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Last Name	KAISI
First Name	~~JO~~ NADIA
Specialty	Pathologist
Party	Plaintiff D
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Type of Document	~~Articles~~ Depo
Type of Injury	lung cancer
Type of Case	Medical
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IN THE COURT OF COMMON PLEAS
OF CUYAHOGA COUNTY, OHIO

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WILLIAM J. GILL, III, Executor
of the Estate of
DANIEL P. GILL, deceased,
Plaintiff,
vs Case No. 457639
Judge Russo

ROGER A. MANSNERUS, M.D.,
et al.,
Defendants.

- - - - -

DEPOSITION OF NADIA KAISI, M.D.
TUESDAY, OCTOBER 28, 2003

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Deposition of NADIA KAISI, M.D., a Witness herein, called by counsel on behalf of the Plaintiff for examination under the statute, taken before me, Vivian L. Gordon, a Registered Diplomate Reporter and Notary Public in and for the State of Ohio, pursuant to agreement of counsel, at the offices of Parma Community General Hospital, 7007 Powers Avenue, Parma, Ohio, commencing at 1:30 o'clock p.m. on the day and date above set forth.

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APPEARANCES:

On behalf of the Plaintiff
Becker & Mishkind
HOWARD D. MISHKIND, ESQ.
Skylight Office Tower Suite 660
1220 W. 2nd Street
Cleveland, Ohio 44113
241-2600

On behalf of the Defendant
Reminger & Reminger
ROBERT D. WARNER, ESQ.
1400 Midland Building
Cleveland, Ohio 44115
687-1311

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(Thereupon, KAISI Deposition Exhibits 1 and 2 were marked for purposes of identification.)

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NADIA KAISI, M.D., a witness herein, called for examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, was deposed and said as follows:

EXAMINATION OF NADIA KAISI, M.D.

BY MR. MISHKIND:

Q. Would you please state your name for the record.

A. Nadia Kaisi, also known as Nadia Al-Kaisi, A-L-K-A-I-S-I.

Q. Do you prefer to be referred to as Dr. Kaisi or Dr. Al-Kaisi?

A. Kaisi is fine.

Q. Dr. Kaisi?

A. Right.

Q. You are a pathologist; is that correct?

A. Yes.

Q. You have been identified as an expert on behalf of Dr. Mansnerus and that's why I am here to talk with you today. You understand that, don't you?

A. Yes.

Q. Have you had your deposition taken before?

A. Yes.

Q. Tell me how many times.

A. Probably 12, 15 times.

Q. So you generally know the routine in terms of I'm going to be asking you questions about your background and questions about your opinions that you hold in this case. Do you understand that?

A. Yes.

Q. Even though you have had your deposition taken 12 to 15 times before, you and I have never met; correct?

A. Right.

Q. Let me just give you a couple precautions so that we can try to move the deposition along as smoothly as possible.

I'll wait until you are done with an answer before I move on to the next question.

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

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authored in this case?
A. Yes.
Q. In looking through the material that you have with you today, I do not see any notes written --
(Telephone interruption.)
Q. In looking through your file or the material that you have with you, I do not see any written notes or any typed notes. Was my perusal of your file accurate in terms of there not being any notes?
A. That's correct.
(Telephone interruption.)
Q. Let's try that one more time. Am I correct in my statement that there aren't any written or typed notes in the file?
A. That's correct.
Q. Did you at the time that you reviewed the case make any notes?
A. No, I don't believe so.
Q. When you say you don't believe so, just in fairness to you, I want to make certain that your answer is unequivocal in terms of I didn't make any notes.
A. I did not make notes. I typed the

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

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

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A. Yes.
Q. In fact, you don't know what that date of January 9, 2003 represents; true?
A. That's true.
Q. And as you look at this report, recognizing that there is no date on this report, are you able to tell me when this report was prepared?
A. I can from looking at the records, if you want me to go into these letters that Mr. Warner had sent me.
Q. Well, let me ask you this. You received some material from Mr. Warner before preparing this report; correct?
A. Yes.
Q. And the material that you received from Mr. Warner before preparing this report came with a cover letter; true?
A. Yes.
Q. And that cover letter was dated what?
A. December 19th, 2002.
Q. So can we agree that you didn't prepare your report before December 19th, 2002?
A. Yes.
Q. Is the material that you reviewed for

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purposes of your report referenced in your undated report, which is Exhibit 2?
A. Yes. I think the first letter I received from Mr. Warner was December 9th, which accompanied the slides, the glass slides.
Q. Okay.
A. And that's what I usually do is I review the slides before I review any of the medical records.
And then the second cover letter was dated December 19th from Mr. Warner which accompanied the medical records and the reports, the expert witness reports, which I reviewed after that, and my report was sometime after the review of the medical records.
Q. But suffice if to say, you don't know exactly when you prepared your report; correct?
A. That's correct.
Q. Do you normally put a date on your reports?
A. Yes.
Q. In this case, is it fair to say that you just don't know why the date was omitted?
A. I think it was an oversight.
Q. After preparing this report and

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sending it to Mr. Warner, it appears as if you received some additional material; true?
A. Yes.
Q. Did any of that additional material from the standpoint of your opinions in this case have any significance?
A. As to my report and my opinions that I expressed in my report?
Q. Yes.
A. I don't think so.
Q. And just for the record, is it fair to say that the material that you received after preparing your report, that the material that you received were depositions?
A. Yes.
Q. And it appears as if you received Dr. Levitan's deposition?
A. That's true.
Q. It appears as if you have received -- why don't you tell me which depositions you received. Maybe it would be easier.
A. Dr. Levitan's deposition, Dr. Sutherland's deposition, and Dr. Steele's deposition.
Q. Did you read each of those

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depositions from cover to cover?
A. No, I did not read them from cover to cover.
Q. Did you read them sufficiently enough that you are familiar with what those doctors said in their depositions?
A. Yes, I think so.
Q. But you made no notes; true?
A. That's true.
Q. When is the last time you reviewed this material prior to us getting together today?
A. I think it was at the time I received the depositions.
Q. Other than the depositions that you have identified and the material that is referenced in Exhibit 2, which includes the slides, have you reviewed any other material in connection with this case, ma'am?
A. No.
Q. As you sit here right now, do you anticipate reviewing any other material prior to testifying that you believe to be relevant or material to the opinions that you intend to provide in this case?

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A. Not unless Mr. Warner provides me with additional material.
Q. As you sit here right now, do you have any understanding that Mr. Warner is intending to provide you with any additional material?
A. No.
Q. In looking at your report, it appears as if you do not intend to provide opinions with regard to Dr. Mansnerus' care of Mr. Gill; is that true?
A. That's correct.
Q. So you won't be taking the stand and saying that you have an opinion that Dr. Mansnerus complied with the standard of care; true?
A. That's true.
Q. Your focus is with regard to the issue of staging of the lung cancer and providing potential opinions as relate to any alteration in the outcome of this case; is that a fair statement?
A. Yes.
Q. And obviously we are going to talk about those opinions shortly.

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Exhibit 1 is your CV; is that true?
A. Yes.
Q. I want to ask you just a few background questions and then some specifics about your CV for a few minutes.
We are here at Parma Hospital today. What is your position here at the hospital?
A. I'm an associate pathologist.
Q. Whom are you employed by?
A. Cottle Pathology Services, Inc.
Q. How long have you been employed by that group?
A. A little over three years.
Q. How many other pathologists are there in that group?
A. We are a total of three and a half; three full time and one part time.
Q. I was going to ask you how the fourth one became a half person.
A. She is a little short. Just kidding.
Q. Tell me, including yourself, there are three full time or including yourself there are four?
A. Including myself there are three full time.

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Q. Tell me the names of the other two full time.
A. Edward Cottle, C-O-T-T-L-E, and Angelina Bautista, B-A-U-T-I-S-T-A. These are the two full-time pathologists.
Q. And the other one that is short.
A. Caroline Steinetz, S-T-E-I-N-E-T-Z.
Q. Do all three and a half of you work exclusively at Parma?
A. No. The three of us work exclusively at Parma, but Dr. Steinetz works at other hospitals, as well; mostly Marymount and Parma. Sometimes at UH, as well.
Q. You are not board certified in internal medicine; true?
A. True.
Q. You are not board certified in oncology; correct?
A. Correct.
Q. You don't hold yourself out as an expert in the area of oncology; correct?
A. As it relates to pathology. Part of pathology is related to oncology, but not as a medical oncologist, no.
Q. So you are looking at slides or other

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specimens from the standpoint of evaluating staging and assisting potentially with treatment modalities as opposed to actually treating cancer patients?
A. Well, I do not see cancer patients routinely, if that's your question.
Q. When is the last time that you had any hands-on involvement in terms of treating a patient that had a suspicion of lung cancer?
A. Actually seeing the patient and examining him physically?
Q. Yes.
A. When I was a resident.
Q. That would have been how long ago?
A. That was 1986-87.
Q. And I take it also that you don't hold yourself out as an expert in the area of radiology or radiological interpretation?
A. Well, I do have, of course I do have knowledge of radiology as it relates to pathology and how it correlates with the pathology, but I am not an expert in radiology.
Q. Your education in terms of medical school took place where?
A. In Bagdad Medical School, Bagdad,

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Iraq.
Q. And that's where you were born; true?
A. Yes.
MR. MISHKIND: Off the record.
(Discussion off the record.)
Q. Before your affiliation with the pathology group that you mentioned, where did you practice?
A. University Hospitals of Cleveland.
Q. And how many years did you practice there?
A. From 1986 to July 2000.
Q. What was your position at UH?
A. The first year I was there from 1986 to 1987 I did a fellowship in surgical pathology and cytopathology. Then I became a staff pathologist and held various administrative positions, like the director of histology, director of cytology, as outlined in my CV.
Q. What exactly is cytology?
A. Histology?
Q. Cytology.
A. Cytology is the study of the cells.
Q. And histology is study of blood?
A. Of the tissue.

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Q. It's no mystery that we are talking about nonsmall cell lung cancer in this case; correct?
A. What do you mean it's no mystery?
Q. Well, Mr. Gill had, when it was diagnosed, he had a diagnosis in terms of the primary tumor falling within the category of nonsmall cell carcinoma; true?
A. Well, if you are asking me if I agree from reviewing the slides on Mr. Gill that he had nonsmall cell lung cancer, the answer is yes, I do.
Q. There are different categories of lung cancer; correct?
A. Yes.
Q. Those that would fall outside of the area of nonsmall cell are grouped in what title, what category?
A. The ones that fall outside the nonsmall cell?
Q. Yes.
A. Are the small cells.
Q. And within the nonsmall cell there are various types of nonsmall cell; correct?
A. Yes, there are various histologic

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types, yes.
Q. So when one looks under a microscope, one can look for the type of configuration of the cell in terms of trying to define whether or not it's a squamous cell carcinoma or one of the other nonsmall cell carcinomas; correct?
A. There are several criteria that we look at and take into consideration to try to classify the tumor and to classify the nonsmall cell cancer into the different subcategories, like squamous cell carcinoma, adenocarcinoma, merkel undifferentiated carcinoma, neuroendocrine carcinomas and otherwise.
Q. Did Mr. Gill have squamous cell carcinoma?
A. I think there was two types of differentiation, or maybe even three. There was a component that was poorly differentiated nonsmall cell; i.e., the tumor cells did not express any specific differentiation. There were four slides that had squamous differentiation and there were four slides that had that glandular or adenocarcinoma differentiation.
Q. So as we look through the medical

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records, we may see different references to the descriptive terms of his nonsmall cell carcinoma?
A. That's correct.
Q. I think at one point I see it referred to as adenosquamous carcinoma, which is sort of a combination of adenocarcinoma and squamous cell carcinoma?
A. That's correct.
Q. And that would be different from poorly differentiated nonsmall cell carcinoma; true?
A. Not necessarily. Poorly differentiated nonsmall cell carcinomas can have signs of either adeno or squamous differentiation. So the poorly differentiated aspect of it is another characterization of the tumor. So adenosquamous carcinomas and nonsmall cell lung cancers can be poorly differentiated or well differentiated or moderately well differentiated.
Q. We will talk more about that in a little bit. But just to sort of talk in general about what we know the ultimate diagnosis on Mr. Gill to be, I want to focus in on your CV

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and ask you whether there are any lectures that you have given of the 17 that are referenced that would be relevant to the issue of staging or diagnosis of nonsmall cell carcinoma?
A. Can I take a look at my CV?
MR. MISHKIND: Rob, I think you may have the same, just to make it easy for her.
Q. For the record, it's on page five. And if you have the same version, the invited guest lectures on page five and six total 17.
A. I don't see anything related to the lung in these lectures, but the lectures that I do give related to the diagnosis of lung cancer is in the invited seminars and workshops which are mostly at our national meetings, the American Society of Clinical Pathologists national meetings.
Q. What page would that be on your CV?
A. Well, it starts, the lung lectures start on page 11. I think the fourth item, pulmonary cytology workshop, there are several of them in different years, different locations.
Q. Now, the one that I am focusing in on, the first pulmonary cytology workshop that has a parenthesis, three category, one CME hours

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and that was at the American Society of Clinical Pathologists, the national meeting in Seattle in April of 1994, was that a presentation that you were one of a number of presenters?
A. Well, this was solely my presentation.
Q. Did you provide any written material or slide presentations, power point or anything of that nature?
A. Yes. There is an abstract that we provide to the participants at the time of the meeting. There is a set of kodachromes and case histories that we provide to the participants prior to the meeting, and during the meeting there are a set of kodachrome slides.
At that time I did not use the power point presentation, so they were 35 millimeter transparencies.
Q. If someone like Howard Mishkind wanted to acquire a copy of the material that was disseminated at that presentation, what would I have to do?
A. You can ask me.
Q. It's something that you have in your possession?

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A. I have all of the abstracts and the material that I was giving to the participants. The kodachromes that I used for the presentation, I have it, but it's not -- it's part of my kodachrome collection that I use to lecture at the medical school and at University Hospitals, so it's not one. I usually mix and match, depending on the subject and the audience.
Q. In terms of the printed material, though, that you gave back in 1994 -- and it looks like you continued to do that periodically over the years -- did that printed material change at all or was it pretty much the same from year to year?
A. I may have updated the references, but the basic material is pretty much the same.
Q. So you would have a file that would have your printed material that you presented to the American Society of Clinical Pathologists; true?
A. Yes.
Q. And that would have some relevance to the issues that we are talking about in this case?

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A. Mostly in the area of the diagnosis of lung cancer, yes.
Q. If you would be so kind as to provide copies of the printed material, not necessarily the slides, but the printed material to Mr. Warner, and I'll make a request on the record that Mr. Warner provide me with a copy of that.
A. Okay.
Q. Doctor, it looks like the last time that you presented at the cytology workshop was 1998; is that true?
A. 1999. Which is on page 12.
Q. My CV that was faxed to me actually ended on page 11. So you have got a page 12.
A. I'm sorry.
Q. It's not your fault.
MR. MISHKIND: Rob, what I would like to do is --
MR. WARNER: We can get you copies.
MR. MISHKIND: Just for the record, my CV ended at page 11 and the original has 12 pages.
MR. WARNER: When we leave, we will go down to the copy center.

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

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

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

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more junior pathologists there at UH.
Q. Who was it at UH that had asked you to head up the lung pathology?
A. Dr. Katherine DeShriver.
Q. Is Dr. DeShriver still at UH?
A. No.
Q. Where is she at now?
A. I don't know.
Q. When you are looking at lung or breast pathology, you are normally looking at surgical specimens; true?
A. Yes.
Q. And in looking at surgical specimens, you are providing some input to the clinician as to what the patient's prognosis is based upon the cell structure and other findings that you make on that surgical specimen; correct?
A. Yes.
Q. So you may assist in terms of staging, in particular with lung cancer, staging what the stage is of the lung cancer so that a clinical decision can be made as to what type of adjunctive treatment may be appropriate for that patient; true?
A. Yes.

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Q. And also having some prognostic indicators as to how long the patient statistically may live; correct?
A. Yes. These are findings that are related to the staging, basically, and the histologic type of the tumor.
Q. You are not typically asked to provide an opinion as to when the patient progressed from Stage 1 to Stage 2 to Stage 3 to Stage 4, are you?
A. You mean in my daily practice of pathology --
Q. Yes.
A. -- at Parma Hospital? Not as a written report, but as discussions in tumor conferences on specific patients.
Q. But on a day-to-day basis, when you provide an opinion that someone is Stage 4, nonsmall cell poorly differentiated adenosquamous cell carcinoma or whatever the configuration is, your concern is more of giving that information to the clinician as opposed to determining when that patient progressed from Stage 3 to Stage 4; true?
A. That's true.

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Q. Before I move away entirely from your CV, is there anything else in your CV by way of presentations, lectures, book chapters, invited presentations that touch on the topic of lung cancer, other than what we have talked about?
A. I don't think so.
Q. I'm going to focus your attention now on your medical/legal experience and ask you some questions about that, okay?
A. Okay.
Q. You said that you have testified 12 to 15 times; true?
A. Depositions taken.
Q. Depositions.
A. Approximately.
Q. Have you ever testified in a courtroom?
A. Yes.
Q. How many times?
A. Four or five times.
Q. Have you ever testified in a courtroom as an expert witness in a medical negligence case?
A. You mean medical/legal case? I don't really understand what you are saying, medical

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negligence cases.
Q. Sure. You understand in this case, there are allegations that Dr. Mansnerus did not comply with the standard of care. You understand that?
A. Right.
Q. You are not here to provide a defense for Dr. Mansnerus as to whether he did or didn't meet the standard of care; correct?
A. That's correct.
Q. But this case involves issues of medical negligence where there is a plaintiff and a defendant.
A. Yes.
Q. And Dr. Mansnerus is the defendant. In that context, have you testified in a courtroom where there were allegations of malpractice on the part of a physician?
A. Yes.
Q. Of the four to five times that you have testified, how many times have you testified in court in that capacity?
A. Either once or twice.
Q. The other times that you have testified in a courtroom, what was the capacity

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of your appearance?
A. Mostly determining the stage of the tumor and the rate of progression of the tumor.
Q. Were any of these times that you testified in court, were they criminal cases or were they all civil cases?
A. I think they were all civil cases.
Q. The other three times that you have testified in court were not malpractice cases or what you may refer to as medical/legal cases?
A. I'm sorry, say it again.
Q. Sure. Let me make it easier for you so that we are speaking the same language. I'll come at it from a different direction.
The four to five times that you have testified in the courtroom, how many of those times that you have testified in the courtroom have you been retained by the attorney representing a hospital or a doctor?
A. All of them.
Q. Can you explain to me when I asked you about the four to five times why you separated out one to two times that you were testifying in a malpractice case as opposed to the entire four to five times of testifying?

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

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firm had retained you to testify?
A. No.
Q. Do you remember the subject matter of that case that was one year ago?
A. Yes. It was a breast cancer patient.
Q. Did the breast cancer patient die?
A. No. She was alive at the time of trial.
Q. And was your opinion essentially that an earlier diagnosis would probably not have led to a different outcome?
A. Yes.
Q. You don't remember the name of the law firm?
A. No.
Q. Do you keep any records of your medical/legal cases?
A. Yes.
Q. That's something that you would have on your computer?
A. Yes.
Q. I'm going to request that you provide me with a list of the medical/legal cases that you have been involved in.
A. Sure. What kind of information do

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

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

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

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

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including Mr. Warner, on medical malpractice cases?
A. You mean by Reminger & Reminger?
Q. Yes.
A. Yes.
Q. Mr. Warner, how many times has he asked you and you have agreed to serve as an expert on behalf of one of his doctors?
A. Four or five times.
Q. Would this be the fifth or the sixth or would this be -- would that all be encompassing with the Gill case?
A. That's probably additional. But that's not an accurate number.
Q. These are your best estimates?
A. Yes.
Q. So that if we added Gill, your best estimate would be this is now the fifth or sixth time that you have been an expert for Mr. Warner?
A. Probably.
Q. What about other lawyers at Reminger & Reminger?
A. I have reviewed maybe a couple other cases for some other Reminger & Reminger

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lawyers.
Q. Do you remember the name of any of the attorneys?
A. Mr. Malone is one of them.
Q. How many cases have you reviewed for Jim Malone?
A. One.
Q. Any other lawyers that names come to mind?
A. There is a woman lawyer that I can't remember her name.
Q. Marilena?
A. No. Sue.
Q. Sue Seacrist?
A. Sue Seacrist, yes.
Q. How many cases have you reviewed for Ms. Seacrist?
A. One.
Q. Any other attorneys that you have worked with at Reminger & Reminger?
A. Not that I can remember.
Q. Of the five to six cases for Mr. Warner, including the Gill case, how many of them have you given deposition testimony in?
A. Three or four, probably. I can't

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

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around 25 cases.
Q. That you have reviewed over the ten years?
A. Yes.
Q. So the amount is actually increasing as of the current year; is that correct?
A. No, not really. It's been steady for the past few years. For the past three or four years it's been steady.
Q. So early on in that ten year spectrum there might have been one case a year?
A. Yes.
Q. Of the 25 cases that you have reviewed, some of them have gone to deposition; true?
A. Yes.
Q. We have talked about that.
A. Yes.
Q. Some of them have gone to trial?
A. Yes.
Q. Of the total 25 that you have reviewed, tell me how many have been on behalf of an attorney representing the plaintiff as opposed to an attorney representing the defense?
A. Maybe four or five plaintiff cases.

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Q. Were any of them in the State of Ohio?
A. Yes.
Q. Were any of them in the Cleveland area?
A. Yes.
Q. Did any of those cases that you reviewed in the Cleveland area -- actually I just figured out my own answer but I'll ask it any way -- did any of those lead to deposition testimony?
A. I don't remember, so, no.
Q. Do you remember the names of any of the plaintiff's lawyers that you reviewed cases for?
A. At least two of them were for Nurenberg, Plevin, whatever.
Q. I get the gist. Do you remember which lawyer from that firm?
A. There were two different ones. Tom Mester and the other guy.
Q. Harley Gordon?
A. Gordon.
(Discussion off the record.)
Q. Any other plaintiff's firms that you

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

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

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

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

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

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the case that causes you to be able to say that in January or February of 2000, that there was evidence clinically that Mr. Gill had metastatic disease or metastatic lung cancer?
MR. WARNER: Objection. Asked and answered. You can answer again.
A. You are asking me to answer this question based on all the records I have now?
Q. Yes.
A. Or based on the records that were available in January or February of 2000?
Q. The records that were available in January or February of 2000, and December of '99.
A. If I am reviewing a case of a patient that presented with respiratory symptoms, basically symptoms of pneumonia and numbness, would I suspect that the patient had -- I mean, obviously there was no definite diagnosis of cancer in Mr. Gill, so it's unlikely that someone would think of metastatic disease if there is no previous diagnosis or known history of cancer in a patient. Any of these symptoms can be related to either primary or metastatic disease.

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

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

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

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

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

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A. I guess it was, the main cause is lingering cough. I am referring to the notes from January of 2000, January 6th.
Q. Do you know whether this was a scheduled follow up or whether the patient returned for some other reason on January 6th?
A. I don't know. It's not obvious here whether it was scheduled or whether he just returned, the patient returned because he wanted to see the doctor again.
Q. On that January 6th visit, doctor, is there any evidence of nodal involvement that Dr. Mansnerus describes?
A. No, there is no mention of nodal involvement.
Q. Any evidence in January, any evidence suggestive of a metastatic disease in January when Dr. Mansnerus saw the patient?
MR. WARNER: Objection.
A. I'm sorry, repeat it.
Q. Any evidence when Dr. Mansnerus saw him in January of any metastatic disease?
MR. WARNER: Same objection.
A. To Dr. Mansnerus or to me?
Q. To Dr. Mansnerus.

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

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generally accepted or reliable source in the area of cancer staging, is it not?
MR. WARNER: Objection.
A. The AJCC Cancer Staging manual is a reliable source for clinicians to stage lung cancer, but I don't know about the 5th edition, because we have upgraded more than a year ago to the 6th edition and I can't really remember the exact differences in the lung.
There are some organs where there are major differences, but I can't remember the lung.
Q. So what I would have to do is compare the 5th and the 6th edition as it relates to lung to see whether there have been any changes in the cancer staging; correct?
A. Right.
Q. But generally speaking, subject to, perhaps, some changes in the 6th edition -- and in fact, if we were looking at the 6th edition, it's a generally reliable source of information when it comes to staging of lung cancer; true?
A. Well, let me put it this way. It is the protocol that we use to pathologically stage lung cancer.

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Q. You can't ask for anything more than that.
In terms of cancer staging, when one refers to a T1 lung cancer, generally speaking, that's a tumor that's less than three centimeters; correct?
A. As I mentioned before, not necessarily. Because it depends on the other features or criteria. If it's a tumor that is less than three centimeters, but it's invading the mediastinum or invading the pleura or chest wall, then it's a T4 lesion, regardless.
Q. You are absolutely correct. Absent any invasion or extending into the pleura or into the chest wall, or any of the hilar regions or anything of that nature, just a tumor less than three centimeters that does not go outside of the lung, that generally is considered to be T1; correct?
A. I think there are other criteria, which is the presence of atelectasis, the presence of obstructive pneumonitis, the presence of pleura effusions that can upgrade the T stage of the tumor, again, regardless of the size.

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And I can't remember the specifics, because we have a list and I usually refer to it every time I do staging of lung cancer.
Q. You have sort of a cheat sheet that you have right in front of you?
A. It's not a cheat sheet, but it's actually for completeness so we remember all the details.
Q. Is it fair to say that when the tumor gets to be above three centimeters, regardless of whether or not there is atelectasis or whether or not there is any spread, just in and of itself, a tumor greater than three centimeters is at the very least a T2?
A. Yes.
Q. And if a tumor is less than three centimeters and there is no atelectasis, there is no spread of the tumor, and there is no nodal involvement, generally speaking, that would be a T1-N0; correct?
A. If all the lymph nodes are negative pathologically and clinically, obviously, and if the tumor is less than three centimeters and none of the other criteria as stated in the AJCC manual that upstages a tumor, then it would be a

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T1 tumor.
Q. Are you qualified as a pathologist to testify as to what the prognosis is for a patient diagnosed with nonsmall cell lung cancer that's diagnosed at a Stage 1, being a tumor less than three centimeters and no spread, no atelectasis, nothing outside of what you would expect for less than three centimeters, no nodal involvement, and no other evidence of metastasis, clearly by definition a Stage 1, are you qualified to provide an opinion as to what the prognosis is for survival of a Stage 1 nonsmall cell lung cancer?
A. Regardless of the treatment or with the treatment?
Q. Well, good question. With the treatment.
A. I usually refer -- again, this is some data in the AJCC manual that refers to the prognosis of the different stages of breast cancer -- I'm sorry, of lung cancer.
Q. I knew what you meant.
A. But, of course, the literature is full of studies of different subsets and different treatment protocols that can influence

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that. So is there any one single person or medical expert that is qualified to comment on these prognoses and the five-year survival, I think all medical specialists that are involved in assessing lung cancers are qualified to some extent in rendering their opinion.

Q. And you certainly consider reliable the cancer staging information, the AJCC Cancer Staging information in terms of treatment and prognosis for a Stage 1 nonsmall cell lung cancer; true?

A. Well, really there is no treatment recommendations or guidelines in the AJCC manual. And the part that is nice about their survival data is it's usually their large studies. But after a couple of years, a few years, they become kind of old and we have to consider newer data.

Q. What is your opinion as to the likely five-year survival for a nonsmall cell lung cancer patient diagnosed in a Stage 1 clinically and pathologically that receives the appropriate regimen of treatment?

A. Well, again, it varies, depending on if it's only surgical excision, whether the

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tumor was excised entirely, and whether the patient had any chemotherapy.

There are other factors, intrinsic factors to the tumor itself, which includes the exact type of the tumor and the grade of the tumor, whether it's a low grade or a high grade histologically, that can influence the prognosis. But the prognosis of Stage 1 lung cancers, in general, is better than prognosis of the higher stages.

Q. Sure. And in fact, in the Stage 1, there is sort of a range in terms of prognostic factors, are there not? It's not just X percent of patients survive five years; correct?

A. Exactly. So that means that there are certain patients -- if you take 100 patients with Stage 1 nonsmall cell lung cancer, out of these 100, some of them are going to survive five years or longer and some of them are going to die, even though they are the same pathologic and clinical stage. Some of them are going to die for reasons that we may know, some of them we may not know, or we may not know all of them.

Q. What I want to do is just understand your knowledge. If I said to you that the

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statistics in terms of all comers in Stage 1 nonsmall cell lung cancer, that statistically the five-year survival is in the 60 to 80 percent range, would you quarrel with that statistic?

MR. WARNER: Objection.

A. No.

Q. And in fact, is that generally your understanding in terms of all comers in Stage 1; that it's generally for five-year survival 60 to 80 percent?

A. Well, as I said, there are a lot of other factors, so I don't really want to give an exact percentage unless we are talking about a specific group of patients and specific histology and specific type of treatment.

Q. You have seen that statistic, though, in terms of Stage 1 nonsmall cell lung cancer, the survival rate has been reported in certain studies to be in the 60 to 80 percent range; correct?

A. I think I probably have seen it. I don't recall specifically, but probably I have.

Q. Are there any resources, doctor, that you believe to be reasonably reliable or

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authoritative that support any of the opinions that you hold in this case?

A. I don't consider any one source of medical information as authoritative. I look at everything critically and there are some papers and articles published by very famous physicians that have a lot of deficiencies, so I look at every article or every data critically and try to get the best out of each one of them.

Q. Did you do any medical research at all in preparation for this case?

A. Not specifically for this case, but I have my collection of medical literature, and every now and then I go back and look at certain issues when it comes to, when it concerns one of our patients.

Q. What I want to understand is when you take the stand, not in November, but the end of April, in this case, do you intend to testify that a certain journal article or a section of a certain journal article as it relates to nonsmall cell lung cancer, staging and prognosis, is, in your opinion, to be generally reliable or authoritative?

A. I don't think I am going to quote a

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

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appropriate motion with the court. Okay?
A. Okay. I will.
Q. Thank you. By the way, do you know Dr. Mansnerus?
A. No.
Q. There are several other experts in this case. Dr. Levitan. Do you know Dr. Levitan?
A. Yes.
Q. How do you know him?
A. I knew him from when I was working at University Hospitals.
Q. Was it just sort of a passing familiarity with him or did you have occasion --
A. It was a professional relationship. We talked about cases, cancer patients that he is involved with that I have been involved with.
Q. Is it fair to say that you had fairly regular contact with Dr. Levitan when you were at UH?
A. I don't know what regular means.
Q. Either do I. Was it more than once a week that you had contact with him?
A. No. It was less than that. Probably more like once every one or two months or even

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less than that.
Q. How about Dr. Rozman?
A. I don't know Dr. Rozman.
Q. Dr. Botham?
A. I know Dr. Botham.
Q. How do you know Dr. Botham?
A. He is one of the cardiovascular surgeons here at Parma Hospital.
Q. How often do you interact with Dr. Botham?
A. Very little. He works mostly at Hillcrest Hospital.
Q. How long have you known Dr. Botham?
A. Since I started working here at Parma Hospital three years ago.
Q. Have you ever talked with Dr. Botham, Dr. Levitan about this case?
A. No.
Q. Do you know Dr. Steele, Dr. Sutherland or Dr. Bass?
A. No.
Q. One of the most important questions that I forgot to ask you early on is how much are you charging me for this deposition today?
A. $400 an hour.

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

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A. As a general statement, it's good to identify any cancer at an early stage, preferably at the noninvasive stage, if possible.
Q. And noninvasive would be where there isn't any evidence of clinically significant metastasis?
A. No. Invasion refers to, in a field of tumors, usually they start at the stage that we call in situ. For squamous cell carcinomas they start within the epithelium linings, the airways or skin or other parts of the body. The in situ stage they are limited to that epithelium.
When they invade beyond the epithelium into the surrounding tissue and stoma, then that's the stage when they become potentially, when they potentially have the ability to spread and metastasize. Before that they do not.
So before that, it's basically curable if you can diagnose a tumor at that stage.
Q. So at the point where it hasn't invaded the epithelium --

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A. Beyond the epithelium. The epithelium is the lining, so that's where the tumor usually starts.
Q. Originates?
A. Yes, either in the squamous epithelium or the glandular epithelium. But once it invades beyond the epithelium to the stoma surrounding the tumor where usually the lymphatics and the blood vessels are located, that's when the tumor has the potential to spread beyond that location and metastasize.
Q. Do all nonsmall cell cancers that invade beyond the epithelium metastasize?
A. Not necessarily, but they do have the potential to metastasize.
Q. How do we know which ones will from an epidemiological standpoint metastasize and which ones will not metastasize, or don't we know?
A. Well, that's the million dollar question.
Q. Okay.
A. There are some factors that we do know contribute to faster and earlier spread of the tumor of the nonsmall cell lung cancers and

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

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

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contralateral, I think contralateral mediastinum or hilar nodes and multiple nodules on the same side.
Q. I was trying to mark down. He had metastatic disease of the bone, the mediastinum, the hilar nodes and --
A. The neck and contralateral hilar nodes and multiple nodules on the same side of the tumor.
Q. And at the time that he was diagnosed, what was the size of the tumor, the primary tumor?
A. According to CT report?
Q. Yes.
A. I think it was described as four times 4.5 centimeters.
Q. Are you able to tell me to a reasonable degree of medical probability what the size of the tumor was back in January or February?
A. I think so.
Q. On what basis?
A. Based on the knowledge that we know about the tumor growth and the tumor doubling time that is usually done in a more experimental

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in vitro type of environment, as well as some of the clinical studies that have been performed following patients with lung tumors over several month intervals.
Q. I think you told me earlier that he had different types of, different cell types in his nonsmall cell; correct?
A. Different types of differentiation within the same tumor.
Q. The squamous cell, the adenocarcinoma, and then they were poorly differentiated. Is that an accurate statement?
A. Yes.
Q. The progression rate for squamous cell carcinoma, can you tell me about that?
First, when I use the term progression rate, is that a medical term?
A. No.
Q. It isn't?
A. No. Well, it's a vague term. I don't know what you really are referring to by using that term.
Q. Would you agree with this statement? Because of the different types of lung cancers and different ways that they may respond to

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treatment, it's very important to identify the cell type so that the best treatment can be given?
A. Yes. Not only for treatment purposes, but for prognostic purposes, as well.
Q. In terms of nonsmall cell lung cancer, what percentage does that make up of all lung cancer cases?
A. I think it's more than the nonsmall cell lung cancer, in general. I would say one-third is nonsmall cell and then if you lump all the non-small cells together, it's two-thirds or more, maybe.
Q. Where does squamous cell, the squamous cell -- strike that.
I can just refer to nonsmall cell rather than elongating my sentence.
A. Okay.
Q. In terms of the origination of squamous cell when you are dealing with lung cancer, where is the most common site where it originates?
A. Usually it's central or closer to the larger bronchi, and the cell of origin is thought to be metaplastic squamous epithelium

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from the lining epithelium of the bronchi, which are the airways that bring the air into the lungs.
Q. When you are dealing with squamous cell carcinoma, does it stay within the large bronchi or in that area frequently for extended periods of time without spreading?
A. You mean at the in situ stage, the noninvasive stage?
Q. Yes.
A. We don't really know much about the in situ stage, how long it stays there because it's frequently not diagnosed because it's asymptomatic.
We frequently see the in situ stage in connection with the invasive tumor of the periphery or some of the other bronchi adjacent to the tumor. So the answer to your question is that we do not know how long it stays as a noninvasive stage, but probably for years.
Q. Would you agree that with squamous cell cancers that usually start in the large bronchi, that without spreading outside of that area, that typically they stay for longer periods than other types of lung cancers?

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MR. WARNER: Objection.
A. What do you mean they stay for a long period?
Q. Without spreading.
A. Without spreading, without metastasizing outside?
Q. Yes.
A. Well, first of all, even though most nonsmall cell lung, or most squamous cell carcinomas, not all nonsmall cell cancers, but most squamous cell carcinomas arise proximal in the major tracheobronchial tree branches. There is certainly a category of peripheral squamous cell carcinoma that arises peripheral in the lung. It's a well documented entity.
Second of all is that it depends on the degree of differentiation of the squamous cell carcinoma. The well differentiated ones usually grow slower, invade mostly into the lumen of the tracheobronchial tree and causes obstruction and obstructive pneumonia and atelectasis, and by the time they are discovered, they are usually large tumors.
However, the poorly differentiated squamous cell carcinomas, when they are

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

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

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

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

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

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A. Yes.
Q. Where do you fall in that spectrum?
MR. WARNER: Objection. Go ahead.
A. Well, there is a lot of controversy, because doubling time -- well, first of all, I like to refer to it as doubling volume because it's really the time that it takes the tumor to double the volume of the tumor.
But these usually refer to the tumors in the ideal situations where the tumor has grown in vitro in a culture type of environment, provided all the nutrients of all the ideal conditions and not taking into account the tumor necrosis that sometimes exceeds the rate of tumor growth, not taking into account the intrinsic factors such as the blood supply and other factors that we do not know about that contributes to the tumor growth, not taking into account the host response or immunologic system that sometimes can arrest tumor cells, also not taking into account changes in the growth rate of the tumor, we are assuming that it's --
Q. Exponential?
A. -- exponential, but it's not necessarily that.

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

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A. Usually, yes.
Q. Can you state in this case, based upon your review of the pathology slides, that Mr. Gill's tumor did metastasize early in the disease?
A. I cannot only based on the histologic rate of the tumor that it's a high grade, but as I mentioned based on the size as well as the grade as well as the clinical signs and symptoms that he presented with, I have an opinion that it's very likely and it's probable that the patient, that Mr. Gill had metastasis at the time of presentation, and as I said, probably a long time before that.
Q. Okay.
A. Whether you are asking me early in the disease, I don't know what early in the disease means.
Q. I pretty much understand that you are saying that as of December your opinion in this case and what you intend to testify to at trial is that he had metastatic lung cancer in December when he was seen by Dr. Mansnerus; true?
A. Yes, most likely.

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Q. And do you intend to testify that most likely it was Stage 4 metastatic lung cancer or are you not of that opinion as of December?
A. Yes, I think it was Stage 4 at that time.
Q. When did he first develop the lung cancer? How many years before, given everything that you know, looking at the slides, knowing what stage he was at when he was diagnosed?
A. Probably a few years, but I can't really specify it any further than that.
Q. All right. One person's few may be another person's not so few, so I am going to press you just a little bit as best I can.
When you say few, are you talking two or three or are you talking five or six? Give me your best estimate.
A. The way I use few is three to five.
Q. And in the spectrum of the three to five years before, is it three to five years before 1999 that he developed the cancer?
A. Before the diagnosis of the cancer in August of 2000.
Q. So it's your opinion that he had

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cancer, lung cancer -- that was the primary tumor; correct?
A. Yes.
Q. That he had lung cancer going back to either 1995 or 1997, roughly speaking?
A. Yes.
Q. And when along that spectrum, if we take 1995 to 1997, given the tumor type that he had, when in your opinion did this high grade tumor first metastasize? At what interval from '95 up to 2000?
A. I don't really know exactly when. I can't tell, but again, from the clinical signs and symptoms, when he presented with the neck, the symptoms in the neck and the left arm, he probably had the met at that time. How long it's been there, I don't know. I can't tell.
Q. You would just be speculating to give me an opinion as to how long before December he had had metastatic disease; is that a fair statement?
A. Yes.
Q. Don't squamous cell carcinomas normally spread late as opposed to early?
A. It depends on a lot of factors.

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Q. What is it about --
A. If you are asking --
Q. Go ahead.
A. -- if squamous cell carcinomas metastasize later in the stage of the disease than small cell cancers, the answer is yes. If you are asking whether there is a difference between the spread rate of squamous cell carcinomas versus adenocarcinomas, not that significant a difference.
If you are asking in general, squamous cell carcinomas anywhere in the body versus lungs, then actually that depends on their differentiation, the degree of differentiation.
Q. What I'm talking about is in lung cancer cases, squamous cell lung cancer patients that also have adenocarcinoma components and are poorly differentiated -- because I don't want to exclude any of the variables that we have in this case -- are you aware of medical literature that indicates that the spread of that type of lung cancer is usually late as opposed to early in the life span of the cancer?
A. As opposed to what other tumors? Are

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we comparing the squamous cell carcinoma, the high grade with what type of tumor?
Q. With small cell.
A. Yes, I answered that. Small cell cancers spread earlier in the course of the disease than squamous cell carcinomas. Usually, many times they actually present with metastatic disease in other organs.
Q. So that if you had to develop a lung cancer, statistically, all things being equal, you have a better chance of survival if you have a nonsmall cell as opposed to a small cell carcinoma; true?
MR. WARNER: Objection.
A. Well, there are a lot of other variables. The most important is really the stage of the disease and the responsiveness to whether there is available chemotherapy for small cell cancer. Sometimes they disappear with chemotherapy, so there are lots of variables.
Q. Does adenocarcinoma, nonsmall cell adenocarcinoma spread quicker and earlier than squamous cell, nonsmall cell or are they pretty --

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A. It depends really mostly on the degree of differentiation.
Q. In poorly differentiated. Do they both spread at about the same juncture or do you normally see adeno spread earlier than squamous cell?
A. Well, I want to say that the poorly differentiated, even though I use that term also and I am a pathologist, is really a vague term and it's very misleading because it's based on a very old concept of the resemblance of the tumor to the tissue of origin.
So in the case of squamous cell carcinoma, based on the well differentiated tumor, is that the tumors that they resemble, benign squamous epithelium, the poorly differentiated are those that do not resemble the normal squamous epithelium. But it's really vague and inconsistently used by pathologists, let alone other medical specialists.
Q. Let alone lawyers, as well?
A. Let alone lawyers, yes.
The better term and the better criteria to use is the high grade versus the low grade, which really correlates more to the

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biologic behavior and the biologic features of the tumor. So high grade tumors are those tumors that have very bizarre nuclei.
Usually they have and employ DNA contents and these are the tumors that behave bad and spread fast and more lethal than the tumors that are low grade. And these are the tumors, the high grade tumors are those tumors that can metastasize and metastasize earlier than the low grade tumors.
Q. Do you use the term, when you are talking about a high grade or a low grade -- and we will put aside the use of the term poorly differentiated and try to get a little more scientific.
But when you use the term high grade with a lung cancer, do you ever use the term that a high grade lung cancer has from its inception a bad personality? Have you ever heard that term used?
A. Yes. And that's exactly what the biologic behavior of the tumor refers to is that this tumor is determined to be bad, regardless of its size, regardless of the treatment.
Q. But still can you cite me to any

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statistics that even in a high grade nonsmall cell lung cancer case, if one is fortunate enough to be diagnosed early in the stage, Stage 1, and all of the criteria are met from the standpoint of it being high grade but yet you were in the right place at the right time, can you cite me to any literature that would suggest that those patients still more often than not die and don't make it to a five-year survival?
A. I can't cite the literature now, but I know that it is present. There is literature that correlates the survival, the survival of patients with high grade tumors versus survival of patients with low grade tumors, if we compare apples to apples, same stage, same size, basically same time, same stage at the time of diagnosis and same treatment versus those that are low grade.
Q. So I want to make sure I understand. In Mr. Gill's case, hypothetically, if he had been diagnosed at Stage 1 with the high grade nonsmall cell components that we know that he had, regardless of when that time period was that he was at Stage 1, do you have an opinion as to what his probable survival would have

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

MR. WARNER: Objection. Go ahead.

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

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

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

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

Q. Can you tell me what the statistics

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show for a high grade Stage 1 survivor?

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

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

A. That's correct.

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

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

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

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

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

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

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

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

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

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

Q. Okay.

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

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

A. Probably.

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

A. Yes.

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

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

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

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

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

so when he had pain in the femur?
A. Well, the patient had other symptoms that may or may not have been related to his bone mets; fatigue and malaise. And we all have -- I have back pain, if you don't any way.
Q. Lawyers never have back pain.
A. Lawyers are perfect.
Q. Doctor, I think I am done. I just want to make sure that we have covered the opinions that you hold in this case and also that you have told me the areas within which you do not feel qualified to render opinions.
Have I given you an opportunity during the course of this deposition to explain the bases for your opinions?
A. I think so.
Q. I haven't cut you off or limited you in any way, have I?
A. I don't think so.
MR. MISHKIND: I thank you very much. I have nothing further.
Do you want the doctor to read the transcript?
MR. WARNER: I will leave it up to you. Do you want to read?

THE WITNESS: I'll defer to you.
MR. WARNER: I will trust her abilities. You can waive.
- - - - -
(Deposition concluded at 4:10 p.m.)
(Signature waived.)

CERTIFICATE

State of Ohio,
SS:
County of Cuyahoga.

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

I do further certify that this deposition was taken at the time and place specified and was completed without adjournment; that I am not a relative or attorney for either party or otherwise interested in the event of this action. I am not, nor is the court reporting firm with which I am affiliated, under a contract as defined in Civil Rule 28(D).
IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 3rd day of November, 2003.

Vivian L. Gordon, Notary Public
Within and for the State of Ohio
My commission expires June 8, 2004.
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