IN THE COURT OF COMMON PLEAS

SUMMIT COUNTY, OHIO

KAREN WILSON,

Plaintiff,

-vs-

JUDGE MURPHY
CASE NO. CV-2002-06-3340

YOUN PARK, M.D., et al.,

Defendants.

- - - -

Videoconference deposition of WAYNE KOCH, M.D., taken as if upon cross-examination before Tami A. Mitchell, a Registered Professional Reporter and Notary Public within and for the State of Ohio, at Friedman, Domiano & Smith, 600 Standard Building, Cleveland, Ohio, at 12:58 p.m. on Wednesday, August 27, 2003, pursuant to notice and/or stipulations of counsel, on behalf of the Plaintiffs in this cause.

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MEHLER & HAGESTROM
Court Reporters

CLEVELAND
1750 Midland Building
Cleveland, Ohio 44115
216.621.4984
FAX 621.0050
800.822.0650

AKRON
1015 Key Building
Akron, Ohio 44308
330.535.7300
FAX 535.0050
800.562.7100

APPEARANCES:

Donna Taylor-Kolis, Esq.
Friedman, Domiano & Smith
600 Standard Building
Cleveland, Ohio 44113
(216) 621-0070,

On behalf of the Plaintiff;

Stephen Griffin, Esq.
Buckingham, Doolittle & Burroughs
4518 Fulton Drive, N.S.
Canton, Ohio 44735
(330) 492-8717,

On behalf of the Defendants
Youn Park, M.D. and
Youn Park, M.D., Inc.;

WAYNE KOCH, M.D., of lawful age, called by the Plaintiff for the purpose of cross-examination, as provided by the Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION OF WAYNE KOCH, M.D.

BY MS. TAYLOR-KOLIS:

Q. Doctor, solely for identification purposes, can I state your name and professional address for the record?

A. It's Wayne Martin Koch. My address is 601 North Carolina Street, Baltimore, 21287, Baltimore Maryland.

Q. My name is Donna Kolis. I have been retained to represent the estate of Geraldine Bailes. You are ready, willing and able to render expert testimony in this case regarding the care and treatment rendered to Mrs. Bailes by Dr. Park.

Is my understanding about that issue, correct?

A. That's correct.

Q. Doctor, I have had an opportunity to review your report, as well as your curriculum vitae. I want to go through a few preliminary issues with you.

A. Okay.
Q. I gather that you're licensed to practice medicine?
A. Yes.
Q. In what states?
A. Maryland.
Q. No other states at this time?
A. No.
Q. Can I assume that at present you are involved in the clinical practice of medicine at least 50 percent of your time?
A. That's correct.
Q. Doctor, prior to the case of Geraldine Bailes have you had the opportunity to serve as an expert witness in a medical-legal case?
A. Yes, I have.
Q. How frequently do you get involved in medical-legal reviews?
A. I review approximately six cases a year and have done so for about four years.
Q. How is it that you got involved doing medical-legal reviews?
A. Originally I was involved just because people contact doctors at medical centers like Johns Hopkins looking for people to render expert

opinions. I began to accept cases within my area of expertise.

Q. How would you describe your area of expertise?

A. I practice otolaryngology, head and neck surgery as a speciality. Within that specialty I focus and concentrate on matters related to cancer of the head, neck, mouth, throat. I also do a number of cases and procedures involving general otolaryngology concerns such as sleep disturbance and sinus disease and so on.

Q. Would you say the majority of your time, professional time is spent treating head and neck cancer?

A. Yes.

Q. If you had to, and this isn't a precision contest, approximately what percentage of the cases or patients that you're working with have to deal with head and neck cancers?

A. Approximately 75 percent.

Q. Okay. So the other five percent, as you indicated, are generally sleep disorders and other concerns that an otolaryngologist would care for, correct?

A. That's correct.

Q. If you know, once again, most people tell me they

don't know, we'll see, relative to your experience in medical-legal reviews, have you reviewed mostly for doctors, mostly for patients, how does your percentage break out?

A. Pretty close to 50-50 split.

Q. Have you ever testified in a court of law on behalf of a patient?

A. Yes, I have.

Q. On how many occasions?

A. Actual courtroom testimony?

Q. Actually going to trial and testifying?

A. I don't know an exact number. It's possibly around six times.

Q. When was the last time you testified in a court of law on behalf of a patient?

A. Last spring I believe in March but I don't remember the exact date.

Q. What were the allegations against the physician in that case?

A. That was a case of injury related to a sinus surgery that had been done where a patient had had the Cooper formulate between the nose and brain punctured and started to bleed and the patient ultimately died shortly thereafter.

Q. When is the last time you had the opportunity to

testify in a court of law on behalf of a doctor?
A. Shortly after the one that I just mentioned. Again, sometime this last spring.
Q. In that case what were the allegations against the physician?
A. That was a case where a patient had developed very aggressive ethmoid sinus cancer. Actually I had treated that patient. The patient had surgery and radiation and the tumor kept growing and ultimately became inoperable and I believe she now died of that cancer.
Q. Is that how you became involved in that case because you were one of the subsequent treating physician s?
A. In that particular case, that's right.
Q. Have you ever testified either by deposition or at trial in a case involving vestibular nasal cancer or septal nasal cancer, whichever way you want to call what Mrs. Bailes had?
A. To the best of my recollection, no.
Q. Doctor, have you, yourself, been sued for medical negligence?
A. I have on one occasion, yes.
Q. When was that?
A. I believe the suit was filed in 1991 or '2 and

went to trial in 1993.

Q. Okay. Is that only occasion you have been sued?

A. Yes.

Q. Do you recall what you were sued for?

A. Yes, I do.

Q. Can you tell me about it briefly?

A. Sure. A woman came to me because of complaints of chronic hoarseness. We attempted to do an examination in the operating room of her vocal cords. She had a cardiac arrythmia, the procedure was stopped, she left and didn't come back to me. A year later she developed cancer on her vocal cords. So I was sued with the allegation that I had missed a cancer diagnosis.

Q. Were you successful in the defense of your case?

A. The case was dismissed. I was dismissed and the case was settled.

Q. Okay. All right. We are not going to go through your curriculum vitae, I don't like to admit these things, due to the fact I want to be someplace at a certain time. You're eminently qualified to discuss issues of otolaryngology, I don't dispute that.

Your list of presentations and list of publications is quite extensive. In your

opinion, what articles have you published or book chapters have you published have direct bearing on the issues that present themselves in this case?

A. I've published extensively on issues of cancer, biology of cancer, cancer activity, cancers of the mouth and throat and nose. I don't know that there's any one publication that is specifically directed to the issue of nasal vestibular cancer. If you generalize and say head and neck cancer, many of the publications are related to that topic.

Q. I guess since I bring it up, as it relates to nasal vestibular cancer, one shouldn't generalize the knowledge we have in other head and neck cancers to be applicable to those, would you agree with that?

A. I wouldn't make a blanket statement like that. I think there are some things you can generalize and say pertain to squamous cell carcinoma that involve skin and mucosal lining and other things that may be specific because of anatomical location or risk factor. I wouldn't make a general statement like you made.

Q. I probably shouldn't make a general statement.

You have not published anything specifically on vestibular nasal cancer, correct?

A. That's what I said, correct.

Q. All right. You have, once again, I don't know if it's going be germane to either one of us. In reviewing your publication and pulling some of your articles, it looks like you have a large interest in P53 mutation?

A. That's true.

Q. Is that true?

A. Yes.

Q. Does the research that you've done, Doctor, thus far have anything to do with the matter of Geraldine Bailes as it relates to P53 mutation?

A. Not directly in that we don't know whether her tumor had that mutation.

Q. Right.

A. You could say by percentages how likely it was to have it but I would only be able to draw inference from the literature.

Q. Okay. I was going to say something nice. I will say it at the end of the depo. I was going to say I had the opportunity to read your work and it's impressive. To the extent it helps us in the future, I hope you continue in that endeavor.

A. Thanks.
Q. Let's talk about this particular case. Mr. Griffin kindly provided all the correspondence as a housekeeping matter. As I understand, there's only one letter that I don't have. It may have been an initial contact letter sent to you January 8th, 2003?
A. That's right.
Q. Can you briefly tell me what that letter says?
A. Let's see. It's only one paragraph. It lists the case and says Mr. Griffin, the undersigned, represents Youn Park in the above action and asks if I would be willing to review the case. Here's a copy of the complaint to give me a general idea and an expert review form to fill out and return. That's all it says.
Q. All right. Doctor, have you ever testified in the state of Ohio before?
A. Yes, I have.
Q. On how many occasion?
A. Just once in Cleveland.
Q. Who did you testify for, the plaintiff or defendant?
A. It was for the patient, the plaintiff.
Q. What attorney retained your services in that

case?

A. The man's name was Dale Zucker.

Q. Do you remember what that case was about?

A. That was the case I outlined briefly of the woman's whose Cooper formulate was punctured. It was sometime in the early spring, if I recall correctly.

Q. Do you recall what attorney or attorneys plural represented the defendant? I don't know if there was one or more defendants in that case.

A. You know, I don't recall. To my embarrassment, I don't remember.

Q. That's okay. Do you recall the patient's name who you testified for?

A. No, I'm afraid I don't. I probably can find it in my notes if you need it. I don't remember offhand.

Q. If you could, if it's not too much of an inconvenience, let Mr. Griffin know. I'm sure Steve would be willing to communicate that.

Do you recall who the doctor was? Sometimes people remember a doctor's name.

A. My names and remembrances have been blank on that case. I will find -- I'm sure I saw the letter from them and can get it to you.

Q. Do you have any idea how Mr. Griffin discovered your existence?
A. No, I don't.
Q. Okay. You have not testified for him or a member of his law firm, Buckingham, prior to this particular case?
A. Not that I'm aware of.
Q. Okay. All right. So he sent you a form. Do you know if he called you before, Emailed you that form and talked to you in person or no?
A. It may have even been an Email for all I recall. We have communicated a few times by Email. Initially there is some kind of contact before a letter like this.
Q. Fair enough. Shortly thereafter, as far as the correspondence I have been provided with, on January 24, 2003 you received a letter from Stephen indicating that we have enclosed records of Dr. Youn Park. They also enclosed at that time a transcribed version of his notes?
A. That's correct.
Q. At that point in time did you review Dr. Park's medical chart?
A. I'm sure I did.
Q. Okay. Did you take notes or formulate any

opinion based upon the office chart and the transcribed version of the same?

A. I'm not sure how to answer the question. What I typically will do is to look things through. I may put Post-its a few places and call the attorney and give some impression.

I'm sure at that point since all I saw was Dr. Park's notes I did not have a finished opinion about things but obviously there was need for further information to be sent.

Q. Okay. Doctor, out of curiosity -- well, it shouldn't be curiosity. What materials do you have with you today?

A. I have in front of me a pile of depositions taken by experts and others involved in the case. Deposition of Dr. Wenig, deposition of Dr. Makk, deposition of Dr. Manning, deposition of Deborah Ondecker, who I believe is one of the children of the patient, and the deposition of Karen Wilson.

I have two binders of medical records which came at various times and each of these binders have records from a number of different sources in it. I could go through those at length but for now I will say that. I have a couple of individual pieces of medical records that was

supposed to be inserted under tab B, which I didn't do.

I got some correspondence copies from you, Ms. Kolis, to Dr. Wenig that includes his initial opinion dated August 30th back to you. I got the initial complaint that came early on. And then I've got a small pile of reprints and things from the Internet from PubMed about vestibular carcinoma. And I have a transcribed copy Dr. Youn's handwritten notes. That's it.

Q. I'm going to ask you about the material that you just indicated that you have with you. The question initially I was going to ask before I asked what you have with you, were you able to actually read Dr. Park's medical chart and understand what it said without the transcription?

A. For the most part. There are some individual words that are hard to discern so the transcription helped in that regard. For the most part I could understand what he is writing.

Q. Dr. Park's method of keeping records, does it follow pretty much what you would consider to be the standard, I call it, SOAP note, subjective, objective, assessment, plan? Does he seem to

keep a chart that way?
A. You've thrown the word standard in. I guess that is applied to SOAP note not applied to standard of care, is that the question you're asking?
Q. That's correct.
A. His notes are in what I would call outline form. They're certainly not in sentence form or textual form and they roughly follow a soap sort of logic. There's a chief complaint in them and then a few physical findings generally and then an impression and then something of what he's planned or what action is being taken.

So if I understand the question correctly, his notes are in a soap sort of format.
Q. Doctor, I gather you've had an adequate opportunity to go over Dr. Park's records?
A. I think so.
Q. Don't feel you need more time to do that?
A. No.
Q. Do you find anyplace in any note of Dr. Park a place where he elicited a history from Mrs. Bailes as to how long the sore in her nose existed?
A. Let me just pause for a moment and look again.
Q. Sure.

A. Not explicitly from what I'm looking back over.

It's an interesting question in that I have records from Dr. Park going back a number of years and in several of those there is a comment made about a nasal condition. So one way to answer the question is his records show the length of time that she had complaints about her nose because there are serial visits where that was discussed. But in the notes I'm seeing, nor in my recollection, he does not say on the first visit this lesion has been bothering her for a certain period of time.

Q. Doctor, would you agree with me, and once again, I'm paying you for your time today, however long we need to take is all right with me, there is no recognition in any of Dr. Park's notes that Mrs. Bailes has a lesion in the vestibule or septum, whichever terminology we want to use, of the nose?

A. We probably need to stop and define lesion so we don't have to keep doing it over and over again, because you used the term with a pause before it as though it were of some significance and importance. I'm not sure he uses that specific term. And the discussion of whether he would

have used that term or should have used that term is beyond the course of any statement I could make on the notes. But certainly there is attention given to a particular area in the nose on several occasions and -- is that something we should call a lesion? So does the term lesion have implications? I think it's purposeful in a relatively open-ended term that would allow for a number of different diagnoses with it.

And so unless you want to offer a different definition for that term, I would say that he discusses something in his notes, an area of the nose that has some physical features that could have well been called a lesion if he chose to use those terms. If you ask me to paraphrase, I might say he described a lesion in her nose but did he use that term, no.

Q. Does he describe an ulceration in her nose at any time?

A. As I recall there's one comment it was in one of his last notes that talks about an ulceration being difficult to see. I'm looking at the typed transcript and I'm not finding the thing I thought I recalled. Perhaps my memory is faulty. If that note existed, I can't find it. It's the

only place, as I recall, he described ulceration.

Q. Doctor, I will represent to you, once again, I have time, I have had an opportunity since Friday to review the transcription that was supplied, as well as review the deposition, as well as review the chart. And my conclusion based upon what is in writing is that Dr. Park never describes an ulceration while Mrs. Bailes is under his care. I'm asking if you come to the same conclusion?

A. Just again for the sake of time I would like to leave my uncertainty about that open for now. I will agree saying as I look back over these things, the place I thought that wording appeared was not there. And certainly on other notes I see no evidence of him describing this as an ulceration.

Q. Fair enough. Before we go on, I think the rest of the correspondence is straightforward and ends up describing everything you currently have in your possession, to the best of my knowledge.

You indicated you have some reprints of Internet articles relative to, I thought I heard you, vestibular cancer?

A. That's right.

Q. I would like to know the names of the articles

you have in your possession.

A. Okay. I ran a search on PubMed and picked, from the ones that came up, four articles to go and get reprints of and I will read them.

MR. GRIFFIN: Dr. Koch, when you shuffle papers, keep them away from that microphone. We can't hear you and those papers.

THE WITNESS: I'm sorry.

MR. GRIFFIN: Small avalanche on our side.

THE WITNESS: I don't know how good the microphone is.

A. The first one is titled, National Septum Squamous Cell Carcinoma: A Chart Review and Meta Analysis. The first author is M.D. DiLeo, D-i-L-e-o, and it appeared in the Laryngoscope in 1996, Volume 106, beginning Page 1218. Actually I think I have not pulled that article, I only have the abstract.

Q. Can you tell me, in essence, what the abstract of that article says?

A. This is from Tulane University and they reviewed their tumors at three local hospitals over 30 years and found 16 primary tumors of the nasal

septum. And they say they combined their findings with others in the literature in what is called meta analysis to look for predictors of survival. They say there were too few patients in each stage and patient group to determine optimal treatment. And they say that their conclusion is that small lesions can confidentially be treated with either radiation or surgery and combined therapy is necessary for bigger lesions.

Q. Do they in the abstract you have, I understand you did not pull the entire article, define small versus not small?

A. Not in the abstract. I may go pull this article but I don't know right now what the lesion size was.

Q. Next one?

A. Okay. One of the ones that I actually went and got, the first one is called Squamous Cell Carcinoma of the Nasal Vestibule and it is -- the first author is M., last name Samaha, S-a-m-a-h-a, published in the Journal of Otolaryngology in April of 2000, Volume 29 beginning on Page 98.

Q. Okay. And what did --

A. Do you want to talk about each one?

Q. Just give the summary. I am going to ask you to fax those to me.

A. Sure. This article, first of all, says that this is a rare disease, they at some point tell how many cases they treated. They reviewed records over a 24 year period and found 14 cases. This is at McGill University in Quebec. So 14 and they achieved a 78 percent local regional control rate and three year follow-up in patients that had what they call early disease with either radiation or surgery. Then they say all the patients who presented with late disease suffered a recurrence requiring additional therapy and only 20 percent of those that they classified as late had a disease free interval of at least two years.

And they say that the tumors that recurred all resulted in a poor or grave prognosis with only 25 percent of people surviving after three years in that group which tumors recurred.

Q. How are they defining late disease in that particular article?

A. That is one of the things I wanted to see. On the second page, on Page 99, they have the

following definitions: Early lesions were defined as those involving skin, this mucosa or muscle without cartilage, cartilaginous, bony or perineural invasion. To define late lesions, late lesions involved cartilage, bone or nerve or had lymph node metastasis at presentation.

Q. Okay.

A. I'm sorry. I'm shuffling papers again.

Q. That's all right.

A. The next one is entitled Squamous Carcinoma of the Nasal Septum -- Nasal Septum Mucosa, published in a journal called Ear, Nose and Throat Journal in March of 1993, Volume 72, beginning on page 217. The first author is M. Fradis, F-r-a-d-i-s. And this is out of Haifa, Isreal.

They also discussed how few cases they found. They have 16 cases over a 14 year period. This is an interesting sentence in their abstract that caught my eye. The initial -- as the initial signs of this carcinoma are no different from non-neoplastic disease, a high incidence of suspicion is necessary in order to correctly diagnose these lesions. And then they say that the best treatment, in their opinion, is to

excise the lesion and repair it with a skin graft.

They give an extensive list of their tumors. They don't try to separate them into stages. Although later they say in early stages of disease they don't advocate radiation alone. But they don't have any staging criteria. So that's that one.

I will move on unless you want to talk more about it.

The last one is called Squamous Cell Carcinoma of the Nasal Vestibule. Treatment Results. It's a little bit early, published in ACTA, A-C-T-A, Radiology Oncology Journal in 1984, Volume 23, Page 189. And the first author is L.V. Johansen, J-o-h-a-n-s-e-n, and these people, they're in Denmark.

And they had 66 patients with squamous cell carcinoma of the nasal vestibule. The majority treated with radiation therapy and 22 of them were or about one-third had local recurrences. They discuss a classification that is proposed by a doctor from Boston named C.C. Wang who gave a proposed staging and they say that using his staging criteria they found a high proportion of

small tumors T-1 and T-2 were cured and it would be possible to salvage local recurrences in those early cases sometimes with surgery. But that advanced tumors, according to his staging, T-3 had a bad prognosis with 88 percent of them recurring. They say as an alternative, tumor size can be used as a prognostic parameter.

In looking at this they list C.C. Wang's T staging. I didn't go to his original article to try to get any further information but he says T-1 lesion is limited to nasal vestibule, relatively superficial involving one or more sides within. That would be within the nasal vestibule. T-2 had extension from the nasal vestibule to adjacent structure such as upper septum, the upper lip, filtrum, the space between the creases or ridges on your lip, skin of the nose or the nasal fold but not fixed to the bone.

T-3 had tumors that have massive, extensive, hard, palatable in the space between the lip and gum, parameters of the turbinate or adjacent sinuses.

I didn't see in this article any further discussion of the size issue that they brought up. They continue to talk about small versus

large and say patients who presented with early T-1 or 2 disease did well. Here's tumor size in millimeters. They have a little graph here that gives a few patients on it and it looks like the survival is on the Y axis and size on the X axis and they had seven patients whose tumors were bigger than 30 millimeters who did poorly. It doesn't say whether those are millimeters squares or that's the greatest dimensions.

And then there's a group of patients in the intermediate size between one-and-a-half and two-and-a-half centimeters who have a survival better than 75 percent. And then the few people that had very tiny lesions, that being less than a centimeter in size, who had a good outcome with no deaths from carcinoma. So there's a little of bit of a size graph on that one.

Q. Doctor, I am going to ask that at the conclusion of the deposition that you fax those articles to me.

A. I will be glad to do that.

Q. Remember to ask me and I'll tell you my fax number.

A. Okay.

Q. Why did you find it necessary or did you find it

necessary to go to the Internet to find these articles to help you in rendering your opinions in this matter?

MR. GRIFFIN: Object to the question, go ahead.

A. Did I find it necessary? No. Did I find it interesting and useful? Yes. It reconfirmed impressions that I had, a number of impressions that I had. It gives me a little bit of not confidence but backout perhaps in conversation. The reason I thought it important in this kind of a setting is that this tumor is very unusual. It's location -- I keep a database at Johns Hopkins and I have done so for 15 years. I have looked at my database from 1986 to 1996, and this is all the head and neck surgeons at Johns Hopkins, we saw a total of eight people with disease in this location. It's very difficult to draw any kind of conclusions from what's basically anecdotal information.

I remember two of those patients, because they were mine, very clearly; actually three of them were mine. But how can you draw any conclusions from three people? So you go to the literature and you find that other centers that

have tried to do this same thing over a 30 year period can only find one patient a year or thereabouts and you realize that nobody has statistically valid information about these patients, where they have enough patients to try to draw some inference beyond some broad general strokes. Long answer to a short question.

Q. That was all right. I try not to interrupt.

In your search for literature on -- I don't like to call cohorts but groups of people who have been diagnosed and treated with this, did you run into Levendag and Pomp, Radiation Oncology in 1990?

A. If I did, I didn't print it. I don't have the front page from the search that I did with me. So I may have looked at it and read the abstract. I don't recall. Who are the authors?

Q. Levendag, L-e-v-e-n-d-a-g, and Pomp, P-o-m-p.

Is Radiation Oncology a journal which you read because of your interest in treating head and neck cancer?

A. I don't regularly read Radiation Oncology, no. Most of the articles that I look at now I find on searches, such as the one I conducted, and I go from place to place to place. Radiation Oncology

is not a journal I regularly read.

Q. Okay. Have you ever read anything written by Dr. Wenig relative to early diagnosis of vestibular cancer?

A. No, I haven't.

Q. Didn't find him in your literature search on the Internet?

A. I looked him up on the Internet after the deposition because I thought he had written such a thing. I have that one in front of me and I didn't see anything related to squamous carcinoma related to the vestibule in the articles that are listed in PubMed. But not every journal is abstracted in PubMed and any book chapters he may have written wouldn't be there. He may have something that I don't know about.

Q. Okay. Fair enough. Out of the article that you were citing that was published by a group of physicians in Haifa, Isreal, specifically you read into the record that within that article they indicated that you should have a high incidence of suspicion to make this diagnosis since the initial signs and symptoms of nasal vestibular cancer and other problems with the nose, but you can use the correct word.

A. Was that a question?
Q. I'm getting to the question.
A. Okay.
Q. This is what you read into the record. Now, how does one come to a high index of suspicion in nasal vestibular cancer?
A. First of all, let me back up to what you just said. You used the word should have a high index of suspicion. That word to me implies some requirement that could then lead to some kind of standard of care and negligence question. And so I would like to move away from the word should and I will correct it. If I read this incorrectly, I will correct the record.

The statement in the abstract actually says as the initial signs of this carcinoma are non-distinct from neoplastic disease, high incidence of suspicion is necessary in order to correctly diagnose these lesions. I guess the distinction I would make in that terminology is this could be read as saying the standard of care and what most people might assume is that these lesions are present for non-neoplastic reasons and only, now I'm editorializing, only if you have a high index of suspicion are you going to

make the diagnosis.

So everybody would like to make the right diagnosis. The only way you're going to make this diagnosis is if you have a high index of suspicion. And then you could discuss is that high index of suspicion standard of care or not but it doesn't say should. It says it would be necessary in order to make the correct diagnosis.

Q. I will give you everything you just editorialized about. That's why I asked you to refocus. I was writing as I was listening to you.

What would create a high index of suspicion in your opinion?

A. What would create a high index of suspicion?

Q. Sure.

A. You're asking me about physical features of the lesion?

Q. Whatever. It could be history, it could be environment. I'm asking you since I don't have the article in front me. The article makes it pretty clear, or at least the portion you read, the initial signs of vestibular cancer are going to mimic or look like things that are non-neoplastic conditions. So what is it that created this index of suspicion that would go on

to cause you to biopsy?

A. In fact, they actually say a little more than that. On page 220 they say initial symptoms may be nasal sores, nasal mass, nasal crusting or epistatic but non-specific nasal septum carcinoma. So they don't give you any answer to that question, at least in that paragraph. The index of suspicion that you have, I will speak real generally for a minute, is going to be based on a general sense of your patient and their risk factors. It will be based on some of the history, the temporal relationships and whether things come and go or whether they persist and get worse over time. And then it may be based on some very subtle physical findings when you're actually looking at and examining the area.

So now to get more specific, if an area had that clear progression from small to large or from not troublesome to very uncomfortable, did not respond well to treatment and such, then you might say this is something concerning we need to know more about it. If -- the physical findings that you would look for under circumstances such as this I think are very troubling to try to define because typically what we are looking for

to be concerned about a cancer is an area that is easily made to bleed but many, many things on the nasal septum are easily made to bleed, slightly thickened and raised but these inflammatory things they mention in the article are also thickened and raised sometimes.

And so I read this abstract as saying, hey, this is a difficult situation. Frankly sometimes an increased index of suspicion or high index of suspicion is something that happens on gut sense more than on something that you can define in a setting such as this and give a listing for and it's hard for me to be more specific.

Q. You've read Dr. Park's deposition?

A. Yes, I have.

Q. Do you have a copy of it with you?

A. You know I thought I did. Going back through this I couldn't find it.

THE WITNESS: Mr. Griffin was this in one of the binders or freestanding?

MR. GRIFFIN: Freestanding.

A. I'm afraid I may have left that in my office. I thought I grabbed everything. I don't see it here.

Q. What I am going to do in that event, I'm going to

ask you just a couple questions. I will make the representation of what the testimony is and you'll assume that I'm correct. If I'm proved to be wrong later so be it. I am going to ask you some agreement questions.

If Dr. Park testified on page 15 of his deposition, lines 1 through 3, that a non-healing ulcer in the nose should have within it a differential diagnosis of a possible nasal cancer, would you agree with that?

MR. GRIFFIN: Objection. Go ahead.

A. Are you asking me to agree whether his statement is right or whether he said that? You're reading the deposition and I'm supposed to assume.

Q. You're supposed to trust me I'm giving you -- I know that's a terrible thing to ask you to do.

A. That's okay.

Q. I'm reading to you what it says. I'm asking you if you agree with the statement. If it's proved out I'm not reading correctly, then that's my problem.

But if Dr. Park agreed that a non-healing ulcer in the nose should have within it a differential diagnosis of a possible nasal cancer, would you agree with that?

MR. GRIFFIN: Object.

A. The question?

Q. Would you agree with that?

A. I mean, the question is a little convoluted. I think what you're asking me do I think a non-healing ulceration in the noise should have within the differential diagnosis a possibility of cancer. And I think that that's a true statement.

Q. Okay. Would you agree with the statement that the standard of care requires a physician to perform a biopsy on a non-healing ulcer in the vestibule of the nose if it doesn't heal in four to six weeks?

A. Are you reading that from Dr. Park?

Q. I'm asking if you agree with that statement.

A. That statement I don't agree with, no.

Q. If a patient presents with an ulceration and you give it topical treatment and it doesn't clear, over what period of time, A, are you going to follow it?

A. You want me to answer? I thought were you going to go to B.

Q. No. I will do A. Over what period of time will you follow it?

A. The only problem I have answering these categorically, one thing is ulceration is a term that requires some of that subtleties of physical findings I implied when we were talking about findings you need to have a high index of suspicion.

You can have something that is a very shallow excoriation on the nasal septum where there is no heaped up edge and the perimeter around this is fairly indistinct. And I might use the word erosion or excoriation rather than ulceration. Someone else might use the word ulceration. If I brushed against that and it wasn't friable, which is a term that means easily made to bleed, I might not be terribly concerned about that lesion, particularly if I had seen that person over a period of time. I might say that's the thing I have seen there before and not make a specific follow-up appointment for that person. That would be a situation where you say the record says there's an ulceration, I am not going ask that person to come back in any kind of time frame.

On the other hand if there's something completely new, heaped up edges, that is easily

made to bleed, that doesn't get better with a month, say, of some kind of ointment, I would probably biopsy that right away within that four to six week time frame you asked me on the previous question.

There are subtleties you hope an expert in cancer care will recognize that aren't easily defined verbally. They take a lot of discussion and sometimes I know it when I see it.

Q. Is Dr. Park an expert in cancer care?

A. You know, I don't know Dr. Park's practice. I remember reading his CV and his deposition and one way to answer your question is any otolaryngologist, head and neck surgeon is an expert in cancer care. We are all trained in that field. He also published several articles on nasal cancer. It appears he has expertise in head and neck cancer and particularly in comparison to someone who might, say, be a primary care physician. I think it's reasonable to expect that an otolaryngologist has a level of expertise that a primary care physician I would not expect to have.

Specific to his practice and level of knowledge, I don't have first hand information.

Q. To support Dr. Park in this case have you made the assumption that Dr. Neal Manning does not know an ulceration when he sees one?

A. No.

Q. Okay. Have you made the assumption Dr. Manning actually saw an ulceration?

A. I have no reason to believe he did not see an ulceration.

Q. From reading the family's depositions and subsequent medical records, not Dr. Park's, have you come to an understanding Mrs. Bailes indicated that that sore was -- there was a sore present in her nose for a period of time that extended at least two years?

A. I remember seeing that in a number of the subsequent histories that were given. I don't remember the specifics of her daughter's testimony about it but that's consistent with the general impression I had, yes.

Q. Is a sore in the nose consistent with vestibulitis?

A. Yes.

Q. Do you expect vestibulitis to clear with administration of topical antibiotic or cream?

A. Sometimes it does and sometimes it doesn't.

Q. Have you been able to reconcile Dr. Manning's findings that there was a shallow ulceration in Mrs. Bailes' nose in November of 1999 with Dr. Park saying there was no ulceration?

A. First, I think when I look back through the records I didn't see Dr. Park saying there was no ulceration. I just didn't see him use the term. Had he been asked if there was an ulceration, I don't know what his answer would have been.

The fact Dr. Manning's description and Dr. Park's description are different, I think it's reconcilable, yes.

Q. How do you think it's reconcilable?

A. I think there's two factors involved. One is Dr. Manning saw Mrs. Bailes on two occasions prior to the two times that Dr. Park saw her. So the first were a couple visits prior to the 1999, I believe it was the November '99 visit of Dr. Park, and he saw her twice, I believe, in October.

The first time -- I'm going to open and look at his record.

Q. At any time you need to use the records, that's certainly acceptable.

A. So I can be specific. On October 11th, 1999 he

describes that she has a small, shallow ulceration, left side of the septum of the nose with no other nasal lesions. And, in fact, he put her on ointment, Aquaphor ointment, October 11th, '99.

He sees her again three weeks, three-and-a-half weeks later, November 8th of 1999. And on that occasion he says that she has a scabbed over lesion in the left nasal septum. And in his assessment section he says sore on the nasal septum appears to be improving. So then a week later, I believe it is, is when Dr. Park sees her on November 15th and he has a little drawing that shows that her nose looks obstructed to him and there's a small crust on the left side of her nasal septum which he attributes in his impression to vestibulitis.

He says that -- I'm going to have to go to the transcript because one of those words I couldn't read, nasal -- in the transcript it says nasal mucosa -- mucous erythema swell throat negative. I don't know who did this transcription. I would have thought nasal mucosa erythematous with swell, but basically the ideas are there.

I would propose November 15th exactly coincides with Dr. Manning's November 8 record. They agree hundred percent there's a small crust. The area is improving. It's been another week for it to improve even further and I don't see any difference on that occasion.

And Dr. Park sees her again on November 23rd and says there is some thickening, septal thickening with erythema and continues to call that rhinitis, calls it rhinitis and gives her a sample of Flonase. That's the first sequence of visits.

The second one is in 2000. And on August 28 of 2000 Dr. Manning sees Ms. Bailes and said she had a shallow ulceration in the left nasal septum that does not appear infected. Dr. Park sees her about a week later on September 5th and says that she has a septal deviation with vestibulitis. So, again, there has been a week in between. He's concentrating on a buccal lesion at that point that both the patient and Dr. Manning had also mentioned and doesn't describe the nasal lesion in detail.

So there are two factors, as I started to say, one is time. There was a week in between

these. And I think from the record it's clear that physical findings tended to fluctuate over week long intervals of time, particularly if there was treatment given. And the second is what I have been trying to characterize before, which is differences in terminology and expertise of various people and what they see and how they describe it. So a small shallow ulceration to Dr. Manning may appear as something that Dr. Park would call an ulceration or it might be something that he would call excoriation and so on. But at any rate Dr. Park doesn't use the same term. That doesn't trouble me into thinking that he didn't examine the area or to think that he didn't see whatever there was to be seen there.

Q. Okay. Let's ask a few questions this way.

Doctor, do you have any doubt in your mind -- let me pull that back.

Will you be conceding as a factual matter at trial that the location where the cancer was diagnosed is this area has been described in Dr. Manning and Dr. Park's notes?

A. Unless I see evidence to the contrary my understanding is now it's in the vicinity in the same region.

Q. Do you believe, to a reasonable degree of medical probability, that that cancer that was ultimately diagnosed was present in Dr. Manning's examination of October 1999?

A. I don't know whether the cancer was present in October of '99.

Q. Based upon all the records you have what will be your testimony as to when this cancer occurred?

A. I don't know that you can determine from the record when a cancer cell first developed in this area. So I don't have any way to project when the cancer first occurred. I think it's equally, not equally possible but it is possible that there was cancer there in October of '99 or even before that. And it's also possible that there was not cancer present, that had a biopsy been done it would have shown only inflammation or some other activity going on that wasn't cancerous.

Q. Based upon the pathology, you've read the deposition of Dr. Makk, correct?

A. Yes.

Q. You haven't looked at the pathology side slides in this case?

A. I have not.

Q. That would be -- that's not something you do, correct?

A. That's correct.

Q. All right. We are going to accept Dr. Makk's characterization of his cancer. Do you accept this characterization?

MR. GRIFFIN: Object. Go ahead.

A. I have no reason not to. I think it's fine.

Q. Do you agree, irrespective of whoever said this, this was indolent cancer?

A. Indolent implies slow growing.

Q. Correct.

A. I don't know any way, again, to measure the growth of this unless you make some assumption that I just said I wasn't prepared to make about when the first cancer cell developed in this situation.

You could try to make a statement about speed of growth after the treatment and the period of time from when the radiation ended from some pictures I saw and eventually Ms. Bailes' death. But to say anything about it before that would be speculative.

Q. So if this cancer had been diagnosed in -- that's part of your opinion. We are going to get to

that in a minute. I would like to look at your report. Do you have a copy of it?

A. I don't think I do have a copy of that report. I think I have it electronically stored on my computer but I didn't print it.

Q. Okay. I'm assuming that Mr. Griffin here, who is representing Dr. Park, has one handy and he'll correct me if I misstate anything hopefully.

I didn't want to ask you a whole lot about this but I am going to focus on a couple things. In the initial part of your report you indicate Dr. Youn Park had cared for Mrs. Bailes over ten years for a variety of conditions including nasal vestibulitis. Vestibulitis is an inflammatory condition of the nasal opening usually due to an infected hair follicle.

Does that sound like something you wrote?

A. That sounds correct.

Q. When Dr. Manning examines Mrs. Bailes in late August of 1999, I think that's 1999, I'm getting my years confused, August of 2000, you remember you read that description, he describes a shallow ulceration that does not appear infected. Would you agree with that?

A. I agree that's what he says.

Q. That's what he says?

A. That's what he says.

Q. That description is not consistent with vestibulitis?

A. It's not consistent with what I read before. The problem is that either one of these one sentence definitions need to be flushed out. Somebody gets vestibulitis, they have irritation in their nose. There's often some swelling and redness. There's often some crusting that occurs and often times because it's irritable they pick at it, if you pardon my expression, it's hard to leave it alone and that sets up a process that might continue long after the staph infection or whatever it was that started the problem occurs.

There's also a possibility like septal mucosal crusting, in particular some of these things are happening not in August but December, the time when a lot of people have crusts on their nasal septum, when you pick away the crust the skin lining is not present and you might say shallow ulceration or excoriation. If you're going to use a general term to describe that in one word in your medical record, you might say vestibulitis, inflammation of the tissue, the

nasal lining of the opening of the nose without it being that hair follicle infection that was in the sort of classic definition.

So is a shallow ulceration consistent with vestibulitis, yes. Are we sure that's what it is? I can't be sure of it. Is the fact there's no inflammation or apparently does not appear to be infected is that consistent with vestibulitis? In a broad sense of the term with the sort of history that I described before, I would say you could paint a picture where it's all consistent. But would this be your initial impression of this lady on this day given this description? Probably not.

Q. Okay. Before I get back to -- I want to ask you a question. You indicated in your practice at Johns Hopkins that you've actually treated two people with nasal vestibular cancer; is that right?

A. That's correct.

Q. How in the name of heavens did you make the diagnosis is what I want to know?

MR. GRIFFIN: Objection.

Q. If you can recall.

A. You know, one of the cases it had been made,

somebody biopsied it before they came down. In both of those cases there were findings that would be consistent with difficult to define impression that it was -- that I tried to give a couple times -- of tissue that was a little bit heaped up, that was friable, friable is almost as though you take a whole bunch of pins and poked it into tissue and had little bleeding spots from multiple little areas when you brush against something or maybe a little bit of tumor mass thickening present.

Now, I know of one or two of the cases that were not my patients and how they were diagnosed and some of those cases these are people who have large nasal septal perforations that are thought to be due to having your nose cauterized when it bled, cocaine abuse or immune disease like Wegener's, W-e-g-e-n-e-r-'-s, granulomatosis when somebody says it looks a little you unusual and biopsied it and it's found to be a cancer. There's a whole number of things that might lead you to a diagnosis.

Q. Okay.

A. I would also say if you went around and biopsied every little shallow ulceration on everybody's

nose in November, you would do a lot of biopsies and give a lot of people bleeding and a sore area in their nose that wouldn't heal for awhile to no avail.

Q. Ready for my next question?

A. Yes.

Q. Okay. You indicate in your report, just reading it directly from the report, at that time, that refers to the sentence before March 1999, Dr. Neil Manning, Ms. Bailes' primary care physician, began documenting a persistent sore on the left side of her nasal septum which was eventually found to be due to invasive cancer. Do you recall writing that?

A. Not specifically. But if you say it's there, that's nine.

Q. I want to make sure there's no doubt, by the end of the depo you have no doubt the persistent sore is the sight where cancer was eventually found in Mrs. Bailes?

MR. GRIFFIN: Objection. Go ahead.

Q. Correct?

A. I think I've already answered one question that said that. Unless I see something else in the

record that leads me to believe that it was somewhere else, it's in the right area, that the sore that was there it's in the same location as where the cancer developed.

Q. Okay. Moving on in the report. You write, I'm reading these selected sentences, Ms. Bailes did not return to Dr. Park until September of 2000. Now her nasal septum did concern Dr. Park who recommended immediate biopsy.

That's not an accurate statement in your report; is it?

A. As I further reviewed the record I would not make that statement today. I agree that is not an accurate statement.

Q. Do you know when you wrote this report? It's not --

A. I hope there's a date on it but I don't remember. It should have been sometime in the early period when I was reviewing papers. It would have been after I saw Dr. Park's notes.

Q. You know what, I now have a copy dated -- Mr. Griffin's original record dated April 17th of 2003.

A. Okay. That's in the right range.

Q. Did you receive any significant material after

April 17th that would cause you now to correct the misstatement in your original report?

A. Well, the only thing I can think would have pertained to this would have been Dr. Park's deposition and I'm trying to find out when I saw that.

Q. I have a cover letter dated February 26th, 2003. That's when Mr. Griffin forwarded that to you.

A. From the looks of things I may just have made a statement that was inaccurate because I had not put everything together at that point the way I put it together subsequently.

Q. Out of curiosity in terms of you putting it together, in Dr. Park's chart there was a request for biopsy but it was for a buccal lesion. Would you agree with that?

A. That's correct.

Q. And there was no such request for a biopsy of a nasal defect, septal nasal defect, right?

A. That's correct.

Q. And, in fact, in the transcription and Dr. Park's office notes he simply, once again, calls this vestibulitis, doesn't he?

A. He calls it vestibulitis in his December office note, I believe, yes.

Q. September. I want to make sure we get the record straight?
A. September 5th.
Q. Okay. To cut to the chase, Doctor, I gather you're going to render an opinion at trial Dr. Park complied with the accepted standard of medical care?
A. Correct.
Q. All right. Let's talk about what you may testify to as to proximate causation.

Doctor, is it your opinion even if Mrs. Bailes would have been diagnosed in November of 1999 that her outcome would not have been different in this matter?
A. That's correct.
Q. Explain to us the basis that you conclude had diagnosis been made in November of 1999 that Mrs. Bailes still would not have survived her cancer?
A. First of all, the question has the assumption I think that there was a cancer there in 1999. And I've already testified that I'm not certain that there was a cancer there.
Q. All right.
A. So it may have been impossible to make a

diagnosis in October of '99. So let's go past that and now I will answer with the assumption that had a biopsy been done, it would have shown cancer cells present.

Q. Correct.

A. The only object -- well, what happened to Mrs. Bailes was not the expected result of her treatment given her lesion at the stage or the size or the characteristics that it was when it was eventually treated in 2001. It would have been the case in the vast majority of cases like hers that there would have been local regional control of this disease and she would have survived. That didn't happen and it didn't happen for reasons that are difficult to explain.

We can make all sorts of statements about why we think that this tumor did not respond to what should have been adequate treatment to which it should have responded but we don't know the reason why. And so whatever that reason was that it did not respond to treatment, in my opinion is due to the biology of the cells in this cancer that were not responsive to radiation therapy.

In other words, radiation could not kill all cells present here and they went on to grow

again. And whatever that biological capability that those cells had to avoid the radiation beam was apparently not, from what we can tell because the cells were deeply invasive or protected by bone or cartilage, because the lesion and its description at the time of treatment was not deeply invasive or into bone or cartilage, on that basis I would say the reason it didn't respond to radiation is some cell or group of cells in that cancer developed a capability of avoiding the damaging effects of radiation that would kill most cancer. That is true of a number of cancers. Not every cancer is cured by radiation even some very early cancers.

Whatever that biological capability was is something that was inherent to this particular cancer. Now, you can say maybe the cancer developed that capability over time and maybe it did. But that is speculative and it would be equally likely and valid to speculate that the first mutation that those cells developed, had them on their way to being a cancer cell was a mutation that made it so it wouldn't respond to radiation. So the biological capability of this tumor is something that we cannot know the timing

of its development.

So all we have left is staging. And I have read through some of these abstracts to confirm my impression that there is no accepted staging system for cancer of the nasal vestibule. You could use skin cancer as a staging, you could use nasomaxillary sinus cancer as a staging mechanism or try to use staging from an oral cancer, for example. But there is no staging for the nose.

So if you look at any of the criteria that these other authors have used or use any of those sort of transferous stages I just described, you would have to agree, in my opinion, that at the time of diagnosis of the cancer eventually this was still a very early cancer, early cancer that had not developed any of the features that would make it a later stage or a T-2 stage cancer.

So if you try to look at the literature or experience of other patients and doctors and say what should have happened in this treatment. It would be precisely the same by statics when this was eventually diagnosed in 2001, as it would have been if you biopsied and found it was a cancer in 1999, because both of those lesions still would have been early and that's the basis

of my opinion that the results of treatment and outcome would have been the same had she been diagnosed in 1999 as when she was diagnosed in 2001.

Q. Doctor, I think you conceded that there really isn't an agreed upon staging system for vestibular cancer, correct?

MR. GRIFFIN: Object.

A. I don't know that I conceded it. You didn't make that statement, I did. I said it just a moment ago.

Q. The fine.

A. The statement is right.

Q. Okay.

A. I'm sorry.

Q. It's not a problem.

You were not at Dr. Stepnick's deposition. If I'm confused what I asked or said, excuse me. Have you been made aware of the testimony of Dr. Stepnick?

A. I have not seen his deposition.

Q. Have you seen his expert report?

A. I don't believe so. Not in the things I brought here.

Q. Do you know Dr. Stepnick?

A. I don't know him personally. I have seen his name but I don't know him.
Q. Do you know Dr. Lavertu?
A. Yes, I know Pierre Lavertu.
Q. Have you seen Pierre Lavertu's expert report?
A. No, I don't believe I have.
Q. Do you respect Dr. Lavertu?
A. In a general way, yes.
Q. I meant in terms of his talent as an otolaryngologist doing head and neck cancer?
A. I know Dr. Lavertu in the same way Dr. Wenig, having seen him at meetings, when he speaks I listen because I think he's well-trained and well-spoken and I respect him. In terms of clinical judgement or opinions specific to this case or his medical practice, I don't have a reason to think good or bad about any of these people.
Q. Okay.
A. I just don't have information.
Q. So at what point, Doctor, to the best of your ability can you say this tumor began to grow?
MR. GRIFFIN: Object. Go ahead.
A. When did it begin to grow?
Q. Right.

A. One way to answer that question is to say as soon as a cell, any one cell developed capability to grow and divide beyond the limitations of its nature the tumor began to grow. So one way to answer it is this tumor began to grow sometime and maybe a long time before it was visible and visibly growing. That would be one statement that I think is true.

In terms of when it began to grow visibly to people, according to the record that's very difficult to discern. There are notes from Dr. Manning, for example, that seems to describe this small, shallow ulceration similarly over a period of time ranging perhaps eight months or so in duration without any extensive difference.

There's a note I think in Dr. Manning's records again that Mrs. Bailes thought that this was extending or growing when she came back and saw him in 2000 after she had seen Dr. Park for the last time. So apparently her impression was that something was growing in 2000. But those are relatively sparse data points to make a statement about growth.

Tumors grow and they grow progressively and grow over time and their speed of growth is

unknown.

Q. Okay. Doctor, as a matter of medicine, is it more -- I hate asking questions I haven't written out. Is it more likely than not as a matter of medicine that the longer a cancer is in the process of growing, that it will develop these characteristics you're discussing that Mrs. Bailes had down the line?

MR. GRIFFIN: Object.

A. I don't have any basis to make a statement like that except that there is common experience among people who take care of cancers that some cancers eventually take off with rapid growth and in Mrs. Bailes' case that was documented after the radiation ended but not before. I think it was Dr. Makk that characterized -- you asked me the question, the indolent question as to late against present over a long period of time, it hadn't changed very much. It was still small and after treatment it took off.

So you could say maybe that's when something happened that changed this into an aggressive tumor. All I said there's no way to know when that happens. But we do see cancers that present very early that you expect to be able to cure

with treatment on a regular basis and you go ahead and do treatment and that particular cancer, for whatever reason not predicted by anything about the cancer, doesn't respond and goes on and is just devastating. This is not an uncommon situation. It's an unfortunate situation not uncommon situation. And in some of those cases where everything has been done appropriately and done thoroughly and on a timely basis, it still goes on to a bad outcome.

All we can do is say that this was in the cell's capability before the beginning and so it could be that this had the capable of resisting radiation, as I said before, when it developed its very first genetic alteration on its way to becoming a cancer before it would have been recognized as a cancer.

Q. You have absolutely no way scientifically to state this to a medical degree of certainty, correct?

MR. GRIFFIN: Object.

A. You could subject Mrs. Bailes' samples to a variety of laboratory studies that would look at what they might call prognostic factors that might predict radiation responsiveness and so on

and so forth. And you might be able to demonstrate a difference between the tumor at the time of its initial biopsy and post-radiation biopsy.

Your statement I wouldn't agree with. There may be some way to get more information. We don't have any of that information and that information would be not -- not so reliable as to be a hundred percent definitive even if we had it.

Q. Okay. Have you been asked to -- let me withdraw that.

Subsequent to her diagnosis do you have any criticism about the care and treatment rendered to Mrs. Bailes by any of her medical practitioners?

A. Yes, I do.

Q. You didn't write about that in your report?

A. Because I only got those records just recently. I got this big binder of records from the radiation treating facility and the other otolaryngologist just a couple weeks ago.

Q. When a couple weeks ago did you get those records?

A. They came when I was away. August 7th is the

date of the mailing.

Q. Do you know why it is that you didn't receive those records until August 7th?

A. I don't know.

MR. GRIFFIN: I had to wait for them through authorization. Are you doing that to me or you?

MS. TAYLOR-KOLIS: I'm getting the pen off my finger.

Q. The question I have, without getting -- I'm assuming based upon the testimony you rendered with respect to deviation or problems you have with subsequent care ultimately don't make a difference in Mrs. Bailes' outcome because of what you already testified to?

MR. GRIFFIN: Object. Go ahead.

A. I think that was a statement not a question. I think that there is some possibility that if you want to call it deviation, substandard care may have missed an opportunity for Mrs. Bailes to have timely salvage surgery that may have stopped the cancer before it became impossible to stop. So I do believe that it is possible that the care that she was rendered after Dr. Park is out of the picture was not rendered in a way that gave

her every possible chance of survival and did result or contribute to her eventual demise.

Q. Doctor, is it more likely than not she would have survived had whatever you're about to tell me they did wrong more likely than not, not possible?

MR. GRIFFIN: Object. Go ahead.

A. You know, the only way to answer that question with medical certainty I think is to be able to go to literature experience and answer this question how often is salvage surgery successful in this situation and there was one very small statement in one of these four articles that we would have to go back through that said T-1 and 2 lesions that recurred and had salvage surgery continued to do well for the most part.

Now, if you ask me from a statistical point of view is that a valid statement, I would have to say no. The numbers are so very small it's hard to say that. Salvage surgery, and with very broad brush strokes, is not as effective as initial surgery in most head and neck cancer. So salvage surgery might be construed as a long shot.

More likely than not asks me to draw a 50

percent line in the sand and I'm very uncomfortable doing that. If I were to characterize this to a patient who came into me with the findings Mrs. Bailes had sometime after her radiation, it's very worthwhile to do surgery on your nose, we may be able to stop its growth. Is it 50 percent or 30 percent or 60 percent, it may well be, it's not 5 percent, it's not desperate, grasping at straws. 50-50 likelihood I can't answer the question. I don't know.

MS. TAYLOR-KOLIS: Okay. In that event I don't have any further questions.

MR. GRIFFIN: He'll read the deposition.

With the warning, the characterization how you form a question isn't necessarily how it will be asked on direct. And without exploring it further, I'm not forbidden from asking those questions at trial if you fail on what you perceived to be a successful motion in limine.

MS. TAYLOR-KOLIS: I will file a motion to exclude the direct evidence under it's more likely than not.

MR. GRIFFIN: I think you misunderstood his testimony. That's fine, whatever. I'm just telling you, if you don't want the rest of the testimony, that's fine but I'm marking on the record there's more testimony that you're choosing not to take.

BY MS. TAYLOR:

Q. Doctor, I think I asked a straightforward question and you attempted to answer. Are you able to testify, to a reasonable degree of medical probability, that it is more likely than not that Geraldine Bailes would have survived this particular cancer had salvage surgery been initiated after her radiation treatment?

MR. GRIFFIN: Note an objection and indicate loss of chance is also available to the defendants.

MS. TAYLOR-KOLIS: Oh, I think not. I think so not but go ahead.

MR. GRIFFIN: Doctor, you don't have to worry about all the semantics.

A. I understand. I'm trying to answer this question. I would like to be permitted to, because I didn't know this question was going to

come up specifically, to look back at the records from the time that she was seen on a basis after the initial -- after the radiation was done, and look a little bit more at the articles that I had before I would be willing to come down on this 50 percent line one place or the other.

What I can say right now is that in terms of causation there was a missed opportunity that may well have resulted in the cure of this cancer. But to get into specifics you have to look at the dates. There was a time point at which I think it was no longer possible that that was going to happen and look a little bit at statics which are very difficult in this situation because all the case series are small. And so, therefore, I have to step away from statistics for the most part except for the statement by one person that they were able to cure a number of people which makes me think possibly this person as well, and then draw inference from medical records what is going to be fairly typical and subtle set of physical findings.

So more likely than not I think is a difficult distinction to make and I don't have -- I have not yet formulated an opinion to answer

that.

Q. Well, let me say this for the record and we won't ask you any more questions. Doctor, today was the day for me to be able to speak to you prior to trial.

A. I understand.

Q. It's your obligation, obviously, to review the materials so you can answer the questions put forth to you in this regard. You can't -- you did answer it and I'm not going to redepose you on additional research that you've done.

MS. TAYLOR-KOLIS: I will make it that simple. Having said that, I don't have any more questions. Steve, would like you to read the testimony.

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WAYNE KOCH, M.D.

C E R T I F I C A T E

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

I, Tami A. Mitchell, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the above-named witness was by me, before the giving of their deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above-set forth was reduced to writing by me by means of stenotypy, and was later transcribed into typewriting under my direction; that this is a true record of the testimony given by the witness; that said deposition was taken at the aforementioned time, date and place, pursuant to notice or stipulation of counsel; and that I am not a relative or employee or attorney of any of the parties, or a relative or employee of such attorney, or financially interested in this action; that 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 seal of office, at Cleveland, Ohio, this 2nd day of September A.D. 20 03.

Tami A. Mitchell, Notary Public, State of Ohio
1750 Midland Building, Cleveland, Ohio 44115
My commission expires October 23, 2004

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LAWYER'S NOTES

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