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First Name	Roger A.
Specialty	General Internal Medicine
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Date (format =99/99/9999)	6/27/02
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<p style="text-align: right;">Page 1</p> <p>1 IN THE COURT OF COMMON PLEAS 2 OF CUYAHOGA COUNTY, OHIO 3 ----- 4 WILLIAM J. GILL, III, 5 Executor of the Estate 6 of DANIEL P. GILL, 7 deceased, 8 Plaintiff, 9 vs Case No. 457639 10 ROGER A. MANSNERUS, M.D., 11 et al., 12 Defendants. 13 ----- 14 DEPOSITION OF ROGER A. MANSNERUS, M.D. 15 THURSDAY, JUNE 27, 2002 16 ----- 17 Deposition of ROGER A. MANSNERUS, M.D., a 18 Defendant herein, called by counsel on behalf of 19 the Plaintiff for examination under the statute, 20 taken before me, Vivian L. Gordon, a Registered 21 Diplomate Reporter and Notary Public in and for 22 the State of Ohio, pursuant to agreement of 23 counsel, at the offices of Reminger & Reminger, 24 The 113 St. Clair Building, Cleveland, Ohio, 25 commencing at 2:00 o'clock p.m. on the day and date above set forth. -----</p>	<p style="text-align: right;">Page 3</p> <p>1 ROGER A. MANSNERUS, M.D., a witness herein, 2 called for examination, as provided by the Ohio 3 Rules of Civil Procedure, being by me first duly 4 sworn, as hereinafter certified, was deposed and 5 said as follows: 6 EXAMINATION OF ROGER A. MANSNERUS, M.D. 7 BY MR. MISHKIND: 8 Q. Would you please state your name for 9 the record. 10 A. Roger Allen Mansnerus. 11 Q. You are a physician; is that correct? 12 A. Correct. 13 Q. What type of practice do you have, 14 doctor? 15 A. General internal medicine. 16 Q. Have you had your deposition taken 17 before, sir? 18 A. As an expert witness. 19 Q. On how many occasions has your 20 deposition been taken as an expert? 21 A. Two or three. 22 Q. Are you currently serving as an 23 expert in any cases where your deposition has 24 been taken? 25 A. No. I'm due to give one next month.</p>
<p style="text-align: right;">Page 2</p> <p>1 APPEARANCES: 2 On behalf of the Plaintiff 3 Becker & Mishkind 4 HOWARD D. MISHKIND, ESQ. 5 The Skylight Office Tower Suite 660 6 Cleveland, Ohio 44113 7 216-241-2600 8 9 10 11 On behalf of the Defendant 12 Reminger & Reminger 13 ROBERT A. WARNER, ESQ. 14 The 113 St. Clair Building 15 Cleveland, Ohio 44114 16 216-687-1311 17 18 19 20 ----- 21 22 23 24 25</p>	<p style="text-align: right;">Page 4</p> <p>1 Q. So that will become the third or the 2 fourth? 3 A. Correct. Usually they are regarding 4 patients that I have treated that are involved 5 in a lawsuit against someone else. 6 Q. What we might refer to as a personal 7 injury case? 8 A. That, or one of them was a product, 9 drug liability case for Redux. 10 Q. Have you ever served as an expert 11 witness in a medical negligence claim? 12 A. No. 13 Q. So the three to four times, including 14 the one that's coming up, would be personal 15 injury claims or product liability claims; is 16 that a fair statement? 17 A. Correct. Medical testimony, I don't 18 know if you consider it an expert witness to be 19 one who testifies in those kind of trials or 20 not. A physician is an expert witness if he is 21 testifying about medicine. 22 Q. Your testimony was on behalf of your 23 patient in those two to three past situations or 24 not? 25 A. Well, no. One of them was actually</p>

<p>Page 5</p> <p>1 by the drug company, defending against a class 2 action suit. And they had a deposition 3 regarding a patient that I treated with that 4 drug. 5 MR. WARNER: Don't give us any names 6 of patients. 7 THE WITNESS: I won't. I don't 8 remember the name. 9 Q. That was a case that your deposition 10 was taken in that matter; correct? 11 A. Correct. 12 Q. And who was the drug company that -- 13 A. I don't remember the company. They 14 were the manufacturers of, I believe it was 15 Redux, the diet drug that caused the heart valve 16 problems allegedly. 17 Q. How long ago, doctor, would you say 18 it was that you had your deposition last taken? 19 A. Two to three years. 20 Q. The matter that's coming up within 21 the next month, is that in connection with a 22 patient of yours? 23 A. A patient of mine, correct. 24 Q. That has a personal injury action 25 pending?</p>	<p>Page 7</p> <p>1 medical negligence case. 2 A. Correct. 3 Q. Does that still stand? 4 A. With the exception of this case. 5 Q. So the Gill matter is the one and 6 only time that you have been served with papers 7 naming you as a defendant in a medical 8 negligence case? 9 A. Yes. 10 Q. Have you ever had your hospital 11 privileges suspended, revoked, or called into 12 question? 13 A. The only suspension is at hospitals 14 if you were behind so many days on completing 15 your charts, you are put on suspension, but that 16 does not relate to your practice of medicine. 17 Q. And once you complete the dictation, 18 then your privileges were reactivated? 19 A. Automatically restored, correct. 20 Q. Other than that kind of situation -- 21 A. No, no other suspensions. 22 Q. On how many occasions have you had 23 the misfortune of the hospital saying you 24 haven't finished the chart; therefore, until you 25 do so, your privileges are suspended?</p>
<p>Page 6</p> <p>1 A. Correct. 2 Q. You are testifying then as it relates 3 to the care and treatment of that patient; 4 correct? 5 A. I don't know what I am testifying 6 about. 7 Q. You have been asked by that patient's 8 attorney -- 9 A. Yes. 10 Q. -- to give deposition testimony? 11 A. Yes. 12 Q. Is it fair to say that this is the 13 first time that your deposition has been taken 14 in connection with a medical negligence matter? 15 A. Yes. 16 Q. Have you ever served as an expert 17 witness where you have been asked to provide 18 opinions either to a patient's lawyer or a 19 doctor's lawyer in connection with any medical 20 negligence matters? 21 A. I don't believe I have. 22 Q. In reviewing the interrogatory 23 answers that you provided through Mr. Warner, 24 the indication in the answers was that you have 25 not previously been named as a defendant in a</p>	<p>Page 8</p> <p>1 MR. WARNER: Note my objection. 2 MR. MISHKIND: That's fine. 3 MR. WARNER: If you know. 4 A. It's a fairly frequent occurrence for 5 all physicians. They have a suspension list on 6 the door of the lounge at St. John West Shore 7 Hospital. I would say probably a couple times a 8 year. 9 Q. Have you ever applied for privileges 10 at a hospital and been denied? 11 MR. WARNER: Objection. 12 A. I have never been denied. 13 Q. In looking at your CV, which again 14 your attorney was kind enough to provide to me, 15 I note that you had hospital privileges at 16 University Hospitals up until sometime in the 17 year 2000? 18 A. Actually, I still do. I don't make 19 use of them, but I just recently got my 20 reappointment. 21 Q. The CV that I have that your attorney 22 provided to me is dated January 5, 2001. So 23 it's a little bit over a year and a half old or 24 thereabouts. 25 Are there more current versions</p>

<p>Page 9</p> <p>1 than --</p> <p>2 A. No, there is nothing more up to date</p> <p>3 than that.</p> <p>4 Q. To bring it up to date, though, we</p> <p>5 would have to change where it says work</p> <p>6 experience, staff, University Hospitals of</p> <p>7 Cleveland, department of medicine, 1995 to 2000,</p> <p>8 would that need to be altered or is that</p> <p>9 accurate?</p> <p>10 A. Well, technically I am still on the</p> <p>11 staff but I do not practice medicine there. I</p> <p>12 could admit patients there if I chose to, but I</p> <p>13 just keep it current because it's easy to do and</p> <p>14 doesn't cost anything.</p> <p>15 Q. You are not a staff -- you are not on</p> <p>16 the staff at University Hospitals of Cleveland</p> <p>17 at this point?</p> <p>18 A. See, there are two things. I</p> <p>19 previously practiced with University Primary</p> <p>20 Care Practices, and as part of that, you were</p> <p>21 named an instructor at Case Western Reserve</p> <p>22 School of Medicine and also had privileges at</p> <p>23 the hospital. I'm not even sure at this moment</p> <p>24 if I have privileges at the hospital or am just</p> <p>25 an instructor in the department of medicine. I</p>	<p>Page 11</p> <p>1 responsibilities at Case Western Reserve?</p> <p>2 A. No.</p> <p>3 Q. So as an instructor, it has been in a</p> <p>4 clinical capacity as opposed to classroom</p> <p>5 capacity?</p> <p>6 A. Correct.</p> <p>7 Q. Within the area of internal medicine,</p> <p>8 do you have an area that you subspecialize in?</p> <p>9 A. No.</p> <p>10 Q. We are obviously going to be talking</p> <p>11 about the period the end of 1999 and the early</p> <p>12 part of 2000 with regard to Dan Gill, and for</p> <p>13 that matter, some of the time period before</p> <p>14 that.</p> <p>15 But since late '99, early 2000, and</p> <p>16 then jumping ahead to 2002, June 27th, has your</p> <p>17 practice changed in any way in terms of the</p> <p>18 patient population that you see?</p> <p>19 A. Not appreciably.</p> <p>20 Q. Back in December of '99, you were</p> <p>21 affiliated with Westshore Primary Care?</p> <p>22 A. Correct.</p> <p>23 Q. And were you an employee of Westshore</p> <p>24 Primary Care Associates?</p> <p>25 A. Yes.</p>
<p>Page 10</p> <p>1 would have to go back to my record and clarify</p> <p>2 that because it's not really relevant to what I</p> <p>3 do.</p> <p>4 Q. What was the purpose of you preparing</p> <p>5 this CV as of January, 2001?</p> <p>6 A. I believe our group practice wanted</p> <p>7 everybody to have an up-to-date CV for</p> <p>8 credentialing purposes.</p> <p>9 Q. As a clinical instructor, was this</p> <p>10 supervising residents?</p> <p>11 A. It was, in the event that I would</p> <p>12 have occasion to.</p> <p>13 Q. Do you currently supervise interns or</p> <p>14 residents in your practice?</p> <p>15 A. I have a limited amount of</p> <p>16 supervision at Fairview and St. John West Shore</p> <p>17 Hospitals, because they have teaching services</p> <p>18 and they often see the patients that I admit</p> <p>19 there, so I supervise them to that extent, but</p> <p>20 I'm not a regular instructor at either of those</p> <p>21 hospitals.</p> <p>22 Q. Do you have any teaching</p> <p>23 responsibilities at the medical school?</p> <p>24 A. No.</p> <p>25 Q. Have you at any time had any teaching</p>	<p>Page 12</p> <p>1 Q. Are you still an employee of</p> <p>2 Westshore Primary Care Associates?</p> <p>3 A. Yes.</p> <p>4 Q. Are you employed by any other</p> <p>5 professional associations or professional</p> <p>6 corporations other than Westshore Primary Care?</p> <p>7 A. No.</p> <p>8 Q. At Westshore Primary Care, do you</p> <p>9 have other physicians that you practice with?</p> <p>10 A. Yes.</p> <p>11 Q. Who are they, please?</p> <p>12 A. Well, there is roughly 25 in the</p> <p>13 group.</p> <p>14 Q. I'm not going to have you name all of</p> <p>15 them. Are there different offices?</p> <p>16 A. Yes. We have, I believe, now six</p> <p>17 different offices with practicing physicians.</p> <p>18 Q. Is Westshore Primary Care Associates</p> <p>19 owned by a larger entity at this time?</p> <p>20 A. They have a rather complicated</p> <p>21 arrangement that I don't fully understand with</p> <p>22 St. John West Shore Hospital where I believe in</p> <p>23 some fashion they are held in trust but able to</p> <p>24 terminate the agreement any time they wish.</p> <p>25 Q. Do you know whether the arrangement,</p>

<p style="text-align: right;">Page 13</p> <p>1 this complicated arrangement that I'm not going 2 to have you explain to me was in existence back 3 in '99 and 2000, or has that come about since? 4 A. I believe that was in existence then. 5 Q. On your CV you have Health Campus 6 Drive as the address, Suite 2, and to be 7 specific, 29325 Health Campus. 8 A. I am no longer in that office. 9 Q. Where is your office now, sir? 10 A. I relocated in December of last year 11 to 960 Clague Road in Westlake, and I also moved 12 out of my Lakewood office at that time. I 13 previously maintained two offices, one at 14 Lakewood and one out near St. John West Shore 15 Hospital and those were consolidated into one 16 office. 17 Q. And that's the Clague Road? 18 A. Correct. 19 Q. Mr. Gill had been a patient of yours 20 from about 1989 forward? 21 A. Yes. 22 Q. True? 23 A. Yes. 24 Q. During that time, was he seen at one 25 particular office or a number of offices, as</p>	<p style="text-align: right;">Page 15</p> <p>1 Q. I think the term is you were 2 grandfathered? 3 A. Correct. 4 Q. So that your certification which 5 occurred in '77 is grandfathered such that you 6 don't have to sit for recertification; true? 7 A. Yes. 8 Q. Doctor, let me just caution you. 9 Since you haven't had your deposition taken a 10 lot, and certainly not in this context -- thus 11 far you and I are getting along fine -- in 12 fairness to you, wait until I am done with my 13 question, and also for Vivian's benefit, before 14 you start answering so you don't give an answer 15 before I'm done. 16 A. Okay. 17 Q. Sometimes you may wonder whether I am 18 ever going to finish my question, but answering 19 earlier than I finished wouldn't shorten my 20 question. 21 A. Okay. 22 Q. Have you ever authored or co-authored 23 any articles in any medical journals? 24 A. No. 25 Q. Have you ever authored or co-authored</p>
<p style="text-align: right;">Page 14</p> <p>1 best as you can recall? 2 A. Certainly the majority of times would 3 have been in the Lakewood office, but it's 4 possible that because I was only in one office 5 on a given day that I might have seen him on 6 occasion in the Westlake office. 7 Q. Is it fair to say the majority of the 8 offices would have been Lakewood? 9 A. Yes, I believe he lived in Lakewood 10 or close by. 11 Q. You are board certified in internal 12 medicine; is that true? 13 A. Yes. 14 Q. Do you have any other board 15 certifications? 16 A. No. 17 Q. Were you successful in becoming board 18 certified on your first attempt? 19 A. Yes, I was. 20 Q. Is there a recertification process 21 that you are eligible for? 22 A. Not that I am required to do. More 23 recent graduates, I believe, have a 24 recertification process, but I was recertified 25 prior to the date when that was initiated.</p>	<p style="text-align: right;">Page 16</p> <p>1 or contributed to any book chapters, any books, 2 or anything that has been published in any 3 capacity in the medical world? 4 A. No. 5 Q. Have you submitted anything on any 6 medical topics that have been published in any 7 community or association type of newsletters or 8 publications? 9 A. Not that I recall. 10 Q. A moment ago you told me you have a 11 general practice. Over the years, have you 12 developed any type of an interest in any 13 particular area of medicine? 14 For example, is your practice more of 15 an adult practice as opposed to a pediatric or 16 an adolescent practice? 17 A. It is not pediatric at all. It is 18 mostly adult. Certainly patients 16 and over. 19 Most of them are over 21. 20 Q. And by interest or circumstance, have 21 you sort of gravitated to a particular patient 22 profile, if you will, in terms of seeing 23 diabetics or seeing patients with coronary 24 artery disease or something that has taken up a 25 larger percentage of your practice?</p>

<p>Page 17</p> <p>1 A. I would say that I have perhaps more 2 of an interest in cardiovascular diseases than 3 some of the other areas, but I would say that 4 the types of patients I see are a reflection of 5 the prevalent population. 6 Q. If I were a patient of yours, I would 7 be coming to you for yearly physicals and other 8 general ailments of an internal medicine 9 standpoint; true? 10 A. I do both those things, correct. 11 Q. And then when there are issues of 12 specialization, you refer out patients to 13 vascular surgeons? 14 A. If I feel it's not in my area of 15 expertise or I need an additional opinion, I do 16 refer to specialists and subspecialists outside 17 of my area. 18 Q. Have you ever held yourself out as 19 having any expertise in any areas other than in 20 general internal medicine? 21 A. Any other areas of medicine? 22 Q. Other than internal medicine. In 23 other words, have you held yourself out as 24 having expertise in cardiovascular disease or -- 25 A. Well, internal medicine encompasses a</p>	<p>Page 19</p> <p>1 professional associations? 2 A. I have been a member of the AMA at 3 times in the past. 4 Q. What about any local medical 5 associations? 6 A. I believe at one time when I was with 7 the AMA, we were also part of the Ohio State 8 Medical Association. 9 Q. You currently are not a member of 10 either of those organizations? 11 A. No. 12 Q. Is there a reason that you are not a 13 member? 14 A. It's very expensive. 15 Q. Is that the sole reason? 16 A. That's the main reason, correct. 17 Q. Is there another reason besides cost 18 that you are not a member of either of those 19 organizations? 20 MR. WARNER: Objection. Go ahead and 21 answer. 22 A. Primarily cost. 23 Q. And again, I understand that. I want 24 to find out whether there are any other factors 25 besides cost that enter into your decision not</p>
<p>Page 18</p> <p>1 number of subspecialties, cardiovascular, 2 rheumatology, pulmonology, dermatology, allergy, 3 nephrology. It's a very broad field. 4 Q. I guess what I am getting at -- and 5 you have touched on some areas, rheumatology, 6 dermatology -- do you hold yourself out in the 7 community as being an expert in those arenas? 8 A. I do not hold myself out to the 9 public in that respect, no. 10 Q. Currently your privileges would be at 11 what hospitals, doctor? 12 A. At St. John West Shore Hospital in 13 Westlake, Lakewood Hospital in Lakewood, and 14 Fairview Hospital in Cleveland. I'm a little 15 uncertain about my status at University since I 16 don't attend there. 17 Q. Do you spend most of your admitting 18 time at one or more of those hospitals? 19 A. No. I use all three. It varies 20 according to the call schedule where I have the 21 majority of my patients. 22 Q. Are you a member of any professional 23 associations? 24 A. No. 25 Q. Have you been a member of any</p>	<p>Page 20</p> <p>1 to be a member? 2 A. No. 3 Q. You are a member and have been since 4 1993 of the medical practice committee of St. 5 John West Shore; correct? 6 A. Correct. 7 Q. Tell me what that committee's purpose 8 is. 9 A. The committee reviews the clinical 10 care provided by people in the department of 11 medicine at that hospital with regard to 12 adequacy of treatment. They review all deaths 13 within the hospital. There are certain criteria 14 that the joint commission requires hospitals 15 review and that changes from year to year. 16 Q. So I take it you are involved in M&M 17 meetings? 18 A. Yes. They are along that line or 19 there may be specific issues where the quality 20 of care is a question. 21 Q. All matters that are considered to be 22 peer review type of situations? 23 A. Correct, that is a peer review 24 activity. 25 Q. And you still participate in that</p>

<p>Page 21</p> <p>1 committee?</p> <p>2 A. I'm the chairman.</p> <p>3 Q. And actually have been that since</p> <p>4 '93?</p> <p>5 A. I have been the chairman since</p> <p>6 probably '96 or so. I don't remember the exact</p> <p>7 year I assumed the chairmanship.</p> <p>8 Q. I take it you remember Dan Gill?</p> <p>9 A. Yes.</p> <p>10 Q. I'm sure you are aware that William</p> <p>11 Gill, Dan's nephew, was deposed this morning;</p> <p>12 true?</p> <p>13 A. No, I was not aware of that.</p> <p>14 Q. Have you had occasion prior to Dan's</p> <p>15 death in February of 2001 to have had any other</p> <p>16 family members in your practice?</p> <p>17 A. Yes, I believe his mother, Mary Gill,</p> <p>18 was a patient.</p> <p>19 Q. Is Mary, his mom, to your knowledge,</p> <p>20 still a patient?</p> <p>21 A. No.</p> <p>22 Q. Do you know whether she stopped being</p> <p>23 a patient before or after Dan died?</p> <p>24 MR. WARNER: Note my objection. I</p> <p>25 mean, you brought this claim on behalf of</p>	<p>Page 23</p> <p>1 on asking why she left the practice.</p> <p>2 MR. WARNER: Good.</p> <p>3 MR. MISHKIND: My question was,</p> <p>4 whether you permit him to answer or not, was</p> <p>5 whether she left the practice before or after</p> <p>6 Dan Gill's death. I mean, if you are still</p> <p>7 going to instruct him not to answer it, we will</p> <p>8 move on. I think that it's a proper question to</p> <p>9 ask. He may not recall whether he did --</p> <p>10 THE WITNESS: Can I say something in</p> <p>11 general off the record?</p> <p>12 MR. WARNER: There is no such thing.</p> <p>13 It doesn't exist. She is writing it down now.</p> <p>14 THE WITNESS: I don't formally know</p> <p>15 when people leave the practice unless they</p> <p>16 request records be transferred, because people</p> <p>17 may not show up for two or three years because</p> <p>18 of insurance reasons and other things.</p> <p>19 MR. WARNER: You don't know is what</p> <p>20 you are saying.</p> <p>21 THE WITNESS: Knowing who is in the</p> <p>22 practice is not really -- if I have seen</p> <p>23 somebody recently, I can assume they are in my</p> <p>24 practice. If I have not seen them, it doesn't</p> <p>25 necessarily mean they have left the practice, it</p>
<p>Page 22</p> <p>1 Mr. Gill. I sort of let you ask these</p> <p>2 questions, but now you are going to get into, I</p> <p>3 think, patient confidentiality here, and I don't</p> <p>4 want to have -- I don't think you represent Mary</p> <p>5 Gill, so you have enough that it was a patient</p> <p>6 and why she did something or didn't do</p> <p>7 something, and I'm going to instruct him not to</p> <p>8 answer that question. I don't really think it's</p> <p>9 relevant to this case.</p> <p>10 Obviously, you can approach her</p> <p>11 yourself and ask her if you somehow feel it's</p> <p>12 germane, unless you represent Mary Gill and have</p> <p>13 a waiver.</p> <p>14 (Discussion off the record.)</p> <p>15 MR. MISHKIND: For the record, so</p> <p>16 it's not misrepresented, I am the attorney for</p> <p>17 the estate in connection with this lawsuit and</p> <p>18 as such I represent all potential beneficiaries</p> <p>19 under the wrongful death statute, which would</p> <p>20 include Mary.</p> <p>21 MR. WARNER: Can you indemnify and</p> <p>22 hold as harmless? Is that what you are going to</p> <p>23 say?</p> <p>24 MR. MISHKIND: Certainly I would, but</p> <p>25 I understand your concern and I wasn't planning</p>	<p>Page 24</p> <p>1 just means I have not seen them.</p> <p>2 Q. Doctor, aside from Mary, Dan's mom,</p> <p>3 to your knowledge, have any other family members</p> <p>4 been a patient of yours?</p> <p>5 A. I am not sure. I possibly had -- I</p> <p>6 may have seen one of his sisters at some time in</p> <p>7 the past, but no time in recent memory.</p> <p>8 Q. At any time while Dan was a patient</p> <p>9 of yours prior to his being diagnosed with lung</p> <p>10 cancer, did you ever have a conversation with</p> <p>11 any family members concerning his condition?</p> <p>12 A. Not to my recollection.</p> <p>13 Q. After Dan was diagnosed with lung</p> <p>14 cancer and then started his course of treatment,</p> <p>15 up to the time of his demise, did you have any</p> <p>16 conversation with any family members at all</p> <p>17 about Dan's condition?</p> <p>18 A. As I recall, on one subsequent</p> <p>19 follow-up, one or two of his sisters may have</p> <p>20 accompanied him to the office and possibly had a</p> <p>21 few questions. I don't recall the details.</p> <p>22 Q. This would have been after the</p> <p>23 diagnosis of cancer or before?</p> <p>24 A. After.</p> <p>25 Q. Are you able by looking at your chart</p>

<p>Page 25</p> <p>1 to determine what visit that was that one or two 2 of his sisters accompanied him to? 3 A. No, I would not normally record that 4 information. 5 Q. This is something you remember 6 independently; true? 7 A. Correct. 8 Q. Do you have a recollection in 9 general -- because I think you said you don't 10 remember the specifics -- but do you have a 11 recollection in general about the type of 12 questions that one or both of his sisters asked 13 you on that visit? 14 A. Questions they had would have been 15 along general medical lines; perhaps regarding 16 referrals to various institutions. I don't 17 recall the specifics. 18 Q. Do you recall any discussions that 19 either were initiated by one or both of the 20 sisters or initiated by you surrounding the 21 issue of the diagnosis of his cancer and the 22 timeliness, if you will, of the diagnosis? 23 A. We did not discuss that. 24 Q. Other than this conversation with one 25 or both sisters on a subsequent visit after the</p>	<p>Page 27</p> <p>1 sending me copies of their progress notes from 2 University Hospital regarding Dan's treatment, 3 since I was considered to be one of the 4 referring physicians. 5 Q. And is it your supposition that the 6 fact of his death was brought to your attention 7 either by one of the doctors or someone from 8 University Hospitals, or are you just 9 speculating? 10 A. I just do not recall how I learned of 11 that. 12 Q. Nonetheless, you think you learned of 13 it from some medical source as opposed to 14 reading about it in the newspaper? 15 A. Correct. 16 Q. Do you believe that you learned about 17 it close in time to his death or was it quite a 18 period of time after his death? 19 A. I do not recall the interval. 20 Q. When you learned of his death, did 21 you set out to gain any further information 22 about the immediate circumstances leading up to 23 his death? 24 A. No. 25 Q. Did you ever talk with any of the</p>
<p>Page 26</p> <p>1 diagnosis was made, were there any other 2 occasions where you had any conversation in 3 specific or in a general nature with any family 4 members about Dan Gill? 5 A. No, I do not recall any further 6 contacts with any family members. 7 Q. After Dan's death, did you have any 8 contact with any family members discussing with 9 them directly anything about his medical care 10 and circumstances surrounding his cancer? 11 A. No, I have had no contact with them. 12 Q. Have you initiated or attempted to 13 initiate any communication with the family at 14 any time prior to this lawsuit to talk with any 15 family members, his mom, brothers and sisters, 16 just about your patient? 17 A. No. 18 Q. Do you have a recollection of when 19 you learned that Dan had died? 20 A. I don't recall how that information 21 came to my attention. 22 Q. Do you know whether the information 23 came to your attention through the newspaper or 24 through some source? 25 A. As I recall, the oncologist was</p>	<p>Page 28</p> <p>1 doctors at University Hospitals or at The 2 Cleveland Clinic in person? 3 A. Not in person. 4 Q. Did you ever talk with any of the 5 doctors at University Hospitals or Cleveland 6 Clinic over the phone relative to Dan's 7 diagnosis? 8 A. I do not recall any specific 9 conversations. 10 Q. You received copies of various 11 portions of the records? 12 A. Correct. That's typically how the 13 specialists at University Hospitals and 14 Cleveland Clinic communicate, is by sending 15 copies of their progress notes. 16 Q. And I see -- we won't go through all 17 of the various entries -- but I see that you are 18 cc'd and some other people may be cc'd on that. 19 You would get that information periodically, so 20 you were somewhat aware of what Dan was going 21 through; true? 22 A. Yes. I would know that from reading 23 the progress notes. 24 Q. Is it your testimony, however, that 25 other than reading the progress notes that you</p>

<p style="text-align: right;">Page 29</p> <p>1 would receive as one of the referring 2 physicians, that you didn't have any personal 3 consultation or direct communication with any of 4 those doctors to gain any further information 5 from them? 6 A. I do not recall. 7 Q. While Dan was treating at University 8 Hospitals, were you ever requested to provide 9 any medical records to any doctors that were 10 following his care? 11 A. I do not recall. 12 Q. In looking through the records -- 13 which I think you may have provided a copy to 14 me, and certainly if not you, Mr. Warner would 15 have provided a copy -- I don't see any evidence 16 that there was a direct request from University 17 Hospitals or even from the family members for 18 you to send over a copy of your records for the 19 treatment of his pneumonia or any of his other 20 treatment. Is that your recollection, as well? 21 A. If there was a request for records, 22 it would very likely be documented somewhere in 23 the chart. 24 Q. Did you ever talk with Dr. Olencki 25 who was one of the doctors?</p>	<p style="text-align: right;">Page 31</p> <p>1 A. I have reviewed my office notes from 2 that period. 3 Q. Have you looked at any of the 4 records, other than those that you were cc'd on 5 from University Hospitals or The Cleveland 6 Clinic? 7 A. No. 8 Q. So information that you have in your 9 chart relative to his treatment after June or 10 July of 2000 would consist of consult notes and 11 things that you were kind enough to be copied on 12 by the doctors; true? 13 A. They routinely provide the referring 14 physicians copies of their notes, which are 15 really quite detailed. 16 Q. Sure. Have you reviewed any medical 17 literature in preparation for today's 18 deposition? 19 A. No. 20 Q. You, I presume, subscribe to 21 journals? 22 A. I subscribe to some, and I review 23 others in the medical library. I read many 24 abstracts that appear in various publications, 25 medical newsletters.</p>
<p style="text-align: right;">Page 30</p> <p>1 A. I do not recall any direct 2 conversations with him. It's possible that he 3 called me and I simply don't remember the 4 details. 5 Q. Is it fair to say that you don't 6 recall ever providing him with any type of a 7 history, either by way of documents or verbal 8 history on the patient? 9 A. I don't recall what I may or may not 10 have provided him. 11 Q. So it would be pure speculation on 12 your part to say that you did provide him with 13 something; is that true? 14 A. Correct. 15 Q. I want to back up for a second. I'm 16 not trying to jump all over the place. If I 17 move from one area to another, I'll try not to 18 make it a moving target. I'll let you know 19 where I'm going. 20 A. Okay. 21 Q. I want to go back in time and the 22 next topic can sort of be called what have you 23 reviewed for purposes of this deposition. And 24 with that in mind, I take it you have looked at 25 your chart; true?</p>	<p style="text-align: right;">Page 32</p> <p>1 Q. Tell me which journals in the area of 2 internal medicine do you subscribe to. 3 A. I receive regular copies of the 4 Journal of the American Medical Association, and 5 the Archives of Internal Medicine. And I have 6 regularly listened to the Audio Digest Tapes. 7 Q. Who publishes the Audio Digest Tapes? 8 A. It's the California Medical 9 Association. 10 Q. And other publications are available 11 to you? 12 A. If I wish to locate them, yes. 13 Q. And you would go to the library as 14 opposed to receiving them on a subscription 15 basis? 16 A. Correct. Other sources, we have 17 weekly lectures at Lakewood Hospital called 18 medical grand rounds where local experts come or 19 visiting experts also come and lecture on 20 specific topics. 21 Q. Do you hold yourself out in the 22 community as an expert in the treatment of 23 cancer? 24 A. No. 25 Q. Do you have any patients that you</p>

<p>Page 33</p> <p>1 follow currently in your practice that have 2 confirmed diagnoses of some form of lung cancer? 3 A. Yes. 4 Q. It's my understanding that Dan had 5 nonsmall cell carcinoma of the lung? 6 A. Correct. 7 Q. Do you have any patients that you 8 follow currently that have nonsmall cell 9 carcinoma of the lung? 10 A. Yes. 11 Q. I'm not going to ask you names and 12 medical history, but just give me an idea of how 13 many such patients do you follow? 14 A. That are currently living? 15 Q. Yes. 16 A. I probably have three at the present 17 time. 18 Q. Any as young as Dan? 19 A. No. 20 Q. Are most of these patients in their 21 60s or 70s? 22 A. Yes. 23 Q. Have you ever had a patient in your 24 practice that was as young as Dan with a 25 diagnosis of nonsmall cell carcinoma of the</p>	<p>Page 35</p> <p>1 in older people, and they have some immune 2 deficiency that predisposes them to cancer or 3 impairs their ability to fight it, and they may 4 actually do worse at some times, as a younger 5 woman with breast cancer. 6 Q. Did Dan have any autoimmune 7 deficiencies or other deficits in his immune 8 system that would negatively affect his 9 prognosis regardless of the stage of his cancer? 10 A. Well, Dan did have a history of, as I 11 recall, of allergic rhinitis, which is a 12 disorder of the immune system, though not a 13 deficiency. 14 Q. Is there anything about that that you 15 can state to a reasonable degree of probability 16 that would make his prognosis with his age and 17 any comorbidities that he had worse than any 18 other patient of his age at the stage that his 19 cancer was? 20 A. I'm not aware of any correlation. 21 Q. Based upon your knowledge -- 22 (Telephone interruption.) 23 Q. Are you aware of any studies that you 24 consider to be reliable in the literature that 25 comment on the prognosis for patients that are</p>
<p>Page 34</p> <p>1 lung? 2 A. Not that I remember. 3 Q. From your knowledge and reading and 4 experience, is the prognosis for a patient with 5 a diagnosis of nonsmall cell carcinoma, Stage 1, 6 better in a younger patient than an older 7 patient? 8 A. Can you restate that question again? 9 Q. Sure, I'd be happy to. In terms of 10 your knowledge base and your experience, is the 11 prognosis for a patient that's diagnosed with a 12 Stage 1 nonsmall cell carcinoma of the lung, is 13 that patient's prognosis better for a younger 14 patient than a patient with the same diagnosis 15 that is older in their 60s or 70s? 16 A. Not necessarily. 17 Q. What factors, from your experience, 18 determine the long-term survival of patients 19 that have Stage 1 nonsmall cell carcinoma? 20 A. One would be whether in fact it is a 21 correct stage. I think many times tumors 22 diagnosed as Stage 1 are, in fact, more 23 advanced. 24 There would be some commonly young 25 patients who get tumors that are commonly seen</p>	<p>Page 36</p> <p>1 diagnosed with nonsmall cell carcinoma? 2 A. Well, the prognosis for all forms of 3 lung carcinoma are uniformly poor. 4 Q. Would you agree that Stage 1 nonsmall 5 cell carcinoma prognosis following resection is 6 more favorable than Stage 2 or Stage 3 or 7 Stage 4? 8 MR. WARNER: Objection. You can 9 answer if you can. 10 A. Only if it is, in fact, truly 11 Stage 1. 12 Q. Again, assuming the diagnosis is made 13 in Stage 1 and there is resection done at 14 Stage 1 and it's confirmed, do you know what the 15 medical literature suggests to be the prognosis 16 for a patient? 17 A. I do not know the estimated five-year 18 survival figures for that circumstance. 19 Nonsmall cell is not a uniform tumor type 20 either. There's a whole collection of tumors 21 with different prognoses. 22 Q. Do you know the histological type of 23 nonsmall cell carcinoma that Dan Gill had? 24 A. They always referred to it simply as 25 nonsmall cell.</p>

<p style="text-align: right;">Page 37</p> <p>1 Q. Do you have an opinion as to the 2 prognosis for the type that you are aware, from 3 what you have seen, of his nonsmall cell 4 carcinoma, if, in fact, it had been diagnosed 5 truly in a Stage 1 category? 6 A. I don't know the exact figures. 7 Q. Do you know, based upon your 8 knowledge and experience and readings, what the 9 ranges are that are reflected in the literature 10 in terms of survival for Stage 1, nonsmall cell 11 carcinoma? 12 MR. WARNER: Objection. Go ahead and 13 answer if you know. 14 A. Again, if we are assuming that this 15 Stage 1 is indeed accurate -- because even one 16 cell having metastasized would be a different 17 prognosis. Stage 1 does not mean it's a limited 18 disease, and therefore I think the five-year 19 survival rate would be different even if a 20 micrometastasis had occurred, perhaps. 21 I do not know how they use these 22 terms, but if somebody goes five years and no 23 metastatic disease has showed up, that would 24 certainly mean it was indeed the Stage 1. And 25 whether they use those criteria in these</p>	<p style="text-align: right;">Page 39</p> <p>1 nodal spread and tumors that have distant 2 metastasis. 3 Q. If you wanted to get specific 4 information on the staging criteria for nonsmall 5 cell carcinoma, where would you start your 6 search for that information? 7 MR. WARNER: Objection. Asked and 8 answered. He already responded to that 9 question. There are many sources. 10 Q. Go ahead. 11 A. Staging is a formal system. 12 Q. Are you able to cite me to any 13 journals or any textbooks that contain the 14 staging criteria? 15 A. Any textbook discussing the subject 16 of oncology would likely list the staging 17 criteria. 18 Q. You are familiar with DeVito's Cancer 19 Textbook, are you not? 20 A. No, I'm not. 21 Q. Obviously, Harrison's Principles of 22 Internal Medicine? 23 A. Harrison's I'm familiar with. 24 Q. I presume you own Harrison's 25 Principles of Internal Medicine?</p>
<p style="text-align: right;">Page 38</p> <p>1 studies, I don't know, but a tumor that has not 2 metastasized would definitely have a better 3 prognosis for local recurrence from one that 4 had. 5 Q. And the studies and the source of the 6 information that you have gathered with regard 7 to Stage 1 versus micrometastasis, which would 8 take it out of the Stage 1 category, where have 9 you come up with that information? Is it cancer 10 journals or medical journals? 11 MR. WARNER: Objection. Go ahead. 12 A. These figures are widely quoted in 13 different articles. I don't have a single 14 source that I could refer to. 15 Q. In the course of this case, have you 16 looked back at any medical literature to 17 familiarize yourself with the staging on 18 nonsmall cell lung cancer? 19 MR. WARNER: Objection. 20 A. I haven't reviewed that specifically. 21 The staging of most cancers is similar. There 22 are several different ways of staging, but 23 basically there are tumors that are localized, 24 without evidence of spread, there are tumors 25 that have adjacent spread, tumors that have</p>	<p style="text-align: right;">Page 40</p> <p>1 A. I own it, though I don't commonly 2 refer to it. 3 Q. Which other internal medicine books 4 do you own besides Harrison's? 5 A. I have the Scientific American 6 Medical Textbook, which is a three-volume series 7 that has regular updates. Commonly I would 8 speak with an oncologist if I wanted information 9 in that area. 10 Q. Short of speaking with an oncologist, 11 is the Scientific American, the three-volume, a 12 fairly reliable source for some of the staging 13 criteria? 14 MR. WARNER: Objection. Go ahead and 15 answer. 16 A. For that kind of thing, yes. 17 Q. And to your knowledge, does 18 Harrison's also have some of the staging 19 criteria? 20 A. I have never looked it up 21 specifically in Harrison's, but I would assume 22 they all have the same criteria, since those are 23 specified by committees. 24 Q. Is that the American Cancer 25 Association?</p>

<p style="text-align: right;">Page 41</p> <p>1 A. I do not know specifically who makes 2 up the staging for lung cancer, if it's that or 3 the Thoracic Society. 4 Q. From time to time do you look at 5 Harrison's for information in the area of 6 internal medicine? 7 MR. WARNER: Objection. Asked and 8 answered. Go ahead and answer again. 9 A. If I have a specific question 10 available to me, I would look it up there. 11 Q. And even though there are a number of 12 other internal medicine textbooks, would you 13 agree that Harrison's is a reasonably reliable 14 source of information in the area of internal 15 medicine? 16 MR. WARNER: Objection. 17 A. Reasonably reliable, but never 18 completely up to date. 19 Q. Sure. Obviously, journal articles 20 would be more up to date than a textbook; 21 correct? 22 A. It would be more current, yes. 23 Q. But all things being equal, 24 Harrison's is a reasonably reliable source for 25 information in the area of internal medicine?</p>	<p style="text-align: right;">Page 43</p> <p>1 other medical conditions, the type and extent of 2 pneumonia, so I would say there is no one 3 protocol that is appropriate for that. 4 Q. As an internal medicine specialist, 5 board certified internal medicine doctor, are 6 there any guidelines that you are aware of that 7 are promulgated by any internal medicine groups 8 that provide for standards as it relates to 9 different types of pneumonias in terms of what 10 the clinical signs are, what type of testing 11 should be done, and what type of follow-up is 12 indicated? 13 MR. WARNER: Objection. Go ahead and 14 answer. 15 A. Various hospitals have care paths for 16 treatment of pneumonia depending on the 17 pneumonia, community-acquired, nosocomial, 18 recommended antibiotic regimens. The diagnosis 19 is fairly straightforward. 20 Q. Do you in your practice follow those 21 guidelines or regimens that are used in the 22 hospitals? 23 MR. WARNER: Objection. Go ahead and 24 answer. 25 A. They print care plans, pathways for</p>
<p style="text-align: right;">Page 42</p> <p>1 A. As a starting point. 2 Q. Have you discussed any aspect of your 3 medical care provided to Mr. Gill with any 4 physicians after learning about the fact that he 5 was diagnosed with nonsmall cell lung cancer? 6 A. No. 7 Q. Since his death, have you personally 8 sat down, other than the conversations with your 9 attorney, and reviewed your medical care with a 10 view toward determining whether or not you did 11 or didn't do what you should have done? 12 A. No. 13 Q. As you sit here right now, doctor, 14 are there any journals, abstracts, or portions 15 of any texts that you can cite me to that you 16 believe to be relevant to any of the issues in 17 this particular case? 18 A. None that I can specifically cite, 19 no. 20 Q. Are there any guidelines that you 21 follow or protocols that you follow in your 22 practice in terms of follow-up on patients with 23 diagnosis of pneumonia? 24 A. It is quite variable according to the 25 patient, according to the patient's age, his</p>	<p style="text-align: right;">Page 44</p> <p>1 pneumonia with suggested regimens for antibiotic 2 therapy. Most commonly when I get a patient 3 admitted, it's through the emergency room and 4 the house physician or the resident writes the 5 initial orders and reviews them with me and they 6 tend to follow whatever care path the hospital 7 recommends. 8 Q. In your office setting when you are 9 seeing a community type situation with a patient 10 with pneumonia, do you follow a different 11 pathway in terms of the care of a patient that 12 is being seen in your office as opposed to a 13 patient that is admitted to the hospital? 14 A. What's different is that the people I 15 see in my office are much more likely to be 16 healthier, have milder pneumonias. People who 17 wind up in the emergency room tend to be older 18 and sicker and have more complex pneumonias. 19 Q. What type of pneumonia did Dan Gill 20 have? 21 A. A community-acquired pneumonia. You 22 don't normally, in cases of uncomplicated 23 community-acquired pneumonia, do studies to 24 determine the organism. I would assume that 25 most of the time these are pneumococcal or</p>

<p>Page 45</p> <p>1 mycoplasmal organisms and there are regimens 2 that would cover those possibilities. 3 Q. As a community-acquired pneumonia, do 4 you have an opinion as to what the inciting 5 organism was in his particular case? 6 A. Only in the general sense that most 7 community-acquired pneumonias are mycoplasmal or 8 pneumococcal. 9 Q. Does that fall in the category of 10 bacterial? 11 A. Yes. 12 Q. As opposed to viral? 13 A. Whether viral pneumonias is common is 14 debated. I think the community thinking is 15 viral pneumonias are not as common as they were 16 thought to be, because a lot of the atypical, 17 like Chlamydia and Legionella, which were 18 formally thought to be viral, turned out to be 19 atypical bacterial organisms. 20 Q. So it's your opinion in this case, 21 that more likely than not, his pneumonia, 22 community-acquired pneumonia was bacterial in 23 origin? 24 A. Yes, I would treat patients on that 25 assumption.</p>	<p>Page 47</p> <p>1 up diagnosing it and treating it to the extent 2 it bothers the patient enough for them to come 3 in with complaints. 4 I do not recall the specifics of what 5 I may have given him for anxiety, but I would 6 say he was just generally an anxious person and 7 tended to worry about things more than the 8 average patient, particularly health matters. 9 Q. Was he disabled in any way in terms 10 of being able to handle his activities of daily 11 living -- 12 A. No. 13 Q. -- as a result of the anxiety? 14 A. No. 15 Q. So the anxiety -- 16 A. Not to my knowledge. 17 Q. So his anxiety was controlled with 18 medication? 19 A. Well, I don't recall if he took 20 medication on any sort of a regular basis for 21 it. I tend to think he did not. But he may 22 have required periodic treatment for periods of 23 increased anxiety. 24 Q. Did you ever refer him to a 25 psychologist or a psychiatrist?</p>
<p>Page 46</p> <p>1 Q. And you provided him with 2 Zithromax -- 3 A. Correct. 4 Q. -- as an antibiotic treatment for 5 bacterial community-acquired pneumonia; true? 6 A. Correct. 7 Q. Before we delve into December of '99, 8 January of 2000, and then up to the diagnosis, I 9 want to spend a little bit of time talking with 10 you about Dan before December of '99 -- 11 A. Okay. 12 Q. -- giving you sort of a road map of 13 where I'm going. 14 You had treated him for some anxiety 15 related matters over time; true? 16 A. Yes. 17 Q. I have your records. I don't need to 18 go through all the visits. 19 Can you summarize for me as best as 20 you can what the nature of his condition was? I 21 guess starting with what your diagnosis was 22 relative to his mental health. 23 A. Well, Dan did not have mental 24 disease. I think anxiety is a common symptom 25 and it's a spectrum in the population, and I end</p>	<p>Page 48</p> <p>1 A. Not that I recall. 2 Q. So you never felt that his anxiety 3 was to the level that he needed to have mental 4 health intervention; true? 5 A. No, I feel comfortable treating 6 anxiety on my own. 7 Q. I take it there are situations where 8 the mental health issue is such that you -- 9 A. Severe anxiety that was not 10 responding to treatment I would refer. 11 Q. That's not the case with Dan; true? 12 A. No. 13 Q. Did you ever prescribe any medication 14 to Dan or for Dan relative to his anxiety? 15 A. I would have to review the record to 16 answer that. 17 Q. Do you have a copy of the record with 18 you today? 19 MR. WARNER: I didn't bring it down. 20 A. If I have prescribed anything, it 21 would be documented in the progress notes from 22 the office. 23 Q. All right. Let me ask you this, just 24 to save some time. 25 Do you have a recollection of Dan</p>

<p style="text-align: right;">Page 49</p> <p>1 ever being noncompliant with any aspect of your 2 medical treatment? 3 A. Dan's treatments were for relatively 4 minor self-limited conditions where compliance 5 wasn't a big issue. 6 Q. So is it fair to say that there is 7 nothing that stands out in your mind that would 8 suggest that he would be categorized as being 9 noncompliant? 10 A. Well, with regard to acute or 11 self-limited conditions, no. With regard to 12 chronic conditions, I couldn't comment. It's a 13 different issue when it comes to chronic 14 conditions. 15 Q. What kind of chronic conditions are 16 you referring to? 17 A. Treating a patient for hypertension, 18 for elevated lipids, and compliance becomes an 19 issue in the long run, maybe not in the short 20 run. But the very common drop off in compliance 21 among the general population is in treating 22 chronic conditions. 23 Q. Ativan, is that used to treat 24 anxiety? 25 A. Yes.</p>	<p style="text-align: right;">Page 51</p> <p>1 that he entered your practice through the time 2 of his diagnosis, he didn't carry a history of 3 any current or recurrent smoking; true? 4 A. Well, he never admitted it to me. 5 Q. But did you ever get the sense with 6 Dan that he was less than candid with you in 7 connection with any of the complaints that he 8 had, from head to toe? 9 A. No. Although smokers and drinkers 10 often do not like to volunteer those things. 11 But I have no objective evidence that he was a 12 smoker at the time I cared for him. 13 Q. And he seemed to be, at least from 14 what I can gather -- and I'm not trying to put 15 words in your mouth, so you tell me if I am 16 misstating things -- but it seemed like he was a 17 patient that was concerned about his medical 18 condition. 19 For example, coming in and 20 requesting -- 21 A. I would say he was probably more 22 concerned than the average patient. 23 Q. One example is that when he had a 24 particular sexual partner, I see on a number of 25 occasions, he wanted to have HIV testing done.</p>
<p style="text-align: right;">Page 50</p> <p>1 Q. Would .5 milligrams be a fairly mild 2 dosage? 3 A. I believe that is the smallest dose 4 they market. It's possible it comes out in a 5 lower dose, but .5 is a low dose. 6 Q. Selane, S-E-L-A-N-E, is that for -- 7 A. Seldane, perhaps? S-E-L-D-A-N-E? 8 Q. Perhaps I have it typed wrong. 9 A. Seldane is a nonstating antihistamine 10 no longer on the market but was widely used to 11 treat allergies. 12 Q. Was he on any cholesterol lowering 13 medications that you recall? 14 A. I don't think he was. I recall him 15 asking to have his cholesterol checked at some 16 point, but I don't remember that we treated him 17 with any drug therapy. I may have advised him 18 on diet therapy. 19 Q. Dan had been a smoker; true? 20 A. In his younger years. 21 Q. During the ten plus years that he was 22 in your practice, he was an ex-smoker? 23 A. I believe he quit a couple years 24 prior to entering my practice. 25 Q. And as far as you know, from the time</p>	<p style="text-align: right;">Page 52</p> <p>1 A. Well, many people want that done. 2 That's a lethal condition. I think the fact 3 that he came in relatively frequently for a male 4 of his age would suggest he had maybe more than 5 the average number of concerns about his health, 6 which was basically good. 7 Q. Prior to December of '99, do you have 8 a recollection of ever treating him for any type 9 of community-acquired pneumonia? 10 A. I don't recall treating him for that. 11 Q. Did you ever treat Dan on an 12 inpatient basis? 13 A. I do not recall treating him in the 14 hospital. 15 Q. You may or may not be able to answer 16 this question. If you can't, just tell me. If 17 you can, great. 18 Did Dan, as of December of 1999 or 19 January of 2000, have any medical conditions, 20 diseases, or illnesses that in your opinion 21 would suggest his life expectancy, absent 22 cancer, would have been less than a normal life 23 expectancy? 24 A. Probably not. 25 Q. Just a couple general questions and</p>

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1 then we will stay in '99 and 2000.
2 A. Okay.
3 Q. Since he was your patient for about
4 ten years or so, you have told me about the
5 issues that he would come to see you about and
6 the issue of compliance.
7 Tell me what type of individual Dan
8 was. Obviously I never met him. You had
9 occasion to see him on a fairly frequent basis
10 over the ten years. Tell me about him.
11 A. Well, I know Dan was single and I
12 think he was close to his family. I believe he
13 grew up, stayed in this area. I know he worked
14 for the county and was, as I say, very health
15 conscious. He was into endurance type
16 athletics, which I think he lifted weights, was
17 a runner.
18 I don't know much about his social
19 life, you know, what kind of people he kept
20 company with or what he thought about his job.
21 I guess working for the county, I don't think
22 most people who work for the county are obsessed
23 by their career, but I don't remember if we
24 really got into those kind of details.
25 He was an outgoing, friendly guy.

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1 Q. When you and he would see each other
2 at an office visit, did he seem to understand
3 what you were telling him as it relates to any
4 condition, whether it's the anxiety or --
5 A. I would say he probably had about the
6 amount of insight that the average patient in my
7 practice did.
8 Q. When he would come to see you, do you
9 recall him being accompanied on any occasion by
10 any family members or --
11 A. He might have once or twice, but
12 normally he would come on his own.
13 Q. Were there any occasions -- again, we
14 are still preDecember '99 -- were there any
15 occasions that you recall from the records or
16 independently from the records where you had
17 recommended any tests, or treatment, or
18 medications for Dan that he refused to follow?
19 A. I don't recall any specific
20 instances.
21 Q. How significant were his allergies?
22 A. I don't think they were a major
23 problem. He would come in for a Kenalog shot in
24 the spring, because generally that is used --
25 it's an injectable corticosteroid used for

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1 short-term control of seasonal allergies.
2 It might have a duration of four,
3 five, six weeks, and it's not necessarily
4 preferable treatment for allergic rhinitis, but
5 there is a lot of demand for it because it's a
6 single shot and they don't have to take pills.
7 So maybe reluctantly I give it once,
8 occasionally twice a year, and beyond that I
9 tend not to use it for that purpose.
10 Q. To your recollection, did the Kenalog
11 injections control, if you will, his seasonal
12 symptoms?
13 A. I'm certain it did, because he came
14 back for it. And it almost always does.
15 Q. Now, according to the records, you
16 had seen him in May of '99 and I think he had a
17 Kenalog shot at that time, and then when we jump
18 ahead to May of 2000, he had a Kenalog shot.
19 A. I would have to check the record, but
20 he tended to get it the same time every year.
21 Q. Fair enough. Now, you saw Dan on
22 December 9, 1999, and certainly I have my copy
23 of the records here.
24 I'm going to hand you what I believe
25 to be a copy of your office note for December 9,

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1 1999. Does that appear to be your note?
2 A. That's my handwriting.
3 Q. What were his chief complaints on
4 December 9, 1999?
5 A. Well, let's see. He complained to
6 the medical assistant that took the initial
7 information that he had chest pain, numbness in
8 the left side of the arm and neck, and a
9 pinching feeling in the left side of his chest
10 of about six weeks duration. He stated
11 left-sided chest pain in variable locations
12 associated with numbness or weakness of the left
13 arm.
14 Often patients are not quite specific
15 about what they are feeling. They just know
16 they are feeling something isn't quite right.
17 It lasted a few minutes. It would come and go
18 and seemed worse with stress and anxiety, as is
19 fairly common in anxious patients.
20 No exertional chest pain, meaning it
21 was not very suggestive of angina or pain due to
22 coronary disease. Occasional shortness of
23 breath was a complaint that typically suggests
24 anxiety, because shortness of breath due to
25 heart or lung problems is typically exacerbated

14 (Pages 53 to 56)

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1 by physical effort. He was able to do physical
2 activity without symptoms.
3 I reiterated the smoking history. He
4 quit in 1987; that he did not have other risk
5 factors for heart problems, such as cholesterol
6 or family history.
7 The exam essentially was normal of
8 the heart and lungs, and I diagnosed him with
9 noncardiac symptoms, likely related to anxiety
10 and overuse.
11 Q. Overuse of what?
12 A. Apparently that applies overuse of
13 the muscles of the upper trunk and upper
14 extremity as you would see in an athlete or a
15 weightlifter like Dan.
16 Q. What else did you have within your
17 differential to explain this symptom complex?
18 A. That was my differential at the time.
19 There wasn't much to suggest other possibilities
20 at that time.
21 Q. In looking back at his records prior
22 to December of '99, I don't see that he had
23 presented at any time with the symptom complex
24 of chest pain, numbness on the left side,
25 pinching in the left side of the chest or left

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1 anxiety.
2 Q. But yet in Dan's situation, if my
3 statement is correct, he hadn't presented with
4 these symptoms all grouped together before, his
5 anxiety --
6 A. He did not come to my office
7 complaining of those specific symptoms, to my
8 recollection.
9 Q. But in any event, you did attribute
10 them, at least in part, to the anxiety and part
11 to perhaps him being a very active individual?
12 A. Yes. I said likely related to
13 anxiety and overuse.
14 Q. Now, the complaint of left-sided
15 chest pain with numbness of the arm, did that --
16 A. That's very nonspecific. Chest pain
17 of any cause may be referred to the arm due to
18 the way the peripheral nervous system is
19 constructed.
20 Q. What else would be within your
21 differential as a potential cause of that type
22 of --
23 MR. WARNER: Note my objection. You
24 said overuse and anxiety and he has covered that
25 three or four times. Note my objection.

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1 side of the neck.
2 A. Claudia, my assistant, stated the
3 pinching feeling on the left side of the chest.
4 That's apparently quoting his term for it. I
5 did not use that term myself in writing the
6 progress note.
7 Q. I guess my question was, in looking
8 at what's noted in December of '99, and going
9 back in history of your treatment of Dan, I
10 didn't see that he had ever presented with that
11 symptom complex.
12 A. He may not have, although anxious
13 people are very frequent office visitors with
14 those symptoms, because they elicit worries
15 about possible coronary disease, and I think as
16 patients get older they tend to fret about that
17 more if somebody they know has had a heart
18 problem or they read an article. It doesn't
19 take much to bring them in with these things.
20 Q. So your differential was pretty
21 limited at that time?
22 A. At that time, yes.
23 Q. And it was noncardiac and just sort
24 of a muscular strain?
25 A. And symptoms fairly typical of

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1 Q. Go ahead.
2 A. In the absence of respiratory
3 symptoms, pulmonary symptoms are not a
4 significant concern with those particular
5 symptoms. Lungs do not experience -- there are
6 not any pain receptors in the lung proper; they
7 are in the pleura and require a pulmonary
8 process, something that would extend to the
9 periphery of the lung and the pleura of the
10 chest. Pleural pain would be experienced. His
11 pain was really not pleuritic either. It
12 sounded primarily musculoskeletal.
13 Q. Did he also have some occasional
14 shortness of breath at rest?
15 A. At rest, but not with activity, which
16 again would divert attention away from cardiac
17 and pulmonary symptoms to, you know, noncardiac,
18 nonpulmonary.
19 Q. And again within the differential,
20 other than anxiety related, or muscle strain,
21 what else would explain dyspnea at rest?
22 MR. WARNER: Note my objection. You
23 asked this question about the fourth or fifth
24 time and he has given the answer. He said he
25 didn't have any more differentials and you are

15 (Pages 57 to 60)

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1 asking it the sixth time and saying you must
2 have another differential. That's not proper.
3 I think you should stop that.

4 MR. MISHKIND: I think you should
5 stop testifying. Keep in mind the local rules.
6 This is the first time I talked about dyspnea at
7 rest and I am asking him occasional dyspnea at
8 rest and what would be within the differential
9 with regard to that.

10 A. Dyspnea at rest when not present at
11 exertion would point away from anything in the
12 way of cardiac or pulmonary problems. Dyspnea
13 basically is caused by perception of increased
14 work of breathing, and when you exert yourself
15 physically, you are required to breathe harder
16 and that will elicit symptoms of dyspnea.

17 If you have underlying heart and lung
18 problems but dyspnea only at rest and not with
19 activity, that is basically a reassuring symptom
20 that there is not something going on within the
21 chest.

22 Q. Are complaints of chest pain, dyspnea
23 at rest, numbness in the arm, symptoms
24 consistent with lung cancer?

25 A. No. Lung cancer does not cause chest

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1 Q. I understand.

2 A. But I do emphasize that to the
3 patient.

4 Q. Again, I'm talking about what's noted
5 in the record.

6 A. No, we can read what is in the record
7 and that is not there.

8 Q. I guess I'm curious as to why you
9 would note that you didn't see any reason for a
10 stress test and wouldn't indicate to the patient
11 or mark down in the record that patient advised
12 to return.

13 A. Well, I didn't say I didn't indicate
14 to the patient. I simply did not write it down.
15 I have only so much time I can spend on a chart,
16 and I write these notes primarily for my own
17 use, so when the patient comes back I can refer
18 to them. So things that I might do quite
19 routinely I do not necessarily write down every
20 time.

21 Q. Even though you are writing them down
22 for your own use, obviously, they need to
23 communicate what your treatment is for the
24 patient; correct?

25 A. Yes. I mean, if one of my partners,

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1 pain unless it is spread to the chest wall or
2 involves the nerves of the chest wall.

3 Q. What was your plan of treatment on
4 that day, doctor?

5 A. Well, as I stated, it's reassurance,
6 check electrocardiogram to make sure there was
7 not some unexpected cardiac cause, and
8 basically, although I did not write it down, I
9 would routinely tell the patients, if your
10 symptoms continue or get worse or new ones
11 develop, you need to call me.

12 Q. In fact, in the plan area, you didn't
13 mark anything down about returning?

14 A. I don't necessarily write that down
15 if I don't have a specific plan. I think it's
16 understood that if you have continuing problems,
17 you'll get back to me.

18 Q. On December 9, however, in terms of
19 the plan, you made a point of saying you didn't
20 see any reason for a stress test; correct?

21 A. Correct.

22 Q. But you don't make any note in the
23 plan if the patient has any continuation of
24 these symptoms that he should return; true?

25 A. I did not write that down.

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1 for example, were to see the patient on a
2 therapy visit, I would like to write it so they
3 can see what my thinking was, what the pertinent
4 findings were.

5 Q. By the way, did any of your partners
6 see Dan?

7 A. I do not think they did. It would be
8 in the record if they had.

9 Q. And from your review, does it appear
10 like it's you and Dan?

11 A. I do not recall seeing anybody else's
12 notes in the chart.

13 Q. Okay.

14 A. Other than my medical assistant's.

15 Q. The medical assistant on December 9,
16 what's his or her name?

17 A. Claudia Conforto.

18 Q. Is Claudia still with you?

19 A. Yes.

20 Q. Is she a certified medical assistant,
21 do you know?

22 A. She does not have a formal training
23 certificate.

24 Q. On-the-job training?

25 A. On-the-job. She is considered one of

16 (Pages 61 to 64)

<p style="text-align: right;">Page 65</p> <p>1 the best in the group. 2 Q. And is she assigned to your patients 3 or does she see -- 4 A. She sees primarily my patients. 5 Q. Why did you note in the chart on 6 December 9 no reason for stress test? What was 7 your thought process? 8 A. Just what I was going through in my 9 mind with regard to these complaints, were they 10 or were they not suggestive of myocardial 11 ischemia. I think I would say I probably gave 12 some consideration suggested by a stress test 13 and my answer at that time was they were not 14 sufficiently indicative of myocardial ischemia 15 to do a stress test. 16 Q. Is it fair to say that your thought 17 process on December 9, 1999 did not include the 18 possibility of any pulmonary involvement? 19 A. That was not a significant concern at 20 that time. 21 Q. Let's forget about the word 22 significant. Was pulmonary involvement a 23 consideration in your mind? 24 A. I considered it to the extent that I 25 stated he had dyspnea at rest, but not with</p>	<p style="text-align: right;">Page 67</p> <p>1 follow-up from the December 9th visit, or was 2 this a return on his own for other reasons? 3 A. That was, I'm certain, a return on 4 his own for his acute symptoms. 5 Q. At the time he had cough and sore 6 throat and chest congestion; true? 7 A. Claudia stated he had cough, sore 8 throat and chest congestion. I stated a history 9 of four-day cough with yellow-green sputum; 10 nonpleuritic substernal chest soreness; sore 11 throat, fatigue, malaise, felt short of breath 12 taking the stairs. 13 Q. Did you do a sputum culture? 14 A. No. 15 Q. Why? 16 A. I do not routinely do sputum cultures 17 on community-acquired pneumonias because they 18 are not of much help. 19 Q. Had you already concluded before 20 doing a chest x-ray that this was a 21 community-acquired pneumonia? 22 A. No. Because I stated under the 23 impression, viral bronchitis or upper 24 respiratory infection, rule out influenza or 25 pneumonia.</p>
<p style="text-align: right;">Page 66</p> <p>1 strenuous activity. 2 Q. From the standpoint of there being 3 any potential serious pulmonary condition being 4 causative of the dyspnea on exertion, did you 5 consider that? 6 A. I considered it, but I rejected the 7 possibility, because he did not have shortness 8 of breath with exertion. 9 Q. In order to have gotten to that point 10 where you would have seriously considered it, 11 you would have needed shortness of breath on 12 exertion? 13 A. If a patient comes in with symptoms 14 in a certain anatomic region, you have to give 15 consideration to all the things that could cause 16 symptoms in that region, but you don't 17 necessarily do it consciously, it's sort of a 18 subconscious sorting process you go through any 19 time you see a patient. These are categorized 20 in terms of probabilities worth following up and 21 probabilities that are not worth following up at 22 that time. 23 Q. You saw Dan on December 30th; true? 24 A. Yes, on December 30th, 1999. 25 Q. Was he returning for a scheduled</p>	<p style="text-align: right;">Page 68</p> <p>1 Q. Having not arrived at a diagnosis of 2 community-acquired pneumonia, why didn't you do 3 a sputum culture where he presented with 4 productive sputum? 5 A. Because a sputum culture is not 6 informative in that situation. 7 Q. Under what circumstances is a sputum 8 culture -- 9 A. If someone came into the hospital 10 with a pneumonia, they would probably get a 11 sputum culture, although more often than not the 12 results are not helpful. 13 The one thing, they don't come back 14 for two or three days, by which time you have 15 already selected a course of treatment and it is 16 not really the standard of practice to do 17 routine sputum cultures in this situation. 18 Q. Under your impressions on that day, 19 would that constitute your differential 20 diagnosis on the patient? 21 A. Those were the leading possibilities. 22 I mean, the differential diagnosis could be 20 23 things, but that's the ones that are worth 24 consideration at the time of the visit. 25 Q. The ones that would be higher up on</p>

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1 the differential?
2 A. Correct.
3 Q. Lower down on the differential, could
4 you rule out the possibility of lung cancer?
5 A. You can't rule out things without
6 doing specific tests, but these are not the
7 symptoms that lung cancer would typically
8 present with.
9 Q. Why is that?
10 A. Well, lung cancer does not cause
11 fever, routinely. It may as it advances cause
12 fevers. But acute respiratory symptoms with
13 cough, shortness of breath, lung cancer is not
14 an acute process. This was an acute illness.
15 Q. You prescribed Z-Pak. Was that for
16 him, the Zithromax, to take, irrespective of
17 what the x-rays showed, or was it to be taken
18 subject to the interpretation of the x-ray?
19 A. Well, I didn't list prescribing it at
20 the time of the visit. But we did call him
21 later that day. There is a statement here
22 stating that the x-ray showed infiltrate in the
23 left upper lobe consistent with pneumonia. That
24 was phoned to us by the radiologist that same
25 day that I saw him, and at that time we

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1 Q. Did you send Dan to Lakewood Hospital
2 for the x-ray?
3 A. I don't know where he -- he probably
4 went to Lakewood Hospital. That's the only
5 convenient facility in Lakewood.
6 Q. When did you receive the actual
7 written interpretation?
8 A. I couldn't tell you when I received
9 the written report, but I received the phone
10 interpretation, which is what I used to make my
11 decision. I would say since that was the 30th
12 and the next day was New Year's Eve and New
13 Year's, I probably didn't see it for several
14 days.
15 Q. Normal practice is to get it within a
16 week's period or less?
17 A. A week or less. It's not as quick as
18 it might be.
19 Q. Especially when you are dealing with
20 the holiday?
21 A. And that's why they call you. We
22 routinely request that we be called with
23 abnormal results in these situations.
24 Q. You saw Dan for follow-up on January
25 6th?

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1 prescribed by phone a Z-Pak. Prior to that I
2 had just given him Robitussin with Codeine for
3 symptomatic treatment until I saw the results of
4 the chest x-ray.
5 Q. And when did you see the results of
6 the chest x-ray?
7 A. Well, I got the report that same day
8 by phone.
9 Q. Did you actually interpret the chest
10 x-ray?
11 A. No. Radiologists interpret chest
12 x-rays and they send us reports.
13 Q. You pretty much rely on the
14 radiologist in terms of their interpretation; is
15 that true?
16 A. Yes, that's their specialty.
17 Q. The reason I ask it that way, some
18 docs in different disciplines say radiologists
19 read things, but I still read my own x-rays.
20 A. Well, no, I don't think that's a good
21 idea, because I see many patients admitted to
22 the hospital with diagnoses of pneumonia based
23 on the doctor's reading of the x-ray in the
24 emergency department, which the radiologist
25 subsequently says is no pneumonia.

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1 A. Yes.
2 Q. And was that a scheduled follow-up on
3 his pneumonia?
4 A. Yes, that would have been scheduled.
5 Q. And at that time, did you have the
6 interpretation on the x-ray from December 30th?
7 A. I could not be sure if I had the
8 typewritten one, but I had the phone report
9 certainly.
10 -----
11 (Thereupon, Plaintiff's Deposition
12 Exhibit No. 1 was marked for
13 purposes of identification.)
14 -----
15 Q. I'm going to show you a copy of what
16 I believe to be the radiology interpretation
17 from December 30th, '99 and it's marked as
18 Plaintiff's Exhibit 1.
19 Just for the record, would you
20 confirm the fact that Exhibit 1 is a copy of the
21 radiology interpretation from December 30, 1999?
22 A. I will confirm that.
23 Q. And the radiologist -- who is the
24 radiologist on that film?
25 A. I don't see his name here. It should

<p style="text-align: right;">Page 73</p> <p>1 be somewhere in the record. 2 Q. In any event, whoever that 3 radiologist is, your practice is to rely on 4 their interpretations and impressions relative 5 to the x-rays; true? 6 A. Correct. We go by their 7 interpretation of the findings. 8 Q. And on that interpretation, do you 9 see that the radiologist suggested a follow-up? 10 A. Yes, he suggested it. 11 Q. If I can borrow that to quote, it 12 suggests follow-up radiographs to document 13 clearing. And above that it says patchy 14 infiltrate in the left upper lung suggestive of 15 pneumonia. 16 You don't dispute that you received 17 this? 18 A. No, I don't dispute that. 19 Q. Is it more likely than not that you 20 would have had this interpretation when you saw 21 Dan on January 6th, 2000? 22 MR. WARNER: Objection. Asked and 23 answered, but go ahead and answer again. 24 A. Could you state it again? 25 Q. Is it more likely than not when you</p>	<p style="text-align: right;">Page 75</p> <p>1 unless cough fails to resolve, and then I would 2 also observe the blood pressure, which was in 3 the borderline range. 4 Q. Now, the radiologist suggested 5 follow-up to document clearing of the pneumonia. 6 A. He suggested it, yes. 7 Q. You emphasized the word suggest. 8 Tell me whether you interpret that to mean that 9 his suggestion was, I guess, optional. 10 A. Well, the radiologist basically makes 11 an interpretation. They do not usually have 12 many, if any, clinical parameters about the 13 patient. 14 They know how old the patient is, 15 they know the chief reason they were sent over, 16 but they do not know if the patient is a smoker 17 typically, they don't know their medical 18 history, so they are not prepared to make any 19 very specific recommendations, so they made the 20 general suggestion that chest x-ray be repeated 21 to document clearing. 22 Q. When you are following a patient that 23 has a community-acquired pneumonia, is there, to 24 your knowledge, a standard of care that requires 25 a follow-up chest x-ray to document resolution</p>
<p style="text-align: right;">Page 74</p> <p>1 saw Dan on January 6th that you would have 2 received the interpretation, the written 3 interpretation that's marked as Plaintiff's 4 Exhibit 1? 5 MR. WARNER: Note my objection. 6 Asked and answered. He already responded to 7 that, but respond again, doctor. 8 A. It is likely, but I have no way of 9 determining that. 10 Q. On January 6th, you examined Dan and 11 why don't you tell me what your findings were. 12 A. Well, according to the note, the 13 history stated that he had been seen a week 14 earlier with pneumonia, treated with a Z-Pak and 15 mostly back to normal except for a lingering 16 cough. 17 On the physical exam, lungs clear to 18 auscultation, and no coughing, meaning the 19 patient was not observed to cough while I was in 20 the room with him. Clear to auscultation means 21 I am listening to the chest with a stethoscope. 22 I had no abnormal sounds that would indicate 23 pneumonia or other pulmonary problems. 24 Q. And your plan? 25 A. I stated will not repeat chest x-ray</p>	<p style="text-align: right;">Page 76</p> <p>1 of the infiltrate? 2 A. No, I don't think there is a standard 3 of care on medical grounds that would require 4 that. It's a clinical decision based on the 5 nature of the patient, the nature of the 6 pneumonia. 7 Q. So your testimony is that the 8 standard of care for follow-up on an adult 9 patient with a community-acquired pneumonia does 10 not require a chest x-ray to document 11 resolution? 12 A. I think that's a clinical decision 13 that the clinician makes. 14 Q. Again, just so we are using the same 15 language, your testimony would be, Mr. Mishkind, 16 the standard of care does not require, as an 17 absolute statement, does not require a follow-up 18 x-ray to document resolution of pneumonia? 19 A. That is my opinion. 20 Q. Are you aware of any medical 21 literature or studies or articles or sections of 22 any texts that you deem reliable that would 23 support the proposition that a follow-up x-ray 24 to document resolution of the infiltrate 25 secondary to a pneumonia is not required?</p>

<p>Page 77</p> <p>1 A. I do not recall seeing anything one 2 way or another in that respect. 3 Q. Now, in your plan, you don't indicate 4 when, if at all, Dan is to return to your 5 office; true? 6 A. Correct. 7 Q. In your plan, you don't indicate how 8 long Dan was to wait to get back in touch with 9 you if, in fact, the cough failed to resolve; 10 true? 11 A. I did not state a specific interval 12 on the progress note, but my general practice is 13 to tell the patient if the cough continues to 14 improve and clears up in a reasonable time, 15 meaning within a few weeks, there is no need to 16 return regarding that particular episode. 17 Q. All right. Back in January, I take 18 it, you had a full-time clinical practice? 19 A. Yes. 20 Q. 9:00 to 5:00? 21 A. I don't recall what my office hours 22 were at that time, but they varied from 23 day-to-day. 24 Q. But you had a full-time clinical 25 practice?</p>	<p>Page 79</p> <p>1 MR. WARNER: Objection. Asked and 2 answered. He already talked about that. 3 MR. MISHKIND: Your objection is 4 noted. 5 A. He was to return if he had symptoms 6 or concerns for another visit. 7 Q. When it said observe BP, what does 8 that mean? 9 A. That means we are certainly not going 10 to treat it, but we should repeat it in a 11 reasonable interval to make sure it wasn't going 12 up. 13 I don't remember what I told him 14 specifically. It was basically I think a note 15 to myself that we were to keep an eye on the 16 blood pressure, but we weren't going to be 17 treating it at that time. 18 Q. If we jump ahead, is it fair to say 19 the next encounter you had with Dan was when he 20 came into the office for the Kenalog shot in 21 May? 22 A. I didn't see him myself on that 23 occasion. He came in and got an injection from 24 my medical assistant. Had I seen him other than 25 maybe in the hallway to say hello, I would have</p>
<p>Page 78</p> <p>1 A. Correct, between hospital rounds and 2 office hours. 3 Q. And you would see a number of 4 patients, both in the hospital, as well as in 5 your office; true? 6 A. Yes. 7 Q. Do you recall specifically seeing Dan 8 on December 30th when he presented with the 9 pneumonia? 10 A. It's hard to say what I recall from 11 that specific visit as to what I might recall 12 from rereading the progress note. The progress 13 note is usually my trigger for recalling 14 encounters. 15 Q. Do you recall anything specific about 16 the January 6th office visit other than what's 17 noted in your handwritten note? 18 A. No. I don't recall any details 19 beyond what is documented on the note there. 20 Q. It looks like, as I am looking at 21 your note on January 6th, that other than an 22 indication that if the cough failed to resolve, 23 that you would repeat the chest x-ray, there was 24 no time interval for him to return for any 25 reason to the office; true?</p>	<p>Page 80</p> <p>1 entered a note in the chart. 2 Q. She did indicate that you were in the 3 office, true? 4 A. That is a requirement of the group, 5 is that no injections can be given without a 6 physician in the office. 7 Q. Got it. But as far as you actually 8 seeing him, other than perhaps saying hello -- 9 A. Had I seen him, I would have written 10 a note. 11 Q. The chest x-ray, Exhibit 1, I guess 12 my first question to you is, do you have any 13 basis to criticize what the radiologist has 14 indicated in his interpretation and impressions 15 on that document? 16 A. As far as what he saw or his 17 recommendation? 18 Q. Both. 19 A. I do not have any issue with the 20 interpretation. He said probable pneumonia, 21 which was consistent with the clinical 22 impression and the clinical response to 23 treatment. With regard to suggestion of 24 follow-up radiograph, I think we discussed that 25 previous, and --</p>

<p>Page 81</p> <p>1 Q. And again, that's a suggestion but 2 the ultimate decision is a clinical one? 3 A. It's a blanket suggestion. It's not 4 intended to refer to this specific patient. 5 Q. But the fact that he says suggests 6 follow-up, you are not critical of him for 7 making such a suggestion, are you? 8 A. Not for writing it down, no. 9 Q. Ultimately, as to whether or not it's 10 required in order to comply with the standard of 11 care, that really falls within the clinician's 12 purview? 13 A. That's not the radiologist's area of 14 expertise, what should be done to follow-up on 15 conditions. 16 Q. The presence of the infiltrate that 17 Dan had was in the upper lobe; true? 18 A. Left upper lobe is I believe where he 19 placed it. He says left upper lung. He does 20 not say left upper lobe, though. 21 Q. Do you know whether it was in the 22 left upper lobe or just -- strike that. 23 When pneumonia is diagnosed on x-ray, 24 and an infiltrate is seen, is an infiltrate 25 normally seen in the lower or the upper lobe</p>	<p>Page 83</p> <p>1 finally agree with one of your objections. 2 Q. Was there any downside to you 3 ordering some time in the future for the patient 4 to have a chest x-ray to document resolution of 5 the pneumonia? 6 A. Well, there would be a downside to 7 ordering the day of the follow-up visit or 8 within a couple weeks, because pneumonias are 9 slow to improve on x-ray, slower than they are 10 clinically. 11 Q. Let me stop you for one second. 12 MR. WARNER: I object to you stopping 13 him. I would like to have him finish it and 14 then you can go ahead. Unless you were done, 15 doctor. 16 THE WITNESS: I guess I was done. 17 MR. WARNER: I apologize. 18 MR. MISHKIND: My stopping him wasn't 19 intending to stop him from finishing. 20 Q. So on January 6th, and correct me if 21 I am wrong, to have ordered a chest x-ray to 22 document resolution of the community-acquired 23 pneumonia in your opinion would have been 24 useless? 25 A. Well, it would have been clinically</p>
<p>Page 82</p> <p>1 when it's related to pneumonia? 2 A. Well, an infiltrate can be seen in 3 any of the various lobes of the lung. On the 4 left side it could be the upper lobe, the lower 5 lobe, the lingual. 6 Q. Is it more common in a 7 community-acquired pneumonia that is bacterial 8 in origin to see the infiltrate in the upper or 9 lower lobe, in your experience? 10 A. You know, I don't think there is a 11 wide difference. Statistically one may be more 12 common than the other, but I'm not aware of a 13 strong tendency toward one lobe or the other. 14 Q. I understand what you have said to me 15 about January 6th. 16 My question to you is, when you noted 17 will not repeat the chest x-ray unless the cough 18 fails to resolve, was there any downside from 19 your perspective as Dan's physician in terms of 20 ordering a chest x-ray in two or three weeks or 21 that day to document resolution of the 22 pneumonia? 23 MR. WARNER: Note my objection. One 24 day, two or three weeks? 25 MR. MISHKIND: I'll break it down. I</p>	<p>Page 84</p> <p>1 inappropriate, because it is likely that the 2 x-ray would not have cleared by that time, and 3 you would not get to document clearing. You 4 might as well wait to at least an interval where 5 you anticipate clearing. 6 Q. Why schedule him for a follow-up 7 visit so close in time? 8 A. Because the clinical response to 9 treatment is the most important thing. You want 10 to make sure that the patient is improving; that 11 the physical exam is satisfactory; that he is 12 not lost to follow-up. 13 Q. Why not schedule him after January 14 6th for further follow-up to be able to -- 15 A. Well, because he clinically almost 16 completely resolved and that was actually a 17 quicker response than one would commonly see in 18 community-acquired pneumonia. So due to the 19 excellent clinical response, I did not feel it 20 was necessary to bring him back for further 21 visits unless he had ongoing or continuing 22 problems. 23 Q. Well, he did have the lingering 24 cough. 25 A. Well, he had a lingering history of</p>

<p>Page 85</p> <p>1 some persistent cough a week after he began 2 treatment, but he did not cough while I saw him. 3 And I told him if the cough did not resolve, he 4 indeed should return. 5 Q. Well, you may have said that to him, 6 but we can agree that your note does not 7 indicate for him to return; true? 8 MR. WARNER: Objection. The note 9 speaks for itself. 10 Q. Well, does the note indicate that the 11 patient is to return to the office if the cough 12 does not resolve? 13 A. Well, it implies that he is to 14 contact me, whether in the office or by phone, 15 because I said will not repeat the chest x-ray 16 unless cough fails to resolve. He would have to 17 communicate with me in some fashion to get an 18 office visit for a repeat chest x-ray. 19 Q. If the cough did not resolve in a 20 week or two, would you have ordered a repeat 21 chest x-ray? 22 A. Not in a week. Two weeks possibly I 23 would have had him back to the office to take a 24 look at him. 25 Q. Is it your normal practice, doctor,</p>	<p>Page 87</p> <p>1 documented that he had had pneumonia. Read me 2 what -- 3 A. He had pneumonia in January. Just 4 recapitulating what the previous visits were 5 for. Stated for the past month he complained of 6 some mild shortness of breath, dyspnea on 7 exertion, shortness of breath with effort, and 8 pain in the left pectoral area. He had a slight 9 cough. He had by his own estimate stated that 10 his exercise capacity was decreased by 11 approximately 30 percent. 12 I found him on exam to have some 13 tenderness over the left sternal mastoid muscle, 14 which is the strap muscle here in the neck, but 15 no tenderness over the pectoral muscles or the 16 ribs in that vicinity. Normal heart exam. 17 Lungs were clear. 18 My impression was fibromyalgia, which 19 is a common form of muscular pain, possibly 20 asthmatic bronchitis, and stated I doubted if 21 any of this was due to coronary artery disease. 22 Plan was for observation, trial of 23 Accolate, which is an oral asthma drug, and to 24 consider doing a chest x-ray and a stress test, 25 and H&H, essentially a hemoglobin and</p>
<p>Page 86</p> <p>1 when following a patient for a 2 community-acquired pneumonia, that a follow-up 3 visit to examine the patient to document 4 resolution of the symptoms with or without an 5 x-ray, just to document seeing the patient for 6 resolution of symptoms is not required? 7 MR. WARNER: Objection. Do you 8 understand the question? 9 A. Rephrase that one more time. 10 Q. Sure. This is the context in which 11 the question is being asked. You saw him on 12 January 6th and your plan was to repeat the 13 chest x-ray only if the cough failed to resolve. 14 A. Correct. 15 Q. My question is, is it your opinion 16 that the standard of care does not require a 17 follow-up visit to document resolution of the 18 symptoms of the pneumonia? 19 A. It does not necessarily require that, 20 no. 21 Q. Now, you saw Mr. Gill, it looks like, 22 June 22nd; is that true? 23 A. That was the next time which I saw 24 him, yes. 25 Q. And at that time, on June 22nd, you</p>	<p>Page 88</p> <p>1 hematocrit, to essentially determine if anemia 2 might be present which could also cause 3 shortness of breath, if not better in the next 4 two weeks. 5 Q. You didn't order a stat chest x-ray? 6 A. No. 7 Q. Did you consider within your 8 differential on June 22nd the possibility that 9 he may have some type of neoplasm or 10 pulmonary -- 11 A. Well, I can't tell you what all I 12 possibly might have consciously entertained, but 13 I think I was aware at that time that his 14 symptoms had become more significant; that if he 15 didn't respond to treatment for asthma, we would 16 be required to do further testing within a 17 two-week interval. 18 Q. Is it fair to say that within your 19 differential at that time would have been the 20 possibility that the patient had some lung 21 pathology as being causative of these symptoms? 22 MR. WARNER: Note my objection to the 23 word possibility. Go ahead. 24 A. Well, I think shortness of breath, 25 decrease in exercise capacity and shortness of</p>

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1 breath on exertion would in this situation point
2 to the possibility of some abnormality of lung
3 function.

4 Q. And certainly within that parameter,
5 would you agree that lung cancer could not be
6 ruled out?

7 A. Well, to say it could not be ruled
8 out does not say that it's a likely possibility.
9 Even in a person in this situation, it would
10 still be an unlikely possibility. It would be
11 something that would probably be picked up if
12 the x-ray were obtained.

13 Q. What about a CAT scan, did you
14 consider that?

15 A. Not a CAT scan. That would be done
16 if the chest x-ray were abnormal.

17 Q. Did you review at all with Mr. Gill,
18 other than 30 percent decrease in exercise
19 capacity, what his physical activities had been
20 over the preceding months between January, when
21 you last saw him, and June?

22 A. I do not recall the details of what
23 specifics we discussed.

24 Q. You saw him on July 19th; is that
25 true?

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1 months ago.

2 Q. I understand. Did you feel that the
3 symptoms that he presented with in July had any
4 connection to the pneumonia that he had been
5 diagnosed with back in December of '99?

6 A. I'm certain that that crossed my mind
7 that there might be a linkage.

8 Q. On July 19th, did you order a CAT
9 scan or a chest x-ray?

10 A. According to my note, I ordered a CT
11 scan of the chest and the neck. I treated him on
12 an antibiotic, Augmentin.

13 Q. Were these tests ordered on a stat
14 basis?

15 A. I couldn't tell you. I would have to
16 look and see when they were done. Normally a
17 test like that would be done within a day or two
18 if it were ordered.

19 Q. Stat would probably not be indicated
20 since he was in no acute distress.

21 So if the CAT scan and chest x-rays
22 were performed on the 25th, about six days
23 later, would that be consistent with what you
24 felt to be a reasonable period to do these
25 tests, given what you --

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1 A. I seem to be missing a page or it's
2 probably out of sequence here.

3 Q. Probably out of sequence. Let me
4 save you time.

5 A. That's correct, I saw the patient in
6 the office on July 19th.

7 Q. And he had some swelling on the left
8 side of his neck; true?

9 A. That was his presenting complaint.

10 Q. And continued shortness of breath?

11 A. Still had shortness of breath,
12 correct.

13 Q. And it was your impression at that
14 time that the swelling on the left side of the
15 neck was an inflammatory node?

16 A. Well, let's see, what did I state
17 here? I stated there was a firm tender mass in
18 the neck. I said probably large inflammatory
19 node, as well as persistent dyspnea, recent
20 pneumonia by history, and consider atypical
21 infection, such as fungal infection or a
22 noninfectious process such as tumor or sarcoid.

23 Q. When you saw him in July and you said
24 recent pneumonia by history --

25 A. Recent meaning six months. Six

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1 A. I don't think the health of the
2 patient would be strongly influenced by a few
3 days sooner or later, although sometimes one
4 likes to get those as quickly as possible just
5 to try to alleviate anxiety. I don't know what
6 day of the week that was either.

7 Q. Based upon the results, he was
8 diagnosed with a Stage 4 nonsmall cell cancer of
9 the lung; true?

10 A. Correct.

11 Q. Prognosis for Stage 4 nonsmall cell
12 cancer of the lung?

13 A. Very poor.

14 Q. Statistically, can you give me any
15 ranges for a patient otherwise, with his --

16 A. I'm sure the five-year survival would
17 be well under five percent.

18 Q. Do you agree that early detection of
19 cancer directly correlates with a better
20 prognosis?

21 A. Not necessarily.

22 Q. Would you agree that the earlier one
23 diagnoses cancer, the better?

24 A. Not necessarily.

25 Q. As a general rule, would you agree

<p style="text-align: right;">Page 93</p> <p>1 that the earlier one diagnoses cancer, the 2 better it is? I'm not saying in all cases, but 3 as a general rule, when one -- you may still 4 object -- as a general rule, if you will, would 5 you agree that when one is faced with lung 6 cancer, that early detection of lung cancer is 7 first the goal when you are working a patient 8 up? 9 A. I think that is truer of other 10 cancers than it is of lung cancer. 11 Q. So you would disagree with that 12 statement? 13 A. I would respond that routine chest 14 x-rays, for example, have not been recommended 15 in screening smokers for lung cancer, because 16 they do not pick up lung cancer sufficiently 17 early to be of any real benefit. 18 Q. Is it your opinion that his lung 19 cancer -- or do you have an opinion as to 20 whether his lung cancer was caused by his 21 history of smoking? 22 A. It's the only risk factor that we can 23 identify. 24 Q. I recognize that that may be a risk 25 factor, but do you hold an opinion in this case</p>	<p style="text-align: right;">Page 95</p> <p>1 better in the lower stages. 2 Q. And the same question in terms of 3 diagnosing a patient with lung cancer that's 4 more likely than not caused by smoking, is the 5 prognosis for that patient better if it's 6 diagnosed at Stage 3 as opposed to at Stage 4? 7 A. I doubt there is much difference. 8 Q. Are you able to state to a reasonable 9 degree of probability that there is no 10 difference between the long-term survival 11 between Stage 3 -- 12 A. I would say the prognosis is quite 13 poor in both situations, but I cannot give you a 14 quantitative estimate. 15 Q. Would you agree that it's worse in 16 Stage 4 than it is in Stage 3? 17 MR. WARNER: Objection. He has 18 answered that question twice now and you keep 19 asking the question repetitively. 20 Doctor, answer the question again for 21 the third time. 22 MR. MISHKIND: I wish you would 23 listen to the question because it isn't the 24 third time, but I do appreciate hearing from you 25 ever once and a while, Rob, but go ahead.</p>
<p style="text-align: right;">Page 94</p> <p>1 as to whether or not his -- 2 A. I think it likely had a connection. 3 Q. And is that opinion to a reasonable 4 degree of probability that his smoking caused 5 the cancer or are you not able to state it to a 6 probability? 7 A. By probability, more likely than not, 8 I would say yes. 9 Q. Even though his smoking may have 10 caused his cancer, certainly you would agree 11 that if the smoking caused the cancer and the 12 cancer was diagnosable at an early stage, 13 Stage 1, that's better than diagnosing it at 14 Stage 4; true? 15 A. If it is in fact truly Stage 1, it is 16 better to diagnose Stage 1 than Stage 4. 17 Q. And can we agree also that if the 18 lung cancer, which more likely than not is 19 caused by smoking, is diagnosed at Stage 2, that 20 the prognosis for the patient is better than 21 diagnosing it at Stage 4? 22 MR. WARNER: Objection. 23 A. In a large group of patients with 24 cancers that are not necessarily all the same, 25 there is the general tendency for survival to be</p>	<p style="text-align: right;">Page 96</p> <p>1 A. Repeat the question. 2 Q. You really want me to? 3 A. You want me to repeat the answer, I 4 would like you to repeat the question. 5 Q. Are you saying that the prognosis for 6 survival in a patient with Stage 4 lung cancer 7 is no different than prognosis for a patient 8 with Stage 3? 9 A. Well, prognosis is really a doctor's 10 estimate of the outcome. For a given patient 11 with lung cancer staged correctly, no, in terms 12 of just simply clinical evidence. But if in 13 fact the cancer is truly Stage 1, the prognosis 14 is better than Stage 2. 15 The problem is that we often do not 16 know the cancer is truly Stage 1. The clinical 17 tools for staging cancer are rather crude and 18 can only detect tumor at distant sites which has 19 reached a certain size, which means it 20 metastasized there well in advance of when it 21 was found. 22 Q. All things being equal, staging being 23 accurately performed and consistently performed, 24 is it your testimony that the long-term survival 25 for the same patient is no different whether</p>

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1 they are diagnosed accurately at Stage 3 as
2 opposed to being diagnosed accurately at
3 Stage 4?

4 A. I think a patient with Stage 4 would
5 have a worse prognosis, because their tumor has
6 progressed farther.

7 Q. If a chest x-ray had been repeated by
8 you in January, do you have an opinion to a
9 reasonable degree of probability what it would
10 have demonstrated, knowing what you know as of
11 July in terms of the diagnosis of the nonsmall
12 cell carcinoma?

13 MR. WARNER: Objection. Asked and
14 answered. You went through a whole thing as to
15 why didn't he do one in January and what would
16 it show, but go ahead.

17 MR. MISHKIND: Rob, I have never
18 asked this question.

19 Q. If a chest x-ray had been ordered in
20 January, do you have an opinion, knowing what
21 the diagnosis was in July when the chest x-ray
22 and CAT scan were done, do you have an opinion
23 as to what it would have shown?

24 A. It probably would have shown an
25 infiltrate in the left upper lobe or the left

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1 A. You know, I have not seen subsequent
2 x-rays since the initial one taken and I do not
3 know for a fact that what we saw on the initial
4 x-ray in December was the same infiltrate that
5 they saw later on. I have no way of determining
6 that.

7 Q. Is it fair to say that based upon
8 what knowledge you have at this particular point
9 that you do not know as of February what a chest
10 x-ray would have shown?

11 A. No, because I do not know if what we
12 saw on the initial x-ray was a pneumonia
13 resulting from bronchial obstruction by a tumor,
14 or whether the infiltrate was tumor itself.

15 Q. How would one go about
16 differentiating bronchial obstruction due to
17 tumor versus just an infiltrate from pneumonia?

18 A. Ultimately, you need a bronchoscopy.

19 Q. Do you have an opinion based upon the
20 stage of Dan's cancer, Stage 4, in July, as to
21 how long he likely had this bronchogenic
22 carcinoma?

23 A. I would imagine it has probably been
24 there for a year or more.

25 Q. And do you have an opinion, assuming

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1 upper lung.

2 Q. And if it had shown infiltrate in the
3 left upper lobe or left upper lung, would you
4 more likely than not have ordered any further
5 diagnostic studies at that time, including, but
6 perhaps not limited to a CAT scan?

7 A. No. I probably would repeat the
8 x-ray in a more reasonable interval.

9 Q. And that being?

10 A. Maybe a month.

11 Q. Let's go to February.

12 A. Assuming that the second rather
13 inappropriate x-ray were abnormal, I would wait
14 at least a month before doing another one.

15 Q. So you would say that it would be
16 inappropriate to have done one in January?

17 A. In January, I think so.

18 Q. Fair enough. I hear you. Let's go
19 to February.

20 A. Okay.

21 Q. Again, having the benefit of knowing
22 what the diagnosis was in July, if an x-ray had
23 been done in February, what is your opinion more
24 likely than not as to what the chest x-ray would
25 have shown?

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1 it was subject to being diagnosed in December or
2 January, how that would have impacted, if at
3 all, his likelihood of survival?

4 A. I doubt it would have a significant
5 influence.

6 Q. Tell me why you say that.

7 A. I think he had a highly malignant,
8 aggressive tumor that metastasized quite early
9 in the game, and that metastasis is often
10 determined more by the biologic nature of the
11 tumor and the patient's immune system than it is
12 by simple size or what is often inaccurate
13 staging of the tumor.

14 Q. Is it fair to say then that if you
15 had done things that you believe were not
16 indicated, but had you done a repeat chest
17 x-ray, or a CAT scan, and came upon the
18 diagnosis of bronchogenic carcinoma in January,
19 is it your opinion, and correct me if I am
20 wrong, that he more likely than not would have
21 had metastatic disease at that time?

22 A. I think he likely had metastatic
23 disease at that time.

24 Q. And do you have an opinion as to what
25 likely would have been the stage of his

25 (Pages 97 to 100)

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1 bronchogenic carcinoma if it had been diagnosed
2 in January?

3 A. Well, the stage again is a clinical
4 evaluation which requires metastatic tumor
5 reaching a certain size to be demonstrable, so I
6 don't have an opinion on that.

7 I have the opinion on a biologic
8 basis that cells had metastasized by that time.
9 Whether they would have been clinical apparent
10 on the current staging tools which are rather
11 crude, I don't know.

12 Q. And in terms of, for lack of better
13 terminology, his likelihood or his chance of
14 survival comparing July to January, if the
15 bronchogenic cancer had been detected in
16 January, irrespective of the staging issue, is
17 it your opinion, and correct me if I am wrong,
18 that he likely would have had the same morbidity
19 and mortality in January?

20 A. I believe that the tumor had already
21 spread to the sites where it became apparent and
22 that any resection of the primary tumor would
23 have simply added more morbidity without any
24 real benefit.

25 Q. Those opinions that you are providing

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1 A. No. I think he had no control over
2 the outcome at that time.

3 Q. So if his cancer was caused by the
4 smoking, that's one thing, but in terms of him
5 causing or contributing to the outcome once he
6 was seen in December or January, you are not
7 critical of him for that period of time after
8 December or January; true?

9 A. Well, I do not know what Dan did
10 during that interval. I don't know what
11 symptoms he might have had that he did not
12 report, because there was a big gap from early
13 January until, what was it, June or July before
14 he saw me. He may have had symptoms that he
15 perhaps denied or was afraid to report. He may
16 have felt fine. I don't know what took place
17 during that interval, so it's very hard to
18 comment on what actions he might have taken,
19 what difference it might have made, but likely
20 very little.

21 Q. I guess your last point is,
22 irrespective of his symptoms, it's your opinion
23 that --

24 A. I think the horse was out of the barn
25 in December.

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1 to me are based upon your clinical experience?

2 A. My clinical experience, and just
3 reading the general history on the treatment of
4 lung cancer.

5 Q. Did you read the general literature
6 on the treatment of lung cancer in connection
7 with this case?

8 A. No.

9 Q. Are you able to cite me to any
10 articles in the general medical literature on
11 the treatment of lung cancer that you believe to
12 be supportive of what you have just told me?

13 A. Not at this time.

14 MR. MISHKIND: Let me check my notes.
15 I may be done.

16 (Discussion off the record.)

17 Q. Just a couple final questions.

18 I understand what you have told me in
19 terms of to a probability that Dan's lung cancer
20 was caused by his history of having been a
21 smoker. Is there anything that you believe Dan
22 did beginning in December of 1999 and January of
23 2000 with regard to the follow-up for the
24 diagnosis of pneumonia that caused or
25 contributed in any way to his outcome?

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1 Q. As you were getting progress notes,
2 were you monitoring what he was going through,
3 even though you weren't calling and seeing him,
4 but were you keeping up to date?

5 A. Not specifically, but I get these on
6 many of my patients, I get stacks every day on
7 reports from specialists and I read through them
8 and file them in the chart.

9 Q. I guess what I'm trying to understand
10 is, here is a man that had been your patient for
11 ten plus years, who has a diagnosis of cancer,
12 and then you are getting copies of reports back.
13 Did you no longer consider him to be your
14 patient at that time?

15 A. I think Dan no longer considered me
16 to be his doctor at that time.

17 Q. Tell me why you say that.

18 A. He switched his treatment. When
19 people get serious diseases like that and they
20 are being treated at a specialty center, they
21 tend to just concentrate there.

22 Q. Did you have any conversations with
23 him where you and he discussed any aspect of the
24 diagnosis?

25 A. I don't recall. If it's not

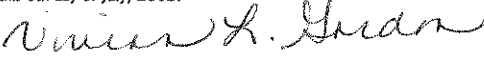
<p>Page 105</p> <p>1 documented in the chart that I saw him, then I 2 didn't, but I would have to look through the 3 chart about any subsequent visits. 4 Q. Looking at the notes for his 5 treatment and what have you, do you have enough 6 understanding of what a cancer patient goes 7 through with the type of treatment? 8 A. Oh, yes, I know all too well. 9 Q. Is this a personal situation? 10 A. Well, my father died of lung cancer 11 or he had lung cancer and died of cancer of 12 unknown cause about three years ago, but I have 13 had many, many of my patients die with terminal 14 cancer. 15 Q. So you know? 16 A. I am well familiar with what they go 17 through and the toxicity of treatment and the 18 myriad of ways that they can make you miserable. 19 Q. From what you can tell, looking at 20 the records, was his course, if you will, from 21 the time the cancer was diagnosed through his 22 treatment, was this a man that went through a 23 lot of suffering? 24 MR. WARNER: Objection. If you know. 25 A. I think he did. I think all cancer</p>	<p>Page 107</p> <p>1 MR. WARNER: I will have him read it. 2 ----- 3 (Deposition concluded at 4:40 p.m.) 4 (Signature not waived.) 5 ----- 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25</p>
<p>Page 106</p> <p>1 patients go through a lot of suffering. 2 Q. Is there anything else relative to 3 his treatment after he left you and was under 4 the care of, first, consultation of the Clinic 5 and then at UH that you have personal knowledge 6 of other than copies of consults? 7 A. No. 8 Q. And after his death, you have never 9 discussed the case with any family members or 10 physicians? 11 MR. WARNER: Objection. Asked and 12 answered. 13 A. No. 14 Q. Is there anything about any of the 15 visits in December, the two visits in December 16 of '99, the visit in January, the passing, 17 perhaps, in the hall when the Kenalog shot was 18 given in May, and then the visits in June and 19 July that you recall that we haven't already 20 talked about? 21 A. No. 22 MR. MISHKIND: Doctor, I have no 23 further questions for you. Thank you for your 24 time. 25 Do you want to reserve signature?</p>	<p>Page 108</p> <p>1 AFFIDAVIT 2 I have read the foregoing transcript from 3 page 1 through 107 and note the following 4 corrections: 5 PAGE LINE REQUESTED CHANGE 6 7 8 9 10 11 12 13 14 15 16 17 18 ROGER A. MANSNERUS, M.D. 19 20 Subscribed and sworn to before me this 21 day of , 2002. 22 23 Notary Public 24 25 My commission expires .</p>

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CERTIFICATE

1
2
3 State of Ohio,
4 SS:
5 County of Cuyahoga.
6
7
8 I, Vivian L. Gordon, a Notary Public within
and for the State of Ohio, duly commissioned and
9 qualified, do hereby certify that the within
named ROGER A. MANSNERUS, M.D. was by me first
10 duly sworn to testify to the truth, the whole
truth and nothing but the truth in the cause
11 aforesaid; that the testimony as above set forth
was by me reduced to stenotypy, afterwards
12 transcribed, and that the foregoing is a true
and correct transcription of the testimony.

13
14 I do further certify that this deposition
was taken at the time and place specified and
was completed without adjournment; that I am not
15 a relative or attorney for either party or
otherwise interested in the event of this
16 action. I am not, nor is the court reporting
firm with which I am affiliated, under a
17 contract as defined in Civil Rule 28 (D).
18 IN WITNESS WHEREOF, I have hereunto set my
hand and affixed my seal of office at Cleveland,
19 Ohio, on this 8th day of July, 2002.

20 
21
22 Vivian L. Gordon, Notary Public
23 Within and for the State of Ohio
24 My commission expires June 8, 2004.
25

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