 27:3</p> <p>Angelina 15:4</p> <p>another 20:17 84:12 86:14 98:8</p> <p>answer 4:25 5:8,11 6:23 18:11 27:20 33:4 43:9 48:11 49:6,7 76:18 79:24 80:4 88:6</p> <p>answered 49:6 89:4 95:15</p> <p>answering 5:2</p> <p>anticipate 12:22</p> <p>anyone 71:5</p> <p>anything 21:11 22:8 26:16 30:2 58:1,16 65:7,21</p> <p>anywhere 33:20 88:12</p> <p>appearance 32:1</p> <p>APPEARANCES 2:1</p> <p>appeared 48:18</p> <p>appears 11:1,16,19 13:8</p> <p>apples 92:15,15</p> <p>apply 54:12</p>	<p>appreciate 46:7</p> <p>appropriate 28:23 61:22 66:1</p> <p>appropriateness 82:24</p> <p>approximate 80:1</p> <p>Approximately 30:15</p> <p>April 22:3 64:19</p> <p>area 15:21 16:17 18:17 24:1 26:24 27:10 43:5,8 44:6 44:9,13 57:2 76:6 76:24 82:9</p> <p>areas 27:4,5 101:11</p> <p>arise 77:11 78:22 78:24</p> <p>arises 77:14</p> <p>arm 48:2 52:19 80:16 87:15</p> <p>around 42:1 94:10</p> <p>arrest 83:20</p> <p>article 64:8,20,21 65:5</p> <p>articles 25:6 26:7 64:6 82:18</p> <p>aside 35:22 37:2 91:13</p> <p>asked 26:19 28:2 29:7 32:21 39:7 49:5 80:17 95:14</p> <p>asking 4:12 18:9 48:5,9,12,15,22 49:7 51:1 52:1 53:4 54:23,25 85:16 88:2,7,11</p> <p>aspect 20:17 25:23</p> <p>aspiration 98:19</p> <p>assess 99:8</p> <p>assessed 80:18</p> <p>assessing 61:5</p> <p>assessment 99:1</p> <p>assigned 27:16</p> <p>assist 28:19</p> <p>assisting 16:2</p> <p>associate 14:8</p> <p>associated 56:15 78:5</p> <p>assuming 71:23 72:4 83:22</p> <p>asymptomatic 76:14</p> <p>atelectasis 58:21 59:11,17 60:7</p>	<p>77:22</p> <p>Atlanta 44:14,20</p> <p>attention 30:7</p> <p>attorney 32:18 33:16 35:2 38:5 38:11,17 42:23,24 44:20 103:15</p> <p>attorneys 38:25 40:3,19 44:5,19 45:2</p> <p>audience 23:9</p> <p>August 80:10 82:13 86:24 95:3</p> <p>authored 5:22 6:1</p> <p>authoritative 64:1 64:4,24 65:1,11 65:16</p> <p>available 45:1 49:11,12 50:25 51:2 89:18</p> <p>Avenue 1:22</p> <p>avoid 37:4,8</p> <p>Avoiding 37:9</p> <p>aware 88:21 93:14</p> <p>away 30:1</p> <p>A-L-K-A-I-S-I 3:17</p> <p>B</p> <p>back 5:15 23:11 25:4 64:14 73:19 81:14 82:10 87:4 95:12 96:13,14 98:13 99:17 101:5 101:6</p> <p>background 4:13 14:4</p> <p>bad 91:6,19,23</p> <p>Bagdad 16:25,25</p> <p>base 82:14 84:17</p> <p>based 28:15 45:11 47:7,19,22 48:13 49:8,10 51:19 73:23 81:12 82:8 82:15 84:23 85:2 85:6,8 90:10,14 99:1</p> <p>bases 101:15</p> <p>basic 23:17</p> <p>basically 29:5 47:25 49:17 69:21 92:16 97:6</p> <p>basing 80:5</p> <p>basis 29:17 45:22</p>
---	--	--	--	--

73:22 Bass 67:20 Bautista 15:4 became 14:19 17:16 Becker 2:3 become 61:17 69:17 84:7 before 1:18 4:7,18 4:25 5:2 8:8 9:13 9:17,23 10:8 17:6 27:22 30:1 46:19 48:10 50:9,9 58:7 69:19,21 80:4,17 80:25 85:14 86:8 86:21,22,23 87:19 100:24 beginning 46:14 52:18 53:16,18,19 behalf 1:16 2:2,10 4:2 39:8 42:22 behave 91:5 behavior 71:9 91:1 91:22 being 3:9 6:11 37:5 60:5 65:1,15 68:14 89:10 92:5 believe 6:20,21 12:23 45:13 63:25 95:9 benign 90:16 besides 25:3 best 39:15,17 64:9 68:23 75:2 86:15 86:18 better 62:9 89:11 90:23,23 93:7,23 97:21 between 88:8 beyond 65:21 69:15 70:1,7,11,13 71:3 bibliography 25:7 bills 68:10 biologic 71:8,9 78:4 91:1,1,22 95:4 biologically 79:15 biopsy 52:6 98:16 98:18,23 bit 20:23 86:15 bizarre 91:3 black 48:23 blastoma 26:4 blood 17:24 70:9 83:16	board 15:14,17 27:3 body 69:12 88:12 bone 73:5 82:1,5,6 101:4 bones 72:25 bony 100:16,22 book 26:13,19,23 30:3 born 17:2 both 78:20 90:4 Botham 41:5 67:4,5 67:6,10,13,16 bottom 7:24 8:10 branches 77:12 breast 27:6,10,14 27:23 28:10 34:5 34:6 60:20 bring 76:2 bronchi 75:24 76:1 76:6,17,23 bronchial 26:8 78:12 bronchitis 53:14 bronchogenic 100:13 bronchoscopic 98:18 bronchoscopy 98:16,23 Building 2:13 bulky 99:18,20,20 99:23 100:6 busy 41:19 B-A-U-T-I-S-T-A 15:4 C calendar 35:20 call 44:22 69:10 called 1:16 3:7 45:7 came 9:18 Cancel 35:19 cancellation 41:4 cancelled 41:2 cancer 13:19 16:4,5 16:9 18:2,11,14 19:10 21:13 24:2 25:9,11,19,22 26:17 28:20,21 30:5 34:5,6 37:23 41:9,11 45:20 47:10,16 49:4,20	49:23 50:17 51:6 51:12,15,19 56:4 56:19 57:2,4,6,16 57:22,25 58:3,4 59:3 60:4,13,21 60:21 61:8,8,11 61:21 62:17 63:2 63:18 64:22 66:16 68:23 69:2 71:15 72:4 75:7,8,10,21 79:5 80:21,22,23 81:8,16 82:19 85:22 86:3,8,22 86:23 87:1,1,4 88:17,17,23,24 89:10,19 91:17,18 92:2 96:14 100:1 100:5 cancers 20:19 25:15 61:5 62:9 70:12,25 74:24 76:22,25 77:10 82:16 88:6 89:5 93:21 candidates 71:16 71:19,23 capacity 31:22,25 carcinoid 25:14 26:9 carcinoma 18:8 19:5,11,12,15 20:3,6,8,11 21:4 25:13 29:20 74:15 76:5 77:14,18 78:10,19 79:13 89:1,13 90:14 98:4 99:3,6,7 100:13 carcinomas 19:6,13 20:14,18 69:10 77:10,11,25 78:3 78:23 79:19 87:23 88:4,9,12 89:6 93:17 cardiovascular 67:7 care 13:10,16 31:4 31:9 career 37:6 Caroline 15:7 case 1:7 4:14 5:23 6:1,19 7:8,11,13 10:22 11:6 12:19 12:25 13:21 18:2	22:12 23:25 30:23 30:24 31:2,11 32:24 33:4 34:4 35:3,15,16,22 36:11,12,13,23 37:23 39:12 40:23 42:11 44:14,24 47:8 48:16 49:1 49:15 54:20 64:2 64:11,12,19 65:18 66:7 67:17 68:8 68:20 72:21 78:9 78:18 79:2,6 80:19 81:13 84:14 85:2,21 88:21 90:13 92:2,20 100:17 101:10 cases 31:1 32:5,6,7 32:9,10 33:5,9,12 33:13,15 34:17,23 36:1 38:2,7,15,16 38:19 39:2,25 40:5,16,22 41:8,9 41:11,13,15,15,18 41:21,23 42:1,13 42:25 43:7,14 44:4,8,10,11,12 44:13 66:16 75:8 88:17 98:17 categories 18:13 category 18:7,18 21:25 25:15 77:13 cause 37:21 38:3 47:15 55:1 103:10 caused 41:6 causes 49:1 77:20 94:15 cell 18:2,8,11,17,20 18:23,24 19:4,5,6 19:10,11,14,19 20:2,8,11,14,19 21:4 25:9 28:16 29:19,20 37:23 41:9 60:4,13 61:10,20 62:17 63:2,18 64:22 69:10 70:12,25 71:15 74:6,7,10 74:15 75:2,6,10 75:11,14,15,16,20 75:24 76:5,22 77:9,9,10,11,14 77:18,25 78:3,10 78:19,23 79:3,4	79:13,19 87:23 88:4,6,8,12,17 89:1,3,4,6,12,12 89:19,22,24,24 90:6,13 92:2,22 93:16,21 97:1,23 97:24 98:4 99:3,6 99:6 cells 17:23 18:22 19:19 52:3 71:2,6 71:7,8,12,12 75:12 83:20 97:2 97:3,20 98:2,3,6,8 98:9 center 24:25 27:14 centimeters 56:9 58:6,10,17 59:10 59:14,17,23 60:6 60:8 73:16 central 75:23 certain 6:22 8:9 44:23 48:19 62:16 63:19 64:14,20,21 65:5 certainly 61:7 65:10,20 77:13 CERTIFICATE 103:1 certification 27:2 certified 3:10 15:14 15:17 certify 103:9,13 chance 89:11 change 23:14 50:21 84:16 changed 96:17 changes 57:15,19 83:21 changing 95:17 chapter 26:14 chapters 30:3 characterization 20:17 characterizing 98:6 charge 27:18 68:1,4 charging 67:24 cheat 59:4,6 chemotherapy 62:2 72:9 89:18,20 chest 50:14 51:9,11 51:14,20,22 52:5 58:11,15 Chuck 36:24
---	--	---	---	--

<p>cite 91:25 92:7,10 civil 3:9 32:6,7 103:17 classified 56:17 classify 19:9,9 clearly 60:10 Cleveland 2:7,14 17:9 25:21 26:2 33:20,23 43:4,8 44:6,9 103:18 clinical 21:16 22:1 23:20 27:3 28:22 47:13,20 52:12 62:21 72:21 74:2 80:13 84:11,13 85:9 87:13 95:5 96:8,12 clinically 49:3 59:22 61:21 69:6 72:3,6 84:8 96:5 96:16 clinician 28:14 29:22 99:12 clinicians 57:5 close 48:10 closer 75:23 CME 21:25 collection 23:5 64:13 Columbus 44:16 column 97:2,15 columnar 97:20 98:2 combination 20:7 79:3 come 32:14 33:16 40:8 65:6 comers 63:1,9 comes 57:22 64:15 65:6 98:19 commencing 1:23 comment 61:2 commented 53:6 comments 52:16 commission 103:24 commissioned 103:8 common 1:1 27:11 75:21 Community 1:21 comorbidities 71:24 compare 57:13 92:14</p>	<p>comparing 89:1 95:23 completed 103:14 completeness 59:7 complied 13:15 comply 31:4 component 19:18 components 88:18 92:22 computer 7:1 34:20 concept 90:11 concern 29:21 concerns 64:15 concluded 102:5 concludes 50:9,10 conditions 83:13 conferences 27:20 29:16 confidential 35:9 configuration 19:3 29:21 confirm 51:5 connection 5:22 12:19 76:16 consider 26:25 61:7 61:18 64:3 consideration 19:8 considered 56:10 56:25 58:18 constitutes 72:21 consultant 35:9 contact 66:19,23 contain 68:19 contents 91:5 context 31:16 continued 23:12 35:16 contract 103:17 contralateral 73:1 73:1,7 contribute 70:24 contributes 71:10 83:18 controversy 83:4 copies 24:4,20 copy 8:4 22:20 24:7 24:25 corner 8:11,25 correct 3:24 4:19 6:12,15,17 8:19 8:20 9:14 10:17 10:18 13:12 15:18 15:19,21 18:3,14 18:24 19:6 20:4,9</p>	<p>28:17 29:3 31:9 31:10 38:22 42:6 45:9 50:24 53:7,8 56:6,8,10 57:16 58:6,13,19 59:20 62:14 63:21 74:7 81:10,18 82:2,19 82:25 87:2 94:9 100:6 103:12 corrections 68:15 correctly 53:19 correlate 84:10 correlates 16:21 90:25 92:12 Cottle 14:10 15:3 cough 55:2 counsel 1:16,21 County 1:2 103:5 couple 4:21 39:24 44:12 61:16 81:2 course 16:19 50:21 60:23 79:17 89:5 101:14 court 1:1 5:6 31:22 32:5,9 35:7 38:14 66:1 103:16 courtroom 30:17 30:22 31:17,25 32:16,17 33:20 35:12 38:10 cover 9:18,20 10:10 12:1,1,2,3 covered 101:9 create 71:3 criminal 32:5 criteria 19:7 56:11 58:9,20 59:24 90:24 92:4 critically 64:5,8 CT 73:13 78:14,15 cubes 97:2,15 cuboidal 97:20 culture 83:11 curable 69:22 current 42:6 cut 101:17 Cuyahoga 1:2 103:5 CV 14:1,5 17:19 20:25 21:5,18 24:14,22 25:4 26:12 30:2,2 cytology 17:19,20 17:22,23 21:21,24</p>	<p>24:11 26:18,19 cytopathology 17:16 27:5 C-O-T-T-L-E 15:3</p> <hr/> <p>D</p> <hr/> <p>D 2:4,12 daily 29:11 Dan 79:6 DANIEL 1:5 data 50:22 60:19 61:15,18 64:8 date 1:24 7:21,24 8:18 9:3,6 10:19 10:23 35:18 68:14 79:21 dated 9:20 10:11 dates 46:19 day 1:23 8:5 103:19 day-to-day 29:17 deal 65:13 dealing 38:3 75:20 76:4 96:12 death 37:21 38:3 debate 82:22 deceased 1:5 December 9:21,23 10:4,11 45:23 46:14,15,17,18,20 47:1,25 48:18 49:13 50:14 52:17 52:18 53:7,10,11 53:20 54:6,10,11 54:14,17 80:14 81:3,4,4,15,17,20 82:10 85:20,23 86:4 87:19 95:7 100:13,23 decision 28:22 99:15 declined 26:20 deem 65:10 defendant 2:10 31:13,15 36:4,5 37:5 38:1 Defendants 1:10 defense 31:7 33:16 42:24 defer 102:1 deficiencies 64:7 define 19:4 52:7 defined 103:17 definite 49:19</p>	<p>definitely 50:2 93:19 definition 60:10 degree 45:12 73:18 77:17 88:14 90:2 demanding 27:24 depending 23:8 51:24 61:24 78:4 depends 58:8 77:16 87:25 88:13 90:1 deposed 3:10 deposition 1:12,15 3:2 4:6,18,23 11:17,22,23,24 36:25 37:13,22 40:24 42:14 43:10 44:16 52:24 65:16 65:22,25 67:24 101:14 102:5 103:13 depositions 11:14 11:20 12:1,6,14 12:15 30:13,14 35:7 36:1 38:9,13 41:1,23,25 describe 97:17,23 98:9 100:9 described 25:12 73:15 describes 55:13 describing 98:8 100:6 description 52:12 52:21 100:10 descriptive 20:2 97:22 99:25 DeShriver 28:4,5 details 33:2 59:8 determined 91:23 determining 29:23 32:2 develop 27:9 65:19 86:7 89:9 developed 27:15 46:8 86:22 100:16 100:20 devote 26:23 diagnose 45:13,19 68:23 69:22 94:16 diagnosed 18:6 60:4,5 61:21 71:14,22 72:5,17 72:23 73:11 76:13 86:10 92:3,21</p>
---	---	--	---	---

93:2,8,11,12,17 93:20,24 94:19 96:14 diagnosis 18:6 20:24 21:4,13 24:1 25:11,23 34:10 45:23 48:15 48:21 49:19,22 53:13 54:22 56:5 78:6 80:10 82:12 86:23 92:17 95:2 99:19 diagnostic 47:14 48:24 50:5,22 51:12 99:8 die 34:6 62:20,22 92:9 difference 88:7,10 differences 57:9,11 71:9 different 18:13 19:10 20:1,10 21:22,22 26:5 32:14 34:11 43:20 60:20,24,25 74:6 74:6,8,24,25 94:18 98:10 100:8 differential 53:13 differentiated 19:18 20:11,14,16 20:19,20,21 29:19 74:12 77:18,24 78:3 79:19 88:19 90:3,8,14,17 91:14 differentiation 19:17,20,22,24 20:16 74:8 77:17 78:21 88:14,15 90:2 Diplomate 1:19 direction 32:14 director 17:18,19 directors 27:18 disappear 89:19 disclosing 35:5 discovered 47:12 77:23 78:1 discussing 26:6 Discussion 17:5 35:21 43:24 discussions 29:15 disease 49:4,21,25 50:4,6,11,18	53:10,12 54:8,8 54:17 55:17,22 56:2 72:24 73:5 79:17 84:24,25 85:5,17,18 87:20 88:5 89:6,8,17 99:5 disseminated 22:21 distal 78:25 79:9 distant 78:7 divide 84:6 DNA 91:4 doctor 24:10 25:3 32:19 38:5,12 45:10 47:7 54:2 55:10,11 63:24 68:22 79:23 81:9 101:8,22 doctors 12:5 39:8 51:18 52:13,16 65:13 document 52:3 documented 77:15 documents 7:15 doing 48:11 dollar 70:20 done 4:24 5:1 47:14 50:14,23 51:4,24 73:25 79:23 101:8 double 83:8 84:7 doubling 73:24 82:19,24 83:5,6 84:2,3 down 5:7 24:25 73:4 Dr 3:19,19,21 4:2 11:17,22,23,23 13:10,15 15:11 28:4,5 31:3,8,15 41:5 45:24 46:7 46:11,21,25 48:18 52:21 53:5 54:7 54:15,24 55:13,18 55:21,24,25 66:4 66:7,7,19 67:2,3,4 67:5,6,10,13,16 67:17,19,20,20 81:5 85:23 dropped 36:23 duly 3:9 103:8,9 during 22:14 46:25 101:14	E each 5:3 11:25 64:9 earlier 34:10 70:24 72:1 74:5 79:17 80:12 84:25 89:5 89:23 90:5 91:9 93:20 early 42:10 48:20 52:25 53:11 54:19 67:23 68:23 69:2 84:24 85:4,16,17 87:24 88:23 92:3 93:12 easier 11:21 32:12 easy 21:7 edition 56:23,25 57:6,8,14,19,20 education 16:23 educational 25:6 26:3 Edward 15:3 efficacy 82:23 effusions 58:23 eight 26:10 either 20:15 31:23 33:20 38:3,12 44:21 49:24 52:23 66:22 70:5 78:7 78:24 79:8 87:5 98:17,22 99:7 103:15 elongating 75:17 employ 91:4 employed 14:9,11 encompassing 39:12 end 53:16 54:14 64:18 ended 24:15,22 enough 12:4 46:5 72:13,15 92:3 93:2 enter 25:14 entire 7:13 32:25 98:20 entirely 30:1 62:1 68:17 entity 77:15 environment 74:1 83:11 epidemiological 70:17 epithelium 69:11	69:14,16,25 70:1 70:2,6,6,7,13 71:3 75:25 76:1 90:16 90:18 equal 89:10 ESQ 2:4,12 essential 99:11 essentially 34:9 Estate 1:4 estimate 39:18 86:18 estimates 39:15 et 1:9 evaluating 16:1 even 4:17 19:17 25:11 33:10 50:13 51:16 62:20 66:25 77:8 78:15 82:22 90:8 92:1 95:20 96:15,16,18 event 103:15 events 48:19 ever 30:16,21 37:22 44:25 45:4 67:16 91:17,19 every 59:3 64:8,8 64:14 66:25 everything 64:5 81:6,12 86:8 94:22 evidence 46:3 47:8 47:11,12 48:25 49:3 50:2 51:14 52:11 54:13,16 55:12,16,16,21 60:9 69:6 72:22 evidentiary 65:12 exact 57:9 62:5 63:14 71:18 79:10 79:21 exactly 10:17 17:20 41:1,3 48:11 62:15 78:16 79:9 79:20 81:21 87:12 91:21 93:5 97:11 exam 52:12 examination 1:17 3:8,12 52:3 104:2 examinations 48:24 84:17,18 examining 16:11 example 44:20 100:2	exceeds 83:14 excised 62:1 excision 61:25 exclude 82:4 88:20 excluding 37:25 exclusively 15:9,10 Executor 1:4 exhibit 5:18,19 7:5 10:2 12:17 14:1 25:2 Exhibits 3:3 104:4 104:5 existed 81:20 existence 51:6 expect 60:8 100:5 experience 30:8 37:2,3,5 38:9 82:15 84:23 experimental 73:25 expert 4:1 10:13 15:21 16:17,22 27:17 30:22 36:2 37:15 38:2,25 39:8,19 45:2 48:25 61:2 expertise 27:6 82:9 experts 66:6 expires 103:24 explain 32:21 101:14 exponential 83:23 83:24 express 19:20 expressed 11:8 extended 46:20 76:6 extending 58:14 extent 61:6 95:17 99:5 eyes 97:25
F				
fact 5:21 8:19 9:2 57:20 62:11 63:8 78:19 factors 62:3,4,13 63:13 70:23 71:1 80:8,9 83:16,17 87:25 96:12 fair 5:16 10:22 11:11 13:22 38:8 59:9 65:9 66:18 72:13,15 87:20				

fairly 66:18 fairness 6:22 fall 18:16,19 83:2 falling 18:7 familiar 12:5 56:19 familiarity 66:14 family 41:5 famous 36:12 64:6 far 38:13 68:8 fast 91:6 faster 70:24 fatigue 101:4 fault 24:17 fax 8:3,3,21,22,24 faxed 8:5,18,19,21 24:14 features 56:16 58:9 80:23 91:1 February 45:14,20 47:9,16,19,24 48:7 49:2,11,13 50:3,7 51:2,5 52:7,14 73:20 94:17 feel 68:16 101:12 fellow 36:9 fellowship 17:15 femur 101:1 few 14:3,5 27:22 42:8 61:16 82:11 86:11,13,14,16,19 95:16 96:4 field 69:8 fifth 39:10,18 figured 43:9 file 6:7,10,16 23:18 65:25 find 65:14,17 72:15 findings 28:16 29:4 47:21 51:25 52:25 fine 3:20 98:18 finishes 5:10 firm 33:25 34:1,14 38:22 43:19 44:13 103:16 firms 43:25 44:3,22 first 3:9 10:3 17:14 21:24 46:13 51:23 53:20 74:16 77:8 81:3 83:5 86:7 87:10 103:9 five 21:8,10 26:2 30:20 31:20 32:15 32:22,25 33:8	39:9 40:22 42:25 62:14,19 68:11 86:17,19,21,21 five-year 61:3,20 63:3,10 92:9 93:1 focus 13:18 20:25 30:7 45:17 focusing 21:23 follow 8:4 55:5 following 74:3 follows 3:11 foregoing 103:12 forgot 67:23 former 47:23 forth 1:24 84:9 99:9 103:11 fortunate 92:2 93:2 found 36:20 52:5 founded 27:14 four 14:23 19:21,22 26:4 30:20 31:20 32:15,22,25 33:9 33:9 38:19 39:9 40:25 41:13 42:8 42:25 68:11 73:15 fourth 14:18 21:20 frame 100:19 frequently 76:6,13 76:15 from 7:18 9:9,13,17 10:4,11 11:5 12:1 12:2 16:1 17:12 17:14 18:10 20:10 23:15 29:9,23 30:1 32:14 33:3 43:19 44:21 46:23 47:5,13 48:16,22 52:11,12,23,23,24 53:24 54:19 55:3 56:1 65:7,12 66:11 70:16 76:1 78:24 79:8 81:25 82:1,3 84:17 87:10,13 91:18 92:4 93:14,15 100:4 front 59:5 68:13 frozen 36:18 full 14:17,22,24 15:2 60:24 full-time 15:5 function 71:7,8 further 51:25 86:12 99:4 101:21	103:13 G gave 23:11 25:21 general 1:22 20:23 25:11 27:8 62:9 69:1 72:1 75:10 80:2,6 84:3 88:11 93:23 95:20 96:13 97:8 98:1,11 generally 4:11 56:18 57:1,18,21 58:4,18 59:19 63:8,10 64:23 65:11,15 Georgia 44:14,20 gets 59:10 71:3 99:3 99:7 getting 12:11 Gill 1:4,5 13:10 18:5,10 19:14 20:25 35:15,22 39:12,17 40:23 46:6,10,24 47:9 47:15,18 49:3,20 50:18 51:1 52:8 52:13 53:11 54:20 54:23 72:17 80:7 80:15,22 81:8,16 85:12 94:16 100:12,16 Gill's 45:14,19 72:4 79:6 85:4 92:20 gist 43:18 give 4:21 21:13 52:22 63:13 80:4 86:17 87:18 97:9 given 21:2 35:6 36:1 37:12 40:24 44:24 75:3 79:2 86:8 87:8 101:13 giving 23:2 29:21 38:13 glandular 19:23 70:6 78:21 glass 10:5 go 5:10 9:10 24:25 41:24 50:8 51:7 53:2,23 58:17 64:14 83:3 88:3 93:4 95:15 99:14 God 37:8 goes 45:15 99:8	going 4:12 5:20 7:3 13:24 14:18 30:7 34:22 62:18,19,21 64:25 65:18 81:14 86:14 87:4 99:13 gold 52:1 gone 42:14,19 good 60:16 69:1 Gordon 1:18 43:22 43:23 103:8,22 grade 62:5,6,6 79:14,18 80:11,11 84:20,22,25 85:7 85:9 87:9 89:2 90:24,25 91:2,7,8 91:10,12,12,17,18 92:1,5,13,14,18 92:21 93:16,21 94:1,8 95:4 grades 93:11 gradually 27:25 greater 59:13 71:21 94:6 group 14:12,15 17:7 63:15 96:8 grouped 18:17 grow 77:19 84:16 grown 83:11 growth 73:24 82:17 83:15,18,21 guess 55:1 guessing 8:24 guesstimate 68:12 guest 21:10 guided 98:18,22 guideline 84:4 guidelines 61:13 guy 43:21 GYN 26:18 H half 14:16,19 15:8 hand 5:20 103:18 Handbook 56:20 hands-on 16:8 Harley 43:22 having 29:1 54:21 head 28:3 heard 91:20 hectic 41:20 held 17:17 her 21:7 40:11 47:5 47:6 102:2	hereinafter 3:10 hereunto 103:18 high 62:6 79:14 80:11 84:19,22 85:7 87:9 89:2 90:24 91:2,8,12 91:16,18 92:1,5 92:13,21 93:11,16 93:21 94:1,8 95:3 higher 62:10 hilar 58:15 73:2,6,7 Hillcrest 67:12 him 16:11 53:20 54:15 55:22 66:10 66:11,14,23 histologic 18:25 29:6 80:11 85:6 95:3 histologically 62:7 histology 17:18,21 17:24 63:16 histories 22:13 history 49:22 hold 4:14 15:20 16:17 64:2 68:20 96:25 101:10 holding 56:22 hospital 1:22 14:6,7 29:14 32:19 36:16 38:6,12 44:22 67:8,12,15 98:12 hospitals 15:12 17:9 23:7 25:21 26:1 36:10 66:12 host 83:19 hour 67:25 68:1,3,6 hours 21:25 68:7,11 Howard 2:4 22:19 hypothetically 72:6 92:20 I ideal 83:10,12 84:6 identification 3:4 identified 4:1 12:16 35:6 identify 69:2 75:1 III 1:4 illness 46:14 53:21 immunologic 83:19 important 67:22 75:1 89:16 Inc 14:10
---	---	---	--	--

<p>inception 91:19 includes 12:17 62:4 including 14:21,22 14:24 39:1 40:23 inconsistently 90:19 increasing 42:5 INDEX 104:1 indicated 51:17 indicates 88:22 indicating 8:18 indication 52:23 indicators 29:2 indirect 94:11 infiltrate 50:15 influence 60:25 62:7 influenza 53:14 information 29:22 34:25 57:21 61:8 61:9 64:4 80:13 95:5 97:10 99:12 initial 98:15 input 28:14 98:21 intend 12:24 13:9 45:18 46:1 64:19 85:21 86:1 intending 13:5 interact 67:9 interest 27:5,9,15 interested 103:15 internal 15:15 interpret 27:13 interpretation 16:18 33:2,6,11 36:19 interpreting 36:22 interruption 6:6,13 interval 87:10 intervals 74:4 intrinsic 62:3 83:16 invade 69:15 70:13 77:19 invaded 56:14 69:25 invades 70:7 invading 58:10,11 invasion 58:14 69:8 invasive 51:24 76:16 invited 21:9,14 25:3 30:3 involve 33:6</p>	<p>involved 34:24 36:17 61:4 66:17 66:17 involvement 16:8 52:14,20 53:1 54:14 55:12,15 59:19 60:9 82:1 involves 31:11 Iraq 17:1 issue 13:19 21:3 33:11 35:5 46:2 issues 23:24 31:11 37:19,20 38:4 64:15 issuing 97:5 item 21:20 i.e 19:19</p> <p>J J 1:4 January 7:25 8:1 9:3 45:14,20 46:4 47:8,16,19,24 48:6 49:2,11,13 50:3,6 51:2,5 52:7,14 54:18,19 54:24 55:3,3,6,11 55:16,17,22 73:19 80:19 94:16 95:12 95:23 96:1,14 99:18 Jim 40:6 journal 64:20,21 65:1,2 Judge 1:7 July 17:12 94:19 95:13,25 96:2,19 99:19 juncture 90:4 June 103:24 junior 28:1 just 4:21 6:22 7:21 8:9 10:23 11:11 14:3,20 20:23 21:7 24:21 25:1 33:8 41:4 43:9 44:16 47:5 54:3 55:8 58:16 59:12 62:13,24 66:13 72:15 75:16 86:15 87:18 94:3 95:20 97:24 99:5 101:8</p>	<p>K Kaisi 1:12,15 3:2,7 3:12,16,19,20,21 103:9 104:2 Kampinski 36:24 Katherine 28:4 keep 34:16 41:2 kidding 14:20 kind 24:3 34:25 47:11 48:10 51:23 61:17 knew 60:22 66:11 know 4:11 8:1,15 8:21 9:2 10:16,23 20:24 28:8 33:5 35:23 37:7 38:21 44:18 46:10,12 47:18,18 48:19 50:13 51:8 54:19 55:4,7 57:6 62:22 62:23,23 65:6 66:3,7,10,21 67:3 67:5,6,19 68:7 70:16,19,24 71:1 71:18,20 73:23 74:21 76:11,19 80:1,22,23 81:6 81:13 82:16 83:17 84:1 85:17 86:9 87:12,17 92:11,22 99:17 100:7 knowing 81:5 86:9 knowledge 16:20 62:25 65:17 72:16 73:23 82:16 84:23 known 3:16 49:22 67:13 knows 71:5 kodachrome 22:15 23:5 kodachromes 22:12 23:3</p> <p>L L 1:18 103:8,22 lab 33:3 language 32:13 large 61:15 76:5,22 77:23 78:1 larger 75:24 99:21 last 12:10 16:7 24:10 26:12 33:19 45:10</p>	<p>late 87:24 88:23 later 88:5 93:13 latter 47:22 law 33:25 34:14 38:22 44:13,22 lawyer 38:18 40:10 43:19 lawyers 39:22 40:1 40:8 43:14 44:21 65:13 90:21,22 101:6,7 lead 43:10 51:25 leading 48:20 least 43:16 44:11 51:23 59:14 65:22 95:22 leave 24:24 72:11 101:24 lecture 23:6 lectures 21:1,10,12 21:12,19 25:20 30:3 led 34:10 left 27:22 48:1 80:15 87:15 left-hand 8:11,25 lesion 52:4 58:12 lesions 27:12 less 41:21 56:9 58:5 58:10,16 59:16,23 60:6,8 66:24 67:1 94:7 99:18 let 4:21 9:12 32:12 54:3 57:23 81:2 90:20,21,22 lethal 91:6 letter 9:18,20 10:3 10:10 letters 9:10 let's 6:14 37:2 56:22 100:1 Levitan 66:7,8,19 67:17 Levitan's 11:17,22 life 88:24 light 96:25 like 17:18 19:11 22:19 23:12 24:10 24:18 33:9 38:17 41:4,18 44:19 66:25 83:6 84:15 94:12,12,21 likely 61:19 72:2 79:7 81:16 85:11</p>	<p>85:25 86:2 95:11 limitations 72:16 limited 69:13 101:17 line 46:5 lingering 55:2 lining 70:2 76:1 78:24 79:8 linings 69:11 list 34:23 35:1 45:1 59:2 listed 25:24 literature 60:23 64:13 88:21 92:7 92:10,11 93:15 litigation 36:3 little 14:13,20 20:23 67:11 86:15 91:14 live 29:3 living 72:14 local 78:7 located 70:9 location 70:11 locations 21:22 long 14:11 16:14 29:2 36:8 41:14 46:10 67:13 76:12 76:19 77:2 80:25 84:5,16 85:14 87:16,19 longer 62:19 76:24 look 9:5 19:3,8,25 21:5 25:4,17 27:7 38:16 41:15 47:5 53:23 54:1 64:4,7 64:14 94:3 96:13 97:25 98:13,20 looked 48:14 97:1 looking 6:3,7 7:18 9:9 13:8 15:25 28:9,10,13 48:25 56:3 57:20 81:13 86:9 96:1 98:7,9 looks 19:2 23:12 24:10 lot 63:12 64:7 82:18 82:22 83:4 87:25 89:15 93:10 94:11 98:4,5 100:3 lots 89:20 low 62:6 90:24 91:7 91:10,12 92:14,18 lower 8:11,25 79:18 84:25</p>
--	--	--	---	--

lumen 77:20 lump 75:11 lung 13:19 16:9 18:2,11,14 20:19 21:12,13,19 24:2 25:9,11,15,19,22 26:5,17 27:7,10 27:16,17,19 28:3 28:9,20,21 30:4 37:23 41:9,11 45:14,20 47:9,16 49:4 51:6,12,15 51:18 56:4 57:5,9 57:12,15,22,25 58:4,18 59:3 60:4 60:13,21 61:5,10 61:20 62:8,17 63:2,18 64:22 68:23 70:25 71:15 74:3,24 75:6,8,10 75:20 76:25 77:9 77:15 80:23 81:16 82:16,19 84:15 85:22 86:2,7 87:1 87:4 88:16,17,23 89:9 91:17,18 92:2 99:25 100:4 lungs 76:3 88:13 lymph 52:20 59:21 78:7 lymphatics 70:9 <hr/> M <hr/> made 7:2 12:8 28:22 45:1,24 68:16 mail 8:5 main 53:13 55:1 major 57:11 77:12 make 6:19,22,24,25 8:9 21:7 24:6 28:17 32:12 68:17 75:7 80:9 92:9,19 99:15 101:9 malaise 101:4 Malone 40:4,6 malpractice 31:18 32:9,24 36:16 39:1 manage 99:12 manner 94:11 Mansnerus 1:8 4:2 13:10,15 31:3,8	31:15 45:24 46:7 46:11,21,25 48:18 52:21 53:5 54:7 54:15,24 55:13,18 55:21,24,25 66:4 81:5 85:23 manual 57:4 59:25 60:19 61:14 many 4:9 14:14 17:10 25:20 30:19 31:21 32:16 38:1 38:15 39:6 40:5 40:16,23 41:16,24 42:22 46:16,24 68:7 71:2,6 78:21 84:12 86:8 89:7 93:9 Marilena 40:12 mark 73:4 marked 3:3 5:18 104:5 Marymount 15:12 mass 52:4 71:12,13 84:14 100:6 match 23:8 material 6:3,8 9:13 9:16,25 11:2,4,12 11:13 12:11,16,18 12:22,24 13:2,6 22:7,20 23:2,10 23:13,17,19 24:4 24:5 27:12,19 33:7,12 36:22 99:2 matter 34:3 41:5 matters 35:3 may 5:5 20:1 21:6 23:16 28:19,23 29:3 32:10 33:10 48:13 51:25 62:22 62:23,23 65:5 74:25 78:2,5,6 86:13 96:15,16 98:9 100:25 101:3 101:3 maybe 11:21 19:17 39:24 41:18 42:25 44:15 75:13 ma'am 12:19 36:8 mean 5:7 18:4 29:11 30:24 39:3 47:17 49:18 76:8 77:2 78:12 81:21 99:20,21	means 62:15 66:21 79:15 85:18 meant 60:22 mediastinum 58:11 72:25 73:1,5 81:25 medical 10:9,12,15 15:24 16:23,25 19:25 23:6 30:22 30:25 31:12 39:1 45:12 48:23 61:2 61:4 64:4,10,13 72:12 73:18 74:17 82:3,6 88:21 90:20 99:23 100:11 medical/legal 30:8 30:24 32:10 33:13 34:17,23 medicine 15:15 meet 31:9 meeting 22:2,12,14 22:14 meetings 21:15,17 memory 47:6 53:24 mention 53:9,12 54:6,8,16 55:14 mentioned 17:7 47:2 58:7 84:19 85:8 95:1 merkel 19:12 Mester 43:21 met 4:19 87:16 92:4 metaplastasis 75:25 metastasis 60:10 69:7 81:20,22 85:12 100:16,20 100:22 metastasis 69:19 70:11,13,15,17,18 71:11 79:17,21 80:12 84:24 85:4 87:10 88:5 91:9,9 metastasized 78:6 79:13,22 80:3,6 metastasizing 77:6 metastatic 47:9,16 49:3,4,21,24 50:3 50:6,11,18 51:6 53:10,12 54:8 55:17,22 56:2 71:4 72:24 73:5 81:16 85:22 86:2 87:20 89:7 95:6	mets 48:8 80:20,24 82:5,7 101:4 microscope 19:2 96:23 97:12 microscopic 94:14 Midland 2:13 might 42:11 millimeter 22:17 millimeters 82:11 95:16,22 96:4,19 million 70:20 mind 40:9 46:6 65:8 minutes 14:5 Mishkind 2:3,4 3:13 17:4 21:6 22:19 24:18,21 25:1 53:25 101:20 104:3 misleading 90:10 missing 7:22 mix 23:7 modalities 16:3 98:24 moderately 20:20 modifications 68:16 molecular 72:7 97:17,24 moment 26:13 48:13 month 53:16,17 74:4 months 66:25 more 6:14 20:22 28:1 29:21 33:9 36:5 50:11 54:1 57:7 58:1 65:12 66:22,25 68:11 71:10 72:2 73:25 75:9,13 78:22,25 79:9,15 90:25 91:6,14 92:8 97:9 99:7,25 100:8 Moskovitz 36:12 most 67:22 71:14 75:21 77:8,9,11 78:16 79:7 81:15 85:25 86:2 89:16 93:12 98:17 mostly 15:12 21:15 24:1 25:22 32:2 37:20 67:11 77:19 80:8 90:1	motion 66:1 move 4:22,25 30:1 Mt 36:16 much 23:14,17 27:23 67:23 68:1 68:4 76:11 85:19 101:20 multiple 73:2,8 myself 14:24 mystery 18:1,4 M.D 1:8,12,15 3:7 3:12 103:9 104:2 <hr/> N <hr/> Nadia 1:12,15 3:7 3:12,16,16 103:9 104:2 name 3:14 5:19 34:13 35:2,3 36:14,23 40:2,11 44:18,24 45:1 named 36:20 37:3,5 37:8,10 103:9 names 15:1 40:8 43:13 44:2 national 21:15,17 22:2 nature 22:9 52:4 58:16 necessarily 20:13 24:4 58:8 70:14 83:25 necessary 26:23 65:24 neck 48:2 52:19,25 72:25 73:7 80:16 81:24 87:14,15 100:20 necrosis 83:14 need 50:11 68:16 needed 50:4 needle 98:18,19,22 negative 59:21 negligence 30:23 31:1,12 neuroendocrine 19:13 25:13 never 4:19 44:16 45:6 101:6 new 38:16 41:15 newer 61:18 next 4:25 7:3 35:11 35:23
---	--	--	---	--

<p>nice 61:14 nodal 52:13 53:1 54:8,13,17 55:12 55:14 59:18 60:8 node 52:20 nodes 59:21 73:2,6 73:8 78:7 84:15 nodules 73:2,8 none 41:8 59:24 nonetheless 95:8 noninvasive 69:3,5 76:9,20 nonsmall 18:2,8,11 18:17,20,23,24 19:6,9,19 20:2,11 20:14,18 21:4 25:8 29:19 37:23 41:8 60:4,13 61:10,20 62:17 63:2,18 64:22 70:12,25 71:15 74:7 75:6,9,11,16 77:9,10 79:19 89:12,22,24 92:1 92:22 93:16,21 99:6 non-small 75:12 normal 90:18 normally 10:19 28:10 87:24 90:5 Notary 1:19 103:8 103:22 note 47:4 53:2,22 65:21 notes 6:4,9,9,11,16 6:19,24,25 7:2 12:8 53:10 54:7 55:2 nothing 36:21 60:7 101:21 103:10 noticed 7:21 notify 65:23 November 35:13,17 52:25 64:18 103:19 nowhere 8:17 nuclei 91:3 number 22:4 25:5,6 25:18,18 26:3,8 26:10 39:14 71:7 71:11 94:2,4 numbness 48:1 49:17 52:19 80:15</p>	<p>Nurenberg 43:17 44:1 nutrients 83:12</p> <hr/> <p>O</p> <p>object 5:5 objection 5:7,10 7:23 47:4 49:5 50:8 51:7,13,21 53:2,22 55:19,23 57:3 63:6 65:21 68:25 71:17 77:1 83:3 89:14 93:4 95:14 objects 5:9 observations 84:11 84:11 obstruction 77:21 obstructive 58:22 77:21 obtained 44:19 52:7 obvious 33:3 55:7 56:1 obviously 13:24 49:19 50:11 52:2 59:22 occasion 36:6 38:24 66:14 Occasionally 5:5 occasions 81:9 occurred 36:17 OCTOBER 1:13 off 17:4,5 35:18,19 35:21 43:24 101:17 office 2:5 8:6,13 103:18 offices 1:21 often 67:9 92:8 Ohio 1:2,20,23 2:7 2:14 3:8 43:2 103:3,8,19,23 okay 5:3,4,11,12 10:6 24:9 30:9,10 35:9,10 50:20 65:4 66:1,2 70:22 75:18 85:15 96:6 old 61:17 90:11 omission 68:14 omitted 10:23 once 31:23 66:22,25 70:7 71:2</p>	<p>oncologist 15:24 51:16 99:4 oncologists 72:12 82:22 oncology 15:18,21 15:23 one 6:14 14:17,19 15:6 19:2,3,5 20:5 21:23,25 22:4 23:7 26:5 27:17,25 32:23 33:1 34:4 36:4,6 36:24 38:1 39:8 40:4,7,18 41:18 42:11 44:11,15 56:23,24 58:3 61:1 64:3,9,15 66:25 67:7,22 84:12 86:13 92:2 98:7 100:5 ones 18:19 41:3 43:20 51:8 70:16 70:18 77:18 one-third 75:11 only 5:25 8:8 41:18 54:21 56:11 61:25 75:4 84:3 85:6 95:21 96:19 op 100:11 operate 71:25 opinion 13:14 29:8 29:18 34:9 46:1 50:21 60:11 61:6 61:19 64:23 78:9 79:25 81:4,15 85:10,20 86:3,25 87:9,19 92:24 95:19,21 96:17 100:12,15 opinions 4:14 5:23 11:5,7 12:24 13:9 13:20,25 64:1 68:20 101:10,12 101:15 opportunity 8:8 65:24 101:13 opposed 8:12 16:3 29:22 32:24 42:24 24:13,15,15,22 87:24 88:23,25 89:12 order 50:1 ordered 51:10 organs 57:10 89:8</p>	<p>origin 75:24 90:12 original 24:22 originated 78:11 79:5,7 originates 70:4 75:22 origination 75:19 other 5:3 12:15,18 12:22 14:14 15:1 15:6,11,25 19:6 28:16 30:5 31:24 32:8 33:4,5 37:3 37:6,12 38:17,25 39:22,24,25 40:8 40:19 43:21,25 44:1,4 50:1 55:6 56:16 58:8,20 59:24 60:9 62:3 63:13 66:6 68:14 68:15 69:12 71:24 76:17,25 83:17 84:8 88:25 89:8 89:15 90:20 94:14 94:25 98:23 101:2 otherwise 19:13 37:9 103:15 out 15:20 16:17 32:23 36:21 43:9 51:5 62:17 64:9 65:17 72:15 outcome 13:21 34:11 94:17 outlined 17:19 outside 18:16,19 44:8 58:17 60:7 76:23 77:6 97:6 over 14:13 23:13 42:2 74:3 98:13 Overall 41:22 overlapping 5:3 98:5 oversight 10:24 own 43:9 o'clock 1:23</p> <hr/> <p>P</p> <p>P 1:5 page 21:8,10,18,20 24:13,15,15,22 25:2 26:2,3,8,10 26:12 pages 24:23 pain 101:1,5,6</p>	<p>palpation 84:9 PAP 33:3 paper 8:22 papers 64:5 paragraph 45:11 parenthesis 21:25 Parma 1:21,22 14:6 15:9,11,12 29:14 67:8,14 part 14:17 15:22 23:5 27:23 31:18 48:20 54:19 61:14 participants 22:11 22:13 23:2 particular 28:20 65:2 parts 69:12 party 36:3 103:15 passing 66:13 past 42:8,8 pathologic 27:12 33:6 62:20 96:9 99:2 pathological 33:12 72:22 pathologically 57:24 59:22 61:22 94:23 pathologist 3:23 14:8 17:17 27:3 44:23 60:2 90:9 98:7,8,12 pathologists 14:14 15:5 21:16 22:2 23:20 28:1 82:23 90:19 99:11 pathology 14:10 15:22,23 16:21,22 17:7,15 26:24 27:4,7,7,8,10,16 27:17,19 28:3,10 29:12 36:22 37:19 37:20 38:4 52:2,6 85:3 94:11 patient 16:9,10 28:24 29:2,8,23 34:5,6 46:11,20 48:5,6 49:15,18 49:23 50:6,10 51:18 52:18 53:6 55:5,9,18 60:4 61:21 62:2 80:14 80:18,20,21 85:12 93:18 99:1,3,7,13</p>
--	--	---	---	---

<p>101:2 patients 16:4,5 29:16 62:14,16,16 63:15 64:16 66:16 71:14,19,22 74:3 84:12 88:17 92:8 92:13,14 93:20,22 patient's 28:15 50:12 PC 7:1 peer 25:6 26:7 people 100:7 per 41:13,21 68:1 percent 38:11 62:13 63:4,11,20 71:21 94:7,7 percentage 63:14 75:7 percentages 71:18 perfect 101:7 performed 74:2 perhaps 8:12 57:19 94:22 98:16 period 46:21 77:3 80:1 92:23 periodically 23:12 periods 76:7,25 peripheral 77:13 77:14 78:2,22 periphery 76:17 peritoneum 100:2 person 14:19 27:20 61:1 personality 91:19 person's 86:13,14 perusal 6:10 phenomenon 71:4 71:21 physically 16:11 physician 31:18 48:4,6 50:10 98:25 physicians 27:21 64:6 pinpoint 79:10 pitfalls 84:2 place 8:14 16:24 92:6 103:14 placed 8:12,15 plaintiff 1:6,17 2:2 31:12 42:23,25 plaintiff's 5:19 43:14,25 44:5</p>	<p>plan 65:12,14 PLEAS 1:1 please 3:14 pleura 58:11,14,23 Plevin 43:17 44:1 pneumonia 45:24 49:17 53:13 54:22 77:21 pneumonitis 56:15 58:22 point 20:5 22:8,17 45:16 69:24 79:10 100:18 polygonal 98:3 poorly 19:18 20:11 20:13,16,19 29:19 74:11 77:24 78:2 88:19 90:3,7,16 91:13 position 14:7 17:13 positions 17:18 possession 22:25 possible 4:23 45:13 45:19 68:24 69:4 94:16 potential 13:20 70:10,15 78:5 potentially 16:2 65:24 69:18,18 power 22:8,16 Powers 1:22 practice 17:8,10 29:11 precautions 4:22 prefer 3:18 preferably 69:3 preparation 64:11 prepare 7:8,14 9:23 prepared 7:12,19 9:8 10:17 preparing 9:14,17 10:25 11:13 presence 58:21,22 58:23 95:5 present 89:7 92:11 presentation 22:3,6 22:17,21 23:4 47:20,25 51:19 52:17 80:14,25 85:13 presentations 22:8 30:3,4 presented 23:19 24:11 38:15 49:16</p>	<p>80:15 85:10 87:14 presenters 22:4 presents 50:13 press 86:15 presume 38:21 96:23 pretty 23:14,17 85:19 89:25 previous 49:22 primary 18:7 49:24 73:12 87:1 principle 96:13 printed 23:10,13,19 24:4,5 prints 8:22 prior 12:11,22 22:14 46:25 privileges 45:7 probability 45:12 73:18 79:12 probable 85:11 92:25 probably 4:10 8:3,5 33:8,8 34:10 39:13,21 40:25 41:25 44:3 63:22 63:23 66:24 68:11 76:20 80:2,24,25 81:24,25 82:11 85:13 86:11 87:16 95:16 96:3,18,21 100:19 Proceed 3:9 Procedure 5:8 98:24 process 65:19 professional 66:15 prognoses 61:3 prognosis 28:15 60:3,12,20 61:10 62:8,8,9 64:23 93:6,7,18,22 prognostic 29:1 62:12 75:5 progress 7:12 progressed 29:9,23 progression 32:3 74:14,17 protocol 57:24 protocols 60:25 provide 12:25 13:5 13:9 22:7,11,13 24:3,7 29:8,18 31:7 34:22 60:11 98:21 99:10,11</p>	<p>provided 3:8 27:13 83:12 provides 13:1 providing 13:20 28:14 proximal 77:11 proximate 37:21 38:3 Public 1:19 103:8 103:22 publications 25:7 26:3 published 64:6 pulmonary 21:21 21:24 26:4,19 pulmonologists 27:21 pure 78:18,22 purpose 51:10 65:16 97:5 purposes 3:4 10:1 75:5,5 purse 97:13 pursuant 1:20 put 10:19 37:2 57:23 68:8 91:13 96:22 Putting 35:22 p.m 1:23 102:5</p> <hr/> <p>Q</p> <p>qualified 60:2,11 61:2,5 96:11 101:12 103:9 quarrel 63:4 question 4:25 5:1,6 5:8,9,11,13 7:3 16:6 45:8 49:8 60:16 70:21 72:11 76:18 96:11 questions 4:12,13 14:4 27:21 30:9 67:22 81:2 quicker 89:23 quickly 25:17 quote 64:25</p> <hr/> <p>R</p> <p>radiation 72:9 radiologic 84:17,18 radiological 16:18 radiology 16:18,20 16:22</p>	<p>range 41:15 62:12 63:4,20 80:2,6 rate 32:3 63:19 74:14,17 83:14,21 85:7 88:8 rates 82:17 rather 47:23 71:7 71:11 75:17 read 5:15 11:25 12:2,4 50:15 101:22,25 really 30:25 33:4 42:7 44:2 57:8 61:12 63:13 71:6 74:21 76:11 83:7 84:5 86:12 87:12 89:16 90:1,9,18 90:25 94:2 97:25 99:24 100:4 reason 50:17 55:6 84:12 93:10 94:25 reasonable 45:12 73:18 reasonably 63:25 reasons 62:22 95:1 recall 44:1 46:12 53:19 63:23 97:8 received 9:13,16 10:4 11:2,12,14 11:16,19,21 12:13 receives 61:22 recognize 36:14 recognizing 9:6 recommendations 61:13 reconvene 65:25 record 3:15 11:11 17:4,5 21:8 24:7 24:21 35:21 41:2 43:24 records 9:9 10:9,12 10:15 20:1 34:16 47:5 48:23 49:8 49:10,12 51:1 52:12,16,22,24 53:23 54:2 56:1 68:2 82:4,6 reduced 103:11 refer 7:16 32:10 59:2 60:18 65:5 75:16 83:6,9 97:15 98:1 reference 54:13</p>
--	---	---	---	---

referenced 10:1 12:17 21:2	8:21,23 9:5,7,7,14 9:17,23 10:1,2,14 10:17,25 11:7,8 11:13 13:8 29:15 45:10 50:16 68:13 68:15,17,19 73:13 97:5,6	46:23 47:7 48:16 51:14 52:11 54:20 85:3 97:10	Seacrist 40:14,15 40:17 seal 103:18 Seattle 22:2 second 10:10 77:16 section 36:18 64:20 65:2	85:9 87:13 similar 93:23 Sinai 36:16 since 67:14 97:4 single 61:1 sit 12:21 13:3 94:5 site 75:21
references 20:1 23:16 25:16	reported 25:13 63:19	reviewed 6:18 7:11 7:15 9:25 10:13 12:10,18 25:6 26:7 39:24 40:5 40:16 42:2,14,22 43:8,14 44:4,8 68:10 80:18 97:4 97:4	see 6:4,8 16:5 20:1 20:5 21:11 48:18 50:4 52:23 54:16 55:10 56:22 57:15 72:7,8,20 76:15 90:5 97:2,11 100:10	sites 78:8 84:8 95:6 situ 69:10,13 76:8 76:12,15 situations 37:14 83:10 84:6 six 21:10 38:19 40:22 41:13 86:17
referrals 44:21	reporter 1:19 5:6 reporting 103:16 reports 7:7 8:4 10:12,13,20 100:11	reviewing 12:22 18:10 27:19 49:15 51:1 68:2	seeing 16:10 48:4,6 seen 46:6,13,17,24 63:17,22 80:18 81:5,9 82:18,21 85:23 98:2,3	sixth 39:10,18 size 56:4,14 58:25 71:12 73:11,19 80:9 82:9 84:16 85:8 91:24 92:15 95:2,9,23,24,25 99:18,22
referred 3:18 20:6 99:4	representing 32:19 38:5,12 42:23,24 represents 8:2 9:3 request 24:6 34:22 38:5,11,25	right 3:22 4:20 12:21 13:3 31:6 41:6,7 48:11 54:25 57:17 59:5 86:13 92:6,6 94:5	seminars 21:14 25:4	skin 69:12 Skylight 2:5 slide 22:8 slides 10:5,5,8 12:18 15:25 18:10 19:21,22 22:15 24:5 48:14 68:2 72:8 85:3 86:9 94:14 96:22 97:4 97:11 98:14
referring 51:9 55:2 74:21 78:14 99:21	research 64:10 resect 99:14 resectable 72:3,6 resection 98:15,19 resemblance 90:11 resemble 90:15,17 resident 16:13 36:15,17	Rob 21:6 24:18 ROBERT 2:12 ROGER 1:8 roughly 87:5 routine 4:11 routinely 16:6 Rozman 67:2,3 rule 51:5 103:17 Rules 3:8 Russo 1:7	sent 9:11 sentence 45:15 75:17 separated 32:23 separately 25:24 serial 84:18 serve 38:24 39:7 Services 14:10 serving 38:2 set 1:24 22:12,15 35:23 103:11,18 seven 26:3,8 several 19:7 21:21 27:18 56:16 66:6 74:3	slower 77:19 small 18:22 88:6 89:3,4,12,19 99:3 smaller 82:12 95:10 95:12,17 96:1,4 96:18 99:21
regard 13:10,18 regarding 33:2 regardless 58:12,24 59:10 60:14 91:23 91:24 92:23	required 72:9 research 64:10 resect 99:14 resectable 72:3,6 resection 98:15,19 resemblance 90:11 resemble 90:15,17 resident 16:13 36:15,17	same 21:7,9 23:14 23:17 32:13 54:12 55:23 62:20 73:2 73:8 74:9 90:4 92:15,15,16,16,17 98:9 100:19 saw 53:6,11,20 54:15 55:18,21 56:2 94:13 96:19 saying 13:14 30:25 35:8 81:7 85:20 96:11	show 94:1 side 73:3,8 Signature 102:6 signed 8:4 significance 11:6 56:5 significant 69:6 88:10 94:23 96:5 96:16 significantly 95:10 signs 20:15 47:20 50:12 52:20 56:2	smears 33:3 smoothly 4:23 Society 21:16 22:1 23:20 solely 22:5 51:19 some 9:13 11:2 14:4 23:23 25:10 28:14 29:1 30:9 38:17 39:25 42:14,19 44:10,13 55:6 56:5 57:10,19 60:19 61:5 62:18 62:19,21,22 64:5 65:19 70:23 71:1 74:1 76:17 84:8 93:20 100:8,9,10
Registered 1:18	resources 63:24 respiratory 48:1 49:16 respond 74:25 response 83:19 responsibilities 26:1 responsibility 27:25 responsiveness 89:17 result 84:14 retained 32:18 33:16 34:1 36:2 37:15	Rob 21:6 24:18 ROBERT 2:12 ROGER 1:8 roughly 87:5 routine 4:11 routinely 16:6 Rozman 67:2,3 rule 51:5 103:17 Rules 3:8 Russo 1:7	shape 97:23,25 shaped 97:2,16 sheet 59:4,6 short 14:20 15:6 shortly 13:25 show 94:1 side 73:3,8 Signature 102:6 signed 8:4 significance 11:6 56:5 significant 69:6 88:10 94:23 96:5 96:16 significantly 95:10 signs 20:15 47:20 50:12 52:20 56:2	slides 10:5,5,8 12:18 15:25 18:10 19:21,22 22:15 24:5 48:14 68:2 72:8 85:3 86:9 94:14 96:22 97:4 97:11 98:14
regular 66:19,21 relate 13:20 25:22 related 15:23 21:11 21:13 29:5 37:21 49:24 95:6 101:3	respective 47:17 48:2 80:16 retrospectively 48:12 81:7,14 return 54:24 returned 54:18,21 55:6,9,9 revealed 47:13 review 7:13 10:8,8 10:15 41:14,24 44:17,23 45:11	Rob 21:6 24:18 ROBERT 2:12 ROGER 1:8 roughly 87:5 routine 4:11 routinely 16:6 Rozman 67:2,3 rule 51:5 103:17 Rules 3:8 Russo 1:7	shape 97:23,25 shaped 97:2,16 sheet 59:4,6 short 14:20 15:6 shortly 13:25 show 94:1 side 73:3,8 Signature 102:6 signed 8:4 significance 11:6 56:5 significant 69:6 88:10 94:23 96:5 96:16 significantly 95:10 signs 20:15 47:20 50:12 52:20 56:2	slides 10:5,5,8 12:18 15:25 18:10 19:21,22 22:15 24:5 48:14 68:2 72:8 85:3 86:9 94:14 96:22 97:4 97:11 98:14
relationship 46:8 46:13 53:21 66:15 relative 103:15 relevance 23:23 25:8,10 relevant 12:23 21:3 reliable 57:1,5,21 61:7 63:25 64:24 65:11,15,20	result 84:14 retained 32:18 33:16 34:1 36:2 37:15	same 21:7,9 23:14 23:17 32:13 54:12 55:23 62:20 73:2 73:8 74:9 90:4 92:15,15,16,16,17 98:9 100:19 saw 53:6,11,20 54:15 55:18,21 56:2 94:13 96:19 saying 13:14 30:25 35:8 81:7 85:20 96:11	shape 97:23,25 shaped 97:2,16 sheet 59:4,6 short 14:20 15:6 shortly 13:25 show 94:1 side 73:3,8 Signature 102:6 signed 8:4 significance 11:6 56:5 significant 69:6 88:10 94:23 96:5 96:16 significantly 95:10 signs 20:15 47:20 50:12 52:20 56:2	slides 10:5,5,8 12:18 15:25 18:10 19:21,22 22:15 24:5 48:14 68:2 72:8 85:3 86:9 94:14 96:22 97:4 97:11 98:14
remember 33:1,4,7 33:25 34:3,13 37:24 40:2,11,21 41:1 43:12,13,18 44:2 46:16,22 47:3 52:15 57:8 57:11 59:1,7 68:9 94:2	result 84:14 retained 32:18 33:16 34:1 36:2 37:15	same 21:7,9 23:14 23:17 32:13 54:12 55:23 62:20 73:2 73:8 74:9 90:4 92:15,15,16,16,17 98:9 100:19 saw 53:6,11,20 54:15 55:18,21 56:2 94:13 96:19 saying 13:14 30:25 35:8 81:7 85:20 96:11	shape 97:23,25 shaped 97:2,16 sheet 59:4,6 short 14:20 15:6 shortly 13:25 show 94:1 side 73:3,8 Signature 102:6 signed 8:4 significance 11:6 56:5 significant 69:6 88:10 94:23 96:5 96:16 significantly 95:10 signs 20:15 47:20 50:12 52:20 56:2	slides 10:5,5,8 12:18 15:25 18:10 19:21,22 22:15 24:5 48:14 68:2 72:8 85:3 86:9 94:14 96:22 97:4 97:11 98:14
Reminger 2:11,11 38:22,22 39:3,3 39:23,23,25,25 40:20,20	result 84:14 retained 32:18 33:16 34:1 36:2 37:15	same 21:7,9 23:14 23:17 32:13 54:12 55:23 62:20 73:2 73:8 74:9 90:4 92:15,15,16,16,17 98:9 100:19 saw 53:6,11,20 54:15 55:18,21 56:2 94:13 96:19 saying 13:14 30:25 35:8 81:7 85:20 96:11	shape 97:23,25 shaped 97:2,16 sheet 59:4,6 short 14:20 15:6 shortly 13:25 show 94:1 side 73:3,8 Signature 102:6 signed 8:4 significance 11:6 56:5 significant 69:6 88:10 94:23 96:5 96:16 significantly 95:10 signs 20:15 47:20 50:12 52:20 56:2	slides 10:5,5,8 12:18 15:25 18:10 19:21,22 22:15 24:5 48:14 68:2 72:8 85:3 86:9 94:14 96:22 97:4 97:11 98:14
render 46:1 101:12 rendering 61:6 repeat 55:20 94:20 rephrase 5:15 report 5:21,25 7:1 7:4,9,12,14,16,17 7:19,20 8:11,17	result 84:14 retained 32:18 33:16 34:1 36:2 37:15	same 21:7,9 23:14 23:17 32:13 54:12 55:23 62:20 73:2 73:8 74:9 90:4 92:15,15,16,16,17 98:9 100:19 saw 53:6,11,20 54:15 55:18,21 56:2 94:13 96:19 saying 13:14 30:25 35:8 81:7 85:20 96:11	shape 97:23,25 shaped 97:2,16 sheet 59:4,6 short 14:20 15:6 shortly 13:25 show 94:1 side 73:3,8 Signature 102:6 signed 8:4 significance 11:6 56:5 significant 69:6 88:10 94:23 96:5 96:16 significantly 95:10 signs 20:15 47:20 50:12 52:20 56:2	slides 10:5,5,8 12:18 15:25 18:10 19:21,22 22:15 24:5 48:14 68:2 72:8 85:3 86:9 94:14 96:22 97:4 97:11 98:14

<p>somebody 35:8 someone 7:6 8:12 22:19 29:18 49:21 50:9 something 22:24 25:18 34:19 35:5 65:6,10,14,20 97:16 sometime 10:14 sometimes 15:13 37:20 83:14,20 89:19 sorry 24:16 32:11 55:20 60:21 81:11 97:14 sort 20:7,23 59:4 62:12 66:13 source 57:1,5,21 64:3 spaces 79:1 span 88:24 speaking 32:13 56:18 57:18 58:4 59:19 87:5 specialists 61:4 90:20 specialty 26:25 27:4 51:17 specific 19:20 25:12 29:16 63:15,15,16 65:1 97:10 100:18 specifically 52:15 63:23 64:12 93:6 specifies 14:4 59:1 97:8 specified 103:14 specify 86:12 specimen 28:17 specimens 16:1 28:11,13 spectrum 42:10 83:2 86:20 87:7 speculating 87:18 spread 59:12,18 60:6 69:19 70:11 70:24 87:24 88:8 88:22 89:5,23 90:4,5 91:6 spreading 76:7,23 77:4,5 squamous 19:5,11 19:14,21 20:8,15 69:10 70:5 74:10 74:14 75:14,15,20</p>	<p>75:25 76:4,21 77:9,11,13,17,25 78:3,10,19,20,23 79:4 87:23 88:4,8 88:12,17 89:1,6 89:24 90:5,13,16 90:18 98:4 99:6 SS 103:4 staff 17:16 stage 28:21 29:9,9,9 29:10,18,24,24 32:2 57:5,24 58:24 60:5,10,12 61:10,21 62:8,11 62:17,21 63:1,9 63:18 69:2,3,9,13 69:17,23 71:15,22 72:2,5,5,18,19,22 76:8,9,12,15,20 81:19 86:2,5,10 88:5 89:17 92:3,3 92:15,16,21,24 93:2,7,8,12,13,17 93:21,24 94:1,8 95:18,24 99:8 stages 60:20 62:10 staging 13:19 16:2 21:3 28:20,20 29:5 56:20 57:2,4 57:16,22 58:3 59:3 61:8,9 64:22 96:7,8,9,12,17 stamp 8:10,14,15 8:21 stand 13:13 64:18 standard 13:15 31:4,9 52:2 standpoint 11:5 16:1 47:13 65:12 70:17 92:5 100:4 start 5:2 21:20 69:9 69:11 76:22 started 27:15 41:17 67:14 78:17 79:10 starts 21:19 70:3 state 1:20 3:14 43:1 85:2 103:3,8,23 stated 54:4 59:24 statement 6:15 13:22 47:22,23 65:9 69:1 74:12 74:23 80:5 87:21 statements 68:10</p>	<p>statistic 63:5,17 statistically 29:3 63:2 89:10 statistics 63:1 92:1 93:25 status 52:8 statute 1:17 stay 76:5,24 77:2 stays 76:12,19 steady 42:7,9 Steele 67:19 Steele's 11:23 Steinetz 15:7,11 stenotypy 103:11 still 27:7 28:5 91:25 92:8 stoma 69:17 70:8 stop 45:16 Street 2:6 strike 46:4 75:15 structure 28:16 72:8 79:3 97:1,17 97:24 structures 56:15 studies 47:14 48:24 50:5,22 51:4 60:24 61:16 63:20 74:2 93:15 99:4 study 17:23,24 subcategories 19:10 subject 23:8 34:3 57:18 subjectivity 98:5 subsets 60:24 subspecialties 27:6 subspecialty 27:1 substitute 25:2 Sue 40:13,14,15 suffice 10:16 sufficient 72:21 sufficiently 12:4 suggest 92:7 suggestive 50:16 53:1 55:17 Suite 2:5 supply 83:16 support 64:1 sure 25:20 31:2 32:12 34:25 54:5 62:11 81:12 92:19 101:9 surgeon 98:22,25 99:13</p>	<p>surgeons 67:8 surgery 72:10 99:9 surgical 17:15 27:4 27:8 28:11,13,17 61:25 71:16,19,23 98:14 surprised 100:10 surrounding 69:16 70:8 survival 60:12 61:3 61:15,20 63:3,10 63:19 89:11 92:9 92:12,12,13,25 93:1,22 94:7,8 survive 62:14,18 survivor 94:1 suspect 48:7 49:18 50:17 suspended 45:7 suspicion 16:9 Sutherland 67:20 Sutherland's 11:23 sworn 3:10 103:10 symptoms 47:20 48:1 49:16,17,23 50:12 81:14,25 82:2 85:9 87:14 87:15 95:6 101:2 system 83:19 S-T-E-I-N-E-T-Z 15:7</p> <hr/> <p>T</p> <hr/> <p>T 58:24 take 5:6 16:16 19:8 21:5 37:18 38:16 45:6 62:16 64:18 71:2 87:8 taken 1:18 4:6,18 30:13 51:9 103:14 takes 71:6 83:7 84:5,15 taking 13:13 83:13 83:15,18,21 talk 4:3 8:8 13:24 20:22,23 37:13 48:13 talked 30:5 42:17 66:16 67:16 93:16 talking 18:1 23:24 38:20 41:22 63:14 86:16,17 88:16 91:12 94:10 97:7</p>	<p>100:21 teaching 25:25 Telephone 6:6,13 tell 4:9 5:14 7:18 9:7 11:20 14:21 15:1 25:17 42:22 46:23 65:8 73:17 74:15 78:16 79:12 79:21 80:4 81:19 82:3,8 87:13,17 93:5,25 94:6,13 94:22 97:11 99:13 tells 84:4 temporal 46:7 ten 41:17 42:2,10 term 74:16,17,20 74:22 81:7 90:8,9 90:23 91:11,13,16 91:18,20 99:23,23 99:24 100:6 terms 4:12 6:10,23 16:8,23 18:6 19:4 20:2 23:10 28:19 38:9 46:6 54:12 58:3 61:9 62:12 63:1,9,18 75:6,19 82:23 93:18 96:7 97:22 100:8 test 51:23,24 testified 30:11,16 30:21 31:16,21,22 31:25 32:5,9,16 32:17 33:19 35:4 35:7 37:22 testify 8:9 33:17 34:1 35:12,23 45:18 60:3 64:19 68:4 85:21 86:1 103:10 testifying 12:23 32:24,25 38:4,9 testimony 8:10 37:13 38:10,14 40:24 41:25 43:11 53:15 103:11,12 tests 51:25 99:8 thank 37:8 46:3 66:3 101:20 their 12:6 61:6,14 61:15 71:8,9,10 78:4 82:17 88:14 themselves 99:16 therapy 72:10</p>
--	---	--	---	--

<p>thing 48:12 things 84:15 89:10 think 7:15 10:3,24 11:10 12:7,13 19:16 20:5 21:6 21:20 26:10,22 30:6 32:7 35:15 38:7 41:10,12,17 41:21 44:10 47:2 49:21 52:17 53:9 53:12,18,19 58:20 61:4 63:22 64:25 65:3 68:18 71:5 72:11 73:1,15,21 74:5 75:9 78:15 79:11 80:19 81:6 86:5 84:24,25 97:19 101:8,16,19 thinking 100:22 though 4:17 23:11 25:12 33:10 50:13 51:16 62:20 63:17 77:8 90:8 95:21 96:15,16 thought 53:5 65:18 65:19 75:25 three 14:13,16,17 14:22,24 15:8,10 19:17 21:25 32:8 40:25 42:8 44:4 56:9 58:5,10,17 59:10,13,16,23 60:6,8 67:15 80:9 86:17,19,20,21 through 6:3,7 19:25 25:4,17 41:3 throw 94:3 time 6:14,18 12:10 12:13 14:17,17,22 14:25 15:2 16:7 22:11,16 24:10 26:22,23 27:14 33:1,19 34:7 36:4 36:15 37:6 38:1 39:19 46:5,13,21 47:18 48:2,3,8,14 50:17,19,23 51:3 52:9,17,20 53:6 53:20 54:9 56:5 59:3 73:10,25 76:7 77:22 78:5 78:16 80:1,2,10 80:13,24,25 82:5 82:7,12 83:5,7</p>	<p>84:2,3,5,16 85:13 85:14 86:6 87:16 92:6,16,16,23 95:2 98:16,22 99:19 100:18,19 100:25 103:14 times 4:9,10,18 30:12,19,20 31:20 31:21,24 32:4,8 32:15,17,22,23,25 35:25 37:12,25 39:6,9 41:24 46:16,24 73:16 78:21 82:19,24 89:7 tissue 17:25 36:19 52:3 69:16 90:12 title 18:17 today 4:3 6:4 12:12 14:6 26:6 41:6 65:17 67:24 94:4 97:13 today's 65:21 together 12:11 75:12 told 48:17 74:5 94:15,21,23 101:11 Tom 43:20 topic 25:8,19 30:4 total 14:16 21:10 42:21 touch 30:4 touching 25:19 Tower 2:5 tracheobronchial 77:12,20 78:25 79:8 training 27:2 84:24 93:15 transcribed 103:12 transcript 101:23 transcription 103:12 transfer 27:24 transparencies 22:18 treat 51:18 99:1 treating 16:3,8 treatment 16:2 28:23 60:14,15,17 60:25 61:9,12,23 63:16 75:1,2,4 91:24 92:17 98:24</p>	<p>tree 77:12,20 78:12 78:25 79:9 trial 34:8 42:19 45:18 65:18 68:5 85:21 tried 44:15 true 9:3,4,18 11:2 11:18 12:8,9 13:11,16,17 14:1 15:15,16 17:2 18:8 20:12 23:21 24:12 28:11,24 29:24,25 30:12 33:17 37:16 42:15 46:8 50:7 51:6 52:9,10 57:22 61:11 81:17 85:24 89:13 95:13 96:2 96:20 103:12 trust 102:2 truth 103:10,10,10 try 4:22 5:14 6:14 19:8 64:8 91:14 trying 19:4 73:4 97:19 TUESDAY 1:13 tumor 18:7 19:9,19 20:18 26:5,9 29:6 29:15 32:3,3 45:14 52:4,8 56:4 56:9,12,14,17 58:5,9,16,24 59:9 59:13,16 68:12,23,25 60:1,5 62:1,4,5,6 69:22 70:3,8,10 70:25 71:3,13 72:2 73:9,11,12 73:19,24,24 74:9 76:16,18 78:17,18 78:20 79:14,14,16 79:20,22 80:2,10 82:9 83:7,8,10,13 83:15,18,20,22 84:2,3,20 85:4,7 87:2,8,10 89:2 90:11,15 91:2,22 91:23 95:2,4,10 95:11,23,24,25 96:1,2,9,18 98:2 98:20 99:14,17 100:3,9 tumors 25:12,14 27:11 69:9 74:3 77:23 78:1,22</p>	<p>79:16,18 80:12 83:9 84:5,14,22 88:25 90:15 91:2 91:3,5,7,8,8,10 92:13,14 93:10,23 97:7 100:2 twice 31:23 46:18 48:18 two 15:1,5 19:16 26:8 32:23 33:5 41:18 43:16,20 46:19 65:19 66:25 80:8 81:9 86:16 two-thirds 75:13 type 7:7 19:3 26:5 28:22 29:6 44:25 62:5 63:16 71:8 74:1 75:2 83:11 84:22 87:8 88:22 89:2 95:3,4 typed 6:9,16,25 7:5 7:16 types 18:24 19:1,16 74:6,6,8,24 76:25 98:2 typically 29:7 51:18 76:24 97:16 98:14 T1 56:10,12 58:4,19 60:1 T1-N0 59:20 T2 59:14 T4 56:17 58:12 <hr/> U <hr/> UH 15:13 17:13 27:13,17,23 28:1 28:2,5 41:19 66:20 98:13 ultimate 20:24 undated 10:2 under 1:17 19:2 25:25 26:7 96:22 103:16 understand 4:3,15 5:13,14 8:7 30:25 31:2,5 56:3 62:24 64:17 85:19 92:19 95:19 96:10 understanding 13:4 63:9 undifferentiated 19:12 unequivocal 6:23</p>	<p>unfortunate 37:4 University 17:9 23:6 25:21 26:1 36:9 44:22 66:12 unless 8:20 13:1 63:14 unlikely 49:20 until 4:24 5:1,9 26:13 65:7 84:6,7 100:25 updated 23:16 upgrade 58:23 upgraded 57:7 upstages 59:25 use 22:16 23:5 57:24 74:16 86:19 90:8,24 91:11,13 91:16,17 97:23 100:7 used 23:3 51:11 81:6 90:19 91:20 97:16 99:25 100:1 using 74:22 82:24 100:5 usually 7:7 8:3,22 10:7 23:7 44:22 51:11,22 59:2 60:18 61:15 69:9 70:3,8 73:25 75:23 76:22 77:19 77:23 78:23 79:16 80:12 83:9 85:1 88:23 89:6 91:4 98:17 99:3 100:1 <hr/> V <hr/> vague 74:20 90:9 90:19 variables 88:20 89:16,21 varies 61:24 various 17:17 18:24 18:25 verify 54:3 version 21:9 versus 53:14 88:9 88:13 90:24 92:13 92:17 95:24 very 25:17 27:11,24 41:19,20 59:14 64:6 65:22 67:11 75:1 84:5,5,16,16</p>
---	--	--	---	--

85:11 90:10,11 91:3 101:20 vessels 70:9 visible 84:7 visit 55:11 vitro 74:1 83:11 Vivian 1:18 5:15 103:8,22 volume 83:6,8 84:3 voluminous 25:16 vs 1:7	well 5:16 9:12 15:12,13 16:5,19 18:5,9 20:20,20 21:19 22:5 25:10 27:11 33:1 36:4 37:7 38:10 54:3 54:15 56:11 57:23 60:16 61:12,24 63:12 65:9 70:20 71:5 72:1 74:1,20 75:5 77:8,15,18 78:2 79:4,18,25 80:9 83:4,5 85:8 85:9 89:15 90:7 90:14,21 95:4 97:3,19 98:25 99:24 100:7 101:2	worry 35:8 wouldn't 35:4 50:4 100:5 write 26:19,23 written 6:5,9,16 22:7 29:15 wrong 56:8 wrote 26:14	1400 2:13 15 4:10,18 30:12 35:25 17 21:2,10 19th 9:21,23 10:11 1986 17:12,14 1986-87 16:15 1987 17:15 36:10 1994 22:3 23:11 1995 87:5,8 1997 87:5,8 1998 24:12 1999 24:13 45:23 46:15,25 47:1 50:15 54:7,17 81:17,20 82:10 86:22 95:7	4:10 102:5 44113 2:7 44115 2:14 457639 1:7
W		X		5
W 2:6 wait 4:24 5:1,9 waive 102:3 waived 102:6 wall 58:12,15 want 6:22 8:9 9:10 14:3 20:25 35:1 37:13 45:15,16 47:5 54:2 62:24 63:13 64:17 72:15 88:19 90:7 92:19 95:20 97:9 101:9 101:22,25 wanted 22:20 55:9 wants 53:24 Warner 2:12 5:5,22 7:23 8:19 9:11,13 9:17 10:4,11 11:1 13:1,4 24:6,7,20 24:24 35:16,19 38:17,21 39:1,6 39:20 40:23 47:4 49:5 50:8 51:7,13 51:21 53:2,22 55:19,23 57:3 63:6 65:23 68:25 71:17 77:1 79:23 83:3 89:14 93:4 95:14 101:24 102:2 Warner's 8:6,13 41:5 way 27:15 30:2 43:10 57:23 66:3 72:7 86:19 98:10 101:5,18 ways 74:25 week 54:21 66:23 weeks 65:19 welcome 54:1	went 41:3 44:16 48:20 100:25 were 3:3 11:14 17:2 19:21,22 22:4,17 25:13 31:17 32:4 32:5,6,7,9,23 33:12 35:9 37:3 38:1,2,4 41:8,11 41:21 43:1,4,16 43:20 44:3,12 47:14 49:10,12 50:23,25 51:2,4 52:25 57:20 66:19 74:11 92:6 104:5 WHEREOF 103:18 while 38:20 95:9 98:3 white 48:23 whole 103:10 WILLIAM 1:4 wind 36:11 witness 1:15 3:7 10:13 30:22 35:17 37:15 102:1 103:18 woman 40:10 words 50:1 work 7:12 15:8,10 worked 40:20 working 66:11 67:14 works 15:11 67:11 workshop 21:21,24 24:11 workshops 21:14 25:3	X 62:13 x-ray 47:21 50:14 51:9,11,14,20,22 52:5 84:8,13	2 2 3:3 5:19 7:5 10:2 12:17 29:9 104:5 2nd 2:6 20th 35:17 2000 17:12 45:15 45:20 47:19,24 48:7,20 49:2,11 49:13 52:14 54:24 55:3 80:10,19 86:24 87:11 94:17 95:3 2002 9:21,23 2003 1:13 7:25 8:1 9:3 103:19 2004 103:24 241-2600 2:8 25 41:25 42:1,13,21 28 1:13 28(D) 103:17	6 5th 56:24 57:6,14 50 71:21 94:7,7
		Y		7
		yeah 99:10 year 17:14 23:15,15 33:22 34:4 38:15 38:19 41:13,19,21 42:6,10,11 57:7 years 14:13 17:10 21:22 23:13 27:18 27:22 41:16,17 42:3,8,9 61:16,17 62:14,19 67:15 76:20 86:8,11,21 86:21 younger 27:25 Youngstown 44:11	2 2 3:3 5:19 7:5 10:2 12:17 29:9 104:5 2nd 2:6 20th 35:17 2000 17:12 45:15 45:20 47:19,24 48:7,20 49:2,11 49:13 52:14 54:24 55:3 80:10,19 86:24 87:11 94:17 95:3 2002 9:21,23 2003 1:13 7:25 8:1 9:3 103:19 2004 103:24 241-2600 2:8 25 41:25 42:1,13,21 28 1:13 28(D) 103:17	7007 1:22
		S		8
		\$300 68:3 \$400 67:25 68:6		8 103:24 80 63:3,11,20
		I		9
		1 3:3 14:1 25:2 29:9 60:5,10,12 61:10 61:21 62:8,11,17 63:1,9,18 71:15 71:22 72:5 92:4 92:21,24 93:3,17 94:1,8 104:5 1:30 1:23 10 25:18 100 38:10 62:16,18 11 21:20 24:15,22 25:18 37:25 12 4:10,18 24:13,15 24:22 25:2 30:11 35:25 1220 2:6 14 26:10 37:25	3 3 29:9,24 3rd 103:19 3:13 104:3 3:3 104:5 30th 46:18 54:17 81:4 35 22:17	9 8:1 9:3 47:1 9th 7:25 10:4 46:18 53:7,20 54:7,10 54:11 81:4 95 87:11 99 49:14 100:13
			4 4 29:10,18,24 72:19 72:22 86:2,5 93:8 93:24 4.5 73:16	