

1                   IN THE COURT OF COMMON PLEAS

2                   SUMMIT COUNTY, OHIO

3           KAREN WILSON,

4                               Plaintiff,

5                                       JUDGE MURPHY

6                   - vs -

CASE NO. CV-2002-06-3340

7           YOUN PARK, M.D., et al.,

8                               Defendants.

9                               - - - - -

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

19                               - - - - -

20                               MEHLER & HAGESTROM  
                                  Court Reporters

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APPEARANCES:

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On behalf of the Plaintiff;

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

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

7                    CROSS-EXAMINATION OF WAYNE KOCH, M.D.

8                    BY MS. TAYLOR-KOLIS:

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

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

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

20                    Is my understanding about that issue,  
21                    correct?

22                    A. That's correct.

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

1 A. Okay.

2 Q. I gather that you're licensed to practice  
3 medicine?

4 A. Yes.

5 Q. In what states?

6 A. Maryland.

7 Q. No other states at this time?

8 A. No.

9 Q. Can I assume that at present you are involved in  
10 the clinical practice of medicine at least 50  
11 percent of your time?

12 A. That's correct.

13 Q. Doctor, prior to the case of Geraldine Bailes  
14 have you had the opportunity to serve as an  
15 expert witness in a medical-legal case?

16 A. Yes, I have.

17 Q. How frequently do you get involved in  
18 medical-legal reviews?

19 A. I review approximately six cases a year and have  
20 done so for about four years.

21 Q. How is it that you got involved doing  
22 medical-legal reviews?

23 A. Originally I was involved just because people  
24 contact doctors at medical centers like Johns  
25 Hopkins looking for people to render expert

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

3   Q.   How would you describe your area of expertise?

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

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

14   A.   Yes.

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

19   A.   Approximately 75 percent.

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

24   A.   That's correct.

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

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

5   A.   Pretty close to 50-50 split.

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

8   A.   Yes, I have.

9   Q.   On how many occasions?

10   A.   Actual courtroom testimony?

11   Q.   Actually going to trial and testifying?

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

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

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

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

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

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

1           testify in a court of law on behalf of a doctor?

2       A.   Shortly after the one that I just mentioned.

3           Again, sometime this last spring.

4       Q.   In that case what were the allegations against  
5           the physician?

6       A.   That was a case where a patient had developed  
7           very aggressive ethmoid sinus cancer.  Actually I  
8           had treated that patient.  The patient had  
9           surgery and radiation and the tumor kept growing  
10          and ultimately became inoperable and I believe  
11          she now died of that cancer.

12      Q.   Is that how you became involved in that case  
13          because you were one of the subsequent treating  
14          physician s?

15      A.   In that particular case, that's right.

16      Q.   Have you ever testified either by deposition or  
17          at trial in a case involving vestibular nasal  
18          cancer or septal nasal cancer, whichever way you  
19          want to call what Mrs. Bailes had?

20      A.   To the best of my recollection, no.

21      Q.   Doctor, have you, yourself, been sued for medical  
22          negligence?

23      A.   I have on one occasion, yes.

24      Q.   When was that?

25      A.   I believe the suit was filed in 1991 or '2 and

1           went to trial in 1993.

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

3       A.   Yes.

4       Q.   Do you recall what you were sued for?

5       A.   Yes, I do.

6       Q.   Can you tell me about it briefly?

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

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

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

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

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



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

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

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

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

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

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

3       A.   That's what I said, correct.

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

9       A.   That's true.

10      Q.   Is that true?

11      A.   Yes.

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

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

17      Q.   Right.

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

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

1 A. Thanks.

2 Q. Let's talk about this particular case.

3 Mr. Griffin kindly provided all the  
4 correspondence as a housekeeping matter. As I  
5 understand, there's only one letter that I don't  
6 have. It may have been an initial contact letter  
7 sent to you January 8th, 2003?

8 A. That's right.

9 Q. Can you briefly tell me what that letter says?

10 A. Let's see. It's only one paragraph. It lists  
11 the case and says Mr. Griffin, the undersigned,  
12 represents Youn Park in the above action and asks  
13 if I would be willing to review the case. Here's  
14 a copy of the complaint to give me a general idea  
15 and an expert review form to fill out and return.  
16 That's all it says.

17 Q. All right. Doctor, have you ever testified in  
18 the state of Ohio before?

19 A. Yes, I have.

20 Q. On how many occasion?

21 A. Just once in Cleveland.

22 Q. Who did you testify for, the plaintiff or  
23 defendant?

24 A. It was for the patient, the plaintiff.

25 Q. What attorney retained your services in that

1 case?

2 A. The man's name was Dale Zucker.

3 Q. Do you remember what that case was about?

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

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

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

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

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

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

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

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

1 Q. Do you have any idea how Mr. Griffin discovered  
2 your existence?

3 A. No, I don't.

4 Q. Okay. You have not testified for him or a member  
5 of his law firm, Buckingham, prior to this  
6 particular case?

7 A. Not that I'm aware of.

8 Q. Okay. All right. So he sent you a form. Do you  
9 know if he called you before, Emailed you that  
10 form and talked to you in person or no?

11 A. It may have even been an Email for all I recall.  
12 We have communicated a few times by Email.  
13 Initially there is some kind of contact before a  
14 letter like this.

15 Q. Fair enough. Shortly thereafter, as far as the  
16 correspondence I have been provided with, on  
17 January 24, 2003 you received a letter from  
18 Stephen indicating that we have enclosed records  
19 of Dr. Youn Park. They also enclosed at that  
20 time a transcribed version of his notes?

21 A. That's correct.

22 Q. At that point in time did you review Dr. Park's  
23 medical chart?

24 A. I'm sure I did.

25 Q. Okay. Did you take notes or formulate any

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

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

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

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

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

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

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

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

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

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

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

1 keep a chart that way?

2 A. You've thrown the word standard in. I guess that  
3 is applied to SOAP note not applied to standard  
4 of care, is that the question you're asking?

5 Q. That's correct.

6 A. His notes are in what I would call outline form.  
7 They're certainly not in sentence form or textual  
8 form and they roughly follow a soap sort of  
9 logic. There's a chief complaint in them and  
10 then a few physical findings generally and then  
11 an impression and then something of what he's  
12 planned or what action is being taken.

13 So if I understand the question correctly,  
14 his notes are in a soap sort of format.

15 Q. Doctor, I gather you've had an adequate  
16 opportunity to go over Dr. Park's records?

17 A. I think so.

18 Q. Don't feel you need more time to do that?

19 A. No.

20 Q. Do you find anyplace in any note of Dr. Park a  
21 place where he elicited a history from  
22 Mrs. Bailes as to how long the sore in her nose  
23 existed?

24 A. Let me just pause for a moment and look again.

25 Q. Sure.



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

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

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

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

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

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

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

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

1           only place, as I recall, he described ulceration.

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

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

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

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

24   A.   That's right.

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

1           you have in your possession.

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

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

9                   THE WITNESS:   I'm sorry.

10                   MR. GRIFFIN:   Small avalanche on  
11                   our side.

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

14   A.   The first one is titled, National Septum Squamous  
15           Cell Carcinoma:   A Chart Review and Meta  
16           Analysis.   The first author is M.D. DiLeo,  
17           D-i-L-e-o, and it appeared in the Laryngoscope in  
18           1996, Volume 106, beginning Page 1218.   Actually  
19           I think I have not pulled that article, I only  
20           have the abstract.

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

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

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

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

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

17 Q. Next one?

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

25 Q. Okay. And what did --

1 A. Do you want to talk about each one?

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

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

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

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

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

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

7 Q. Okay.

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

9 Q. That's all right.

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

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

1       excise the lesion and repair it with a skin  
2       graft.

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

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

11           The last one is called Squamous Cell  
12       Carcinoma of the Nasal Vestibule. Treatment  
13       Results. It's a little bit early, published in  
14       ACTA, A-C-T-A, Radiology Oncology Journal in  
15       1984, Volume 23, Page 189. And the first author  
16       is L.V. Johansen, J-o-h-a-n-s-e-n, and these  
17       people, they're in Denmark.

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



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

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

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

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

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

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

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

21 A. I will be glad to do that.

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

24 A. Okay.

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

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

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

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

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

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

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

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

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

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

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

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

1 is not a journal I regularly read.

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

5 A. No, I haven't.

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

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

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

1 A. Was that a question?

2 Q. I'm getting to the question.

3 A. Okay.

4 Q. This is what you read into the record. Now, how  
5 does one come to a high index of suspicion in  
6 nasal vestibular cancer?

7 A. First of all, let me back up to what you just  
8 said. You used the word should have a high index  
9 of suspicion. That word to me implies some  
10 requirement that could then lead to some kind of  
11 standard of care and negligence question. And so  
12 I would like to move away from the word should  
13 and I will correct it. If I read this  
14 incorrectly, I will correct the record.

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

1 make the diagnosis.

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

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

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

14 A. What would create a high index of suspicion?

15 Q. Sure.

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

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

1 to cause you to biopsy?

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

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



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

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

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

15 A. Yes, I have.

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

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

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

21 MR. GRIFFIN: Freestanding.

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

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

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

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

11 MR. GRIFFIN: Objection. Go ahead.

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

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

17 A. That's okay.

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

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

1 MR. GRIFFIN: Object.

2 A. The question?

3 Q. Would you agree with that?

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

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

15 A. Are you reading that from Dr. Park?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4 A. No.

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

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

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

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

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

22 A. Yes.

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

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

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

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

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

13 Q. How do you think it's reconcilable?

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

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

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

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

1 describes that she has a small, shallow  
2 ulceration, left side of the septum of the nose  
3 with no other nasal lesions. And, in fact, he  
4 put her on ointment, Aquaphor ointment, October  
5 11th, '99.

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 A. Yes.

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

25 A. I have not.

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

3 A. That's correct.

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

7 MR. GRIFFIN: Object. Go ahead.

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

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

11 A. Indolent implies slow growing.

12 Q. Correct.

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

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

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

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

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

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

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

17          Does that sound like something you wrote?

18   A. That sounds correct.

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

25   A. I agree that's what he says.

1 Q. That's what he says?

2 A. That's what he says.

3 Q. That description is not consistent with  
4 vestibulitis?

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

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

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

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

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

20 A. That's correct.

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

23 MR. GRIFFIN: Objection.

24 Q. If you can recall.

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

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

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

23    Q.    Okay.

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



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

5       Q.   Ready for my next question?

6       A.   Yes.

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

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

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

21                               MR. GRIFFIN:  Objection.  Go  
22                               ahead.

23      Q.   Correct?

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

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

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

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

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

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

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

21 Q. You know what, I now have a copy dated --  
22 Mr. Griffin's original record dated April 17th of  
23 2003.

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

25 Q. Did you receive any significant material after

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

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

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

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

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

17 A. That's correct.

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

20 A. That's correct.

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

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

1 Q. September. I want to make sure we get the record  
2 straight?

3 A. September 5th.

4 Q. Okay. To cut to the chase, Doctor, I gather  
5 you're going to render an opinion at trial  
6 Dr. Park complied with the accepted standard of  
7 medical care?

8 A. Correct.

9 Q. All right. Let's talk about what you may testify  
10 to as to proximate causation.

11 Doctor, is it your opinion even if  
12 Mrs. Bailes would have been diagnosed in November  
13 of 1999 that her outcome would not have been  
14 different in this matter?

15 A. That's correct.

16 Q. Explain to us the basis that you conclude had  
17 diagnosis been made in November of 1999 that  
18 Mrs. Bailes still would not have survived her  
19 cancer?

20 A. First of all, the question has the assumption I  
21 think that there was a cancer there in 1999. And  
22 I've already testified that I'm not certain that  
23 there was a cancer there.

24 Q. All right.

25 A. So it may have been impossible to make a

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

5 Q. Correct.

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

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

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

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

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

1 of its development.

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

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

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

1 of my opinion that the results of treatment and  
2 outcome would have been the same had she been  
3 diagnosed in 1999 as when she was diagnosed in  
4 2001.

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

8 MR. GRIFFIN: Object.

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

12 Q. The fine.

13 A. The statement is right.

14 Q. Okay.

15 A. I'm sorry.

16 Q. It's not a problem.

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

21 A. I have not seen his deposition.

22 Q. Have you seen his expert report?

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

25 Q. Do you know Dr. Stepnick?



1 A. I don't know him personally. I have seen his  
2 name but I don't know him.

3 Q. Do you know Dr. Lavertu?

4 A. Yes, I know Pierre Lavertu.

5 Q. Have you seen Pierre Lavertu's expert report?

6 A. No, I don't believe I have.

7 Q. Do you respect Dr. Lavertu?

8 A. In a general way, yes.

9 Q. I meant in terms of his talent as an  
10 otolaryngologist doing head and neck cancer?

11 A. I know Dr. Lavertu in the same way Dr. Wenig,  
12 having seen him at meetings, when he speaks I  
13 listen because I think he's well-trained and  
14 well-spoken and I respect him. In terms of  
15 clinical judgement or opinions specific to this  
16 case or his medical practice, I don't have a  
17 reason to think good or bad about any of these  
18 people.

19 Q. Okay.

20 A. I just don't have information.

21 Q. So at what point, Doctor, to the best of your  
22 ability can you say this tumor began to grow?

23 MR. GRIFFIN: Object. Go ahead.

24 A. When did it begin to grow?

25 Q. Right.

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

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

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

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

1 unknown.

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

9 MR. GRIFFIN: Object.

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

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

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

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

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

21 MR. GRIFFIN: Object.

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

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

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

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

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

17       A.   Yes, I do.

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

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

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

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

1 date of the mailing.

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

4 A. I don't know.

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

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

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

16 MR. GRIFFIN: Object. Go ahead.

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

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

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

7 MR. GRIFFIN: Object. Go ahead.

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

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

25 More likely than not asks me to draw a 50

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

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

13                       MR. GRIFFIN: He'll read the  
14                       deposition.

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

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



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

8 BY MS. TAYLOR:

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

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

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

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

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

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

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

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

1           that.

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

6       A.   I understand.

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

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

16  
17                                       \_\_\_\_\_  
18                                   WAYNE KOCH, M.D.  
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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



# 1

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15 27:14; 34:6  
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## LAWYER'S NOTES

[illegible]