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First Name	Roger A.
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IN THE COURT OF COMMON PLEAS
OF CUYAHOGA COUNTY, OHIO
- - - - -
WILLIAM J. GILL, III,
Executor of the Estate
of DANIEL P. GILL,
deceased,

Plaintiff,

vs Case No. 457639

ROGER A. MANSNERUS, M.D.,
et al.,
Defendants.
- - - - -
DEPOSITION OF ROGER A. MANSNERUS, M.D.
THURSDAY, JUNE 27, 2002
- - - - -
Deposition of ROGER A. MANSNERUS, M.D., a Defendant herein, called by counsel on behalf of the Plaintiff for examination under the statute, taken before me, Vivian L. Gordon, a Registered Diplomate Reporter and Notary Public in and for the State of Ohio, pursuant to agreement of counsel, at the offices of Reminger & Reminger, The 113 St. Clair Building, Cleveland, Ohio, commencing at 2:00 o'clock p.m. on the day and date above set forth.
- - - - -

APPEARANCES:
On behalf of the Plaintiff
Becker & Mishkind
HOWARD D. MISHKIND, ESQ.
The Skylight Office Tower Suite 660
Cleveland, Ohio 44113
216-241-2600

On behalf of the Defendant
Reminger & Reminger
ROBERT A. WARNER, ESQ.
The 113 St. Clair Building
Cleveland, Ohio 44114
216-687-1311

- - - - -

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

EXAMINATION OF ROGER A. MANSNERUS, M.D.
BY MR. MISHKIND:

Q. Would you please state your name for the record.
A. Roger Allen Mansnerus.
Q. You are a physician; is that correct?
A. Correct.
Q. What type of practice do you have, doctor?
A. General internal medicine.
Q. Have you had your deposition taken before, sir?
A. As an expert witness.
Q. On how many occasions has your deposition been taken as an expert?
A. Two or three.
Q. Are you currently serving as an expert in any cases where your deposition has been taken?
A. No. I'm due to give one next month.

Q. So that will become the third or the fourth?
A. Correct. Usually they are regarding patients that I have treated that are involved in a lawsuit against someone else.
Q. What we might refer to as a personal injury case?
A. That, or one of them was a product, drug liability case for Redux.
Q. Have you ever served as an expert witness in a medical negligence claim?
A. No.
Q. So the three to four times, including the one that's coming up, would be personal injury claims or product liability claims; is that a fair statement?
A. Correct. Medical testimony, I don't know if you consider it an expert witness to be one who testifies in those kind of trials or not. A physician is an expert witness if he is testifying about medicine.
Q. Your testimony was on behalf of your patient in those two to three past situations or not?
A. Well, no. One of them was actually

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by the drug company, defending against a class action suit. And they had a deposition regarding a patient that I treated with that drug.

MR. WARNER: Don't give us any names of patients.

THE WITNESS: I won't. I don't remember the name.

Q. That was a case that your deposition was taken in that matter; correct?

A. Correct.

Q. And who was the drug company that --

A. I don't remember the company. They were the manufacturers of, I believe it was Redux, the diet drug that caused the heart valve problems allegedly.

Q. How long ago, doctor, would you say it was that you had your deposition last taken?

A. Two to three years.

Q. The matter that's coming up within the next month, is that in connection with a patient of yours?

A. A patient of mine, correct.

Q. That has a personal injury action pending?

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A. Correct.

Q. You are testifying then as it relates to the care and treatment of that patient; correct?

A. I don't know what I am testifying about.

Q. You have been asked by that patient's attorney --

A. Yes.

Q. -- to give deposition testimony?

A. Yes.

Q. Is it fair to say that this is the first time that your deposition has been taken in connection with a medical negligence matter?

A. Yes.

Q. Have you ever served as an expert witness where you have been asked to provide opinions either to a patient's lawyer or a doctor's lawyer in connection with any medical negligence matters?

A. I don't believe I have.

Q. In reviewing the interrogatory answers that you provided through Mr. Warner, the indication in the answers was that you have not previously been named as a defendant in a

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medical negligence case.

A. Correct.

Q. Does that still stand?

A. With the exception of this case.

Q. So the Gill matter is the one and only time that you have been served with papers naming you as a defendant in a medical negligence case?

A. Yes.

Q. Have you ever had your hospital privileges suspended, revoked, or called into question?

A. The only suspension is at hospitals if you were behind so many days on completing your charts, you are put on suspension, but that does not relate to your practice of medicine.

Q. And once you complete the dictation, then your privileges were reactivated?

A. Automatically restored, correct.

Q. Other than that kind of situation --

A. No, no other suspensions.

Q. On how many occasions have you had the misfortune of the hospital saying you haven't finished the chart; therefore, until you do so, your privileges are suspended?

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MR. WARNER: Note my objection.

MR. MISHKIND: That's fine.

MR. WARNER: If you know.

A. It's a fairly frequent occurrence for all physicians. They have a suspension list on the door of the lounge at St. John West Shore Hospital. I would say probably a couple times a year.

Q. Have you ever applied for privileges at a hospital and been denied?

MR. WARNER: Objection.

A. I have never been denied.

Q. In looking at your CV, which again your attorney was kind enough to provide to me, I note that you had hospital privileges at University Hospitals up until sometime in the year 2000?

A. Actually, I still do. I don't make use of them, but I just recently got my reappointment.

Q. The CV that I have that your attorney provided to me is dated January 5, 2001. So it's a little bit over a year and a half old or thereabouts.

Are there more current versions

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than --
A. No, there is nothing more up to date than that.
Q. To bring it up to date, though, we would have to change where it says work experience, staff, University Hospitals of Cleveland, department of medicine, 1995 to 2000, would that need to be altered or is that accurate?
A. Well, technically I am still on the staff but I do not practice medicine there. I could admit patients there if I chose to, but I just keep it current because it's easy to do and doesn't cost anything.
Q. You are not a staff -- you are not on the staff at University Hospitals of Cleveland at this point?
A. See, there are two things. I previously practiced with University Primary Care Practices, and as part of that, you were named an instructor at Case Western Reserve School of Medicine and also had privileges at the hospital. I'm not even sure at this moment if I have privileges at the hospital or am just an instructor in the department of medicine. I

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would have to go back to my record and clarify that because it's not really relevant to what I do.
Q. What was the purpose of you preparing this CV as of January, 2001?
A. I believe our group practice wanted everybody to have an up-to-date CV for credentialing purposes.
Q. As a clinical instructor, was this supervising residents?
A. It was, in the event that I would have occasion to.
Q. Do you currently supervise interns or residents in your practice?
A. I have a limited amount of supervision at Fairview and St. John West Shore Hospitals, because they have teaching services and they often see the patients that I admit there, so I supervise them to that extent, but I'm not a regular instructor at either of those hospitals.
Q. Do you have any teaching responsibilities at the medical school?
A. No.
Q. Have you at any time had any teaching

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responsibilities at Case Western Reserve?
A. No.
Q. So as an instructor, it has been in a clinical capacity as opposed to classroom capacity?
A. Correct.
Q. Within the area of internal medicine, do you have an area that you subspecialize in?
A. No.
Q. We are obviously going to be talking about the period the end of 1999 and the early part of 2000 with regard to Dan Gill, and for that matter, some of the time period before that.
But since late '99, early 2000, and then jumping ahead to 2002, June 27th, has your practice changed in any way in terms of the patient population that you see?
A. Not appreciably.
Q. Back in December of '99, you were affiliated with Westshore Primary Care?
A. Correct.
Q. And were you an employee of Westshore Primary Care Associates?
A. Yes.

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Q. Are you still an employee of Westshore Primary Care Associates?
A. Yes.
Q. Are you employed by any other professional associations or professional corporations other than Westshore Primary Care?
A. No.
Q. At Westshore Primary Care, do you have other physicians that you practice with?
A. Yes.
Q. Who are they, please?
A. Well, there is roughly 25 in the group.
Q. I'm not going to have you name all of them. Are there different offices?
A. Yes. We have, I believe, now six different offices with practicing physicians.
Q. Is Westshore Primary Care Associates owned by a larger entity at this time?
A. They have a rather complicated arrangement that I don't fully understand with St. John West Shore Hospital where I believe in some fashion they are held in trust but able to terminate the agreement any time they wish.
Q. Do you know whether the arrangement,

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this complicated arrangement that I'm not going to have you explain to me was in existence back in '99 and 2000, or has that come about since?
A. I believe that was in existence then.
Q. On your CV you have Health Campus Drive as the address, Suite 2, and to be specific, 29325 Health Campus.
A. I am no longer in that office.
Q. Where is your office now, sir?
A. I relocated in December of last year to 960 Clague Road in Westlake, and I also moved out of my Lakewood office at that time. I previously maintained two offices, one at Lakewood and one out near St. John West Shore Hospital and those were consolidated into one office.
Q. And that's the Clague Road?
A. Correct.
Q. Mr. Gill had been a patient of yours from about 1989 forward?
A. Yes.
Q. True?
A. Yes.
Q. During that time, was he seen at one particular office or a number of offices, as

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best as you can recall?
A. Certainly the majority of times would have been in the Lakewood office, but it's possible that because I was only in one office on a given day that I might have seen him on occasion in the Westlake office.
Q. Is it fair to say the majority of the offices would have been Lakewood?
A. Yes, I believe he lived in Lakewood or close by.
Q. You are board certified in internal medicine; is that true?
A. Yes.
Q. Do you have any other board certifications?
A. No.
Q. Were you successful in becoming board certified on your first attempt?
A. Yes, I was.
Q. Is there a recertification process that you are eligible for?
A. Not that I am required to do. More recent graduates, I believe, have a recertification process, but I was recertified prior to the date when that was initiated.

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Q. I think the term is you were grandfathered?
A. Correct.
Q. So that your certification which occurred in '77 is grandfathered such that you don't have to sit for recertification; true?
A. Yes.
Q. Doctor, let me just caution you. Since you haven't had your deposition taken a lot, and certainly not in this context -- thus far you and I are getting along fine -- in fairness to you, wait until I am done with my question, and also for Vivian's benefit, before you start answering so you don't give an answer before I'm done.
A. Okay.
Q. Sometimes you may wonder whether I am ever going to finish my question, but answering earlier than I finished wouldn't shorten my question.
A. Okay.
Q. Have you ever authored or co-authored any articles in any medical journals?
A. No.
Q. Have you ever authored or co-authored

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or contributed to any book chapters, any books, or anything that has been published in any capacity in the medical world?
A. No.
Q. Have you submitted anything on any medical topics that have been published in any community or association type of newsletters or publications?
A. Not that I recall.
Q. A moment ago you told me you have a general practice. Over the years, have you developed any type of an interest in any particular area of medicine?
For example, is your practice more of an adult practice as opposed to a pediatric or an adolescent practice?
A. It is not pediatric at all. It is mostly adult. Certainly patients 16 and over. Most of them are over 21.
Q. And by interest or circumstance, have you sort of gravitated to a particular patient profile, if you will, in terms of seeing diabetics or seeing patients with coronary artery disease or something that has taken up a larger percentage of your practice?

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A. I would say that I have perhaps more of an interest in cardiovascular diseases than some of the other areas, but I would say that the types of patients I see are a reflection of the prevalent population.
Q. If I were a patient of yours, I would be coming to you for yearly physicals and other general ailments of an internal medicine standpoint; true?
A. I do both those things, correct.
Q. And then when there are issues of specialization, you refer out patients to vascular surgeons?
A. If I feel it's not in my area of expertise or I need an additional opinion, I do refer to specialists and subspecialists outside of my area.
Q. Have you ever held yourself out as having any expertise in any areas other than in general internal medicine?
A. Any other areas of medicine?
Q. Other than internal medicine. In other words, have you held yourself out as having expertise in cardiovascular disease or --
A. Well, internal medicine encompasses a

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number of subspecialties, cardiovascular, rheumatology, pulmonology, dermatology, allergy, nephrology. It's a very broad field.
Q. I guess what I am getting at -- and you have touched on some areas, rheumatology, dermatology -- do you hold yourself out in the community as being an expert in those arenas?
A. I do not hold myself out to the public in that respect, no.
Q. Currently your privileges would be at what hospitals, doctor?
A. At St. John West Shore Hospital in Westlake, Lakewood Hospital in Lakewood, and Fairview Hospital in Cleveland. I'm a little uncertain about my status at University since I don't attend there.
Q. Do you spend most of your admitting time at one or more of those hospitals?
A. No. I use all three. It varies according to the call schedule where I have the majority of my patients.
Q. Are you a member of any professional associations?
A. No.
Q. Have you been a member of any

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professional associations?
A. I have been a member of the AMA at times in the past.
Q. What about any local medical associations?
A. I believe at one time when I was with the AMA, we were also part of the Ohio State Medical Association.
Q. You currently are not a member of either of those organizations?
A. No.
Q. Is there a reason that you are not a member?
A. It's very expensive.
Q. Is that the sole reason?
A. That's the main reason, correct.
Q. Is there another reason besides cost that you are not a member of either of those organizations?
MR. WARNER: Objection. Go ahead and answer.
A. Primarily cost.
Q. And again, I understand that. I want to find out whether there are any other factors besides cost that enter into your decision not

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to be a member?
A. No.
Q. You are a member and have been since 1993 of the medical practice committee of St. John West Shore; correct?
A. Correct.
Q. Tell me what that committee's purpose is.
A. The committee reviews the clinical care provided by people in the department of medicine at that hospital with regard to adequacy of treatment. They review all deaths within the hospital. There are certain criteria that the joint commission requires hospitals review and that changes from year to year.
Q. So I take it you are involved in M&M meetings?
A. Yes. They are along that line or there may be specific issues where the quality of care is a question.
Q. All matters that are considered to be peer review type of situations?
A. Correct, that is a peer review activity.
Q. And you still participate in that

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committee?
A. I'm the chairman.
Q. And actually have been that since '93?
A. I have been the chairman since probably '96 or so. I don't remember the exact year I assumed the chairmanship.
Q. I take it you remember Dan Gill?
A. Yes.
Q. I'm sure you are aware that William Gill, Dan's nephew, was deposed this morning; true?
A. No, I was not aware of that.
Q. Have you had occasion prior to Dan's death in February of 2001 to have had any other family members in your practice?
A. Yes, I believe his mother, Mary Gill, was a patient.
Q. Is Mary, his mom, to your knowledge, still a patient?
A. No.
Q. Do you know whether she stopped being a patient before or after Dan died?
MR. WARNER: Note my objection. I mean, you brought this claim on behalf of

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Mr. Gill. I sort of let you ask these questions, but now you are going to get into, I think, patient confidentiality here, and I don't want to have -- I don't think you represent Mary Gill, so you have enough that it was a patient and why she did something or didn't do something, and I'm going to instruct him not to answer that question. I don't really think it's relevant to this case.
Obviously, you can approach her yourself and ask her if you somehow feel it's germane, unless you represent Mary Gill and have a waiver.
(Discussion off the record.)
MR. MISHKIND: For the record, so it's not misrepresented, I am the attorney for the estate in connection with this lawsuit and as such I represent all potential beneficiaries under the wrongful death statute, which would include Mary.
MR. WARNER: Can you indemnify and hold as harmless? Is that what you are going to say?
MR. MISHKIND: Certainly I would, but I understand your concern and I wasn't planning

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on asking why she left the practice.
MR. WARNER: Good.
MR. MISHKIND: My question was, whether you permit him to answer or not, was whether she left the practice before or after Dan Gill's death. I mean, if you are still going to instruct him not to answer it, we will move on. I think that it's a proper question to ask. He may not recall whether he did --
THE WITNESS: Can I say something in general off the record?
MR. WARNER: There is no such thing. It doesn't exist. She is writing it down now.
THE WITNESS: I don't formally know when people leave the practice unless they request records be transferred, because people may not show up for two or three years because of insurance reasons and other things.
MR. WARNER: You don't know is what you are saying.
THE WITNESS: Knowing who is in the practice is not really -- if I have seen somebody recently, I can assume they are in my practice. If I have not seen them, it doesn't necessarily mean they have left the practice, it

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just means I have not seen them.
Q. Doctor, aside from Mary, Dan's mom, to your knowledge, have any other family members been a patient of yours?
A. I am not sure. I possibly had -- I may have seen one of his sisters at some time in the past, but no time in recent memory.
Q. At any time while Dan was a patient of yours prior to his being diagnosed with lung cancer, did you ever have a conversation with any family members concerning his condition?
A. Not to my recollection.
Q. After Dan was diagnosed with lung cancer and then started his course of treatment, up to the time of his demise, did you have any conversation with any family members at all about Dan's condition?
A. As I recall, on one subsequent follow-up, one or two of his sisters may have accompanied him to the office and possibly had a few questions. I don't recall the details.
Q. This would have been after the diagnosis of cancer or before?
A. After.
Q. Are you able by looking at your chart

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to determine what visit that was that one or two of his sisters accompanied him to?
A. No, I would not normally record that information.
Q. This is something you remember independently; true?
A. Correct.
Q. Do you have a recollection in general -- because I think you said you don't remember the specifics -- but do you have a recollection in general about the type of questions that one or both of his sisters asked you on that visit?
A. Questions they had would have been along general medical lines; perhaps regarding referrals to various institutions. I don't recall the specifics.
Q. Do you recall any discussions that either were initiated by one or both of the sisters or initiated by you surrounding the issue of the diagnosis of his cancer and the timeliness, if you will, of the diagnosis?
A. We did not discuss that.
Q. Other than this conversation with one or both sisters on a subsequent visit after the

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diagnosis was made, were there any other occasions where you had any conversation in specific or in a general nature with any family members about Dan Gill?
A. No, I do not recall any further contacts with any family members.
Q. After Dan's death, did you have any contact with any family members discussing with them directly anything about his medical care and circumstances surrounding his cancer?
A. No, I have had no contact with them.
Q. Have you initiated or attempted to initiate any communication with the family at any time prior to this lawsuit to talk with any family members, his mom, brothers and sisters, just about your patient?
A. No.
Q. Do you have a recollection of when you learned that Dan had died?
A. I don't recall how that information came to my attention.
Q. Do you know whether the information came to your attention through the newspaper or through some source?
A. As I recall, the oncologist was

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sending me copies of their progress notes from University Hospital regarding Dan's treatment, since I was considered to be one of the referring physicians.
Q. And is it your supposition that the fact of his death was brought to your attention either by one of the doctors or someone from University Hospitals, or are you just speculating?
A. I just do not recall how I learned of that.
Q. Nonetheless, you think you learned of it from some medical source as opposed to reading about it in the newspaper?
A. Correct.
Q. Do you believe that you learned about it close in time to his death or was it quite a period of time after his death?
A. I do not recall the interval.
Q. When you learned of his death, did you set out to gain any further information about the immediate circumstances leading up to his death?
A. No.
Q. Did you ever talk with any of the

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doctors at University Hospitals or at The Cleveland Clinic in person?
A. Not in person.
Q. Did you ever talk with any of the doctors at University Hospitals or Cleveland Clinic over the phone relative to Dan's diagnosis?
A. I do not recall any specific conversations.
Q. You received copies of various portions of the records?
A. Correct. That's typically how the specialists at University Hospitals and Cleveland Clinic communicate, is by sending copies of their progress notes.
Q. And I see -- we won't go through all of the various entries -- but I see that you are cc'd and some other people may be cc'd on that. You would get that information periodically, so you were somewhat aware of what Dan was going through; true?
A. Yes. I would know that from reading the progress notes.
Q. Is it your testimony, however, that other than reading the progress notes that you

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would receive as one of the referring physicians, that you didn't have any personal consultation or direct communication with any of those doctors to gain any further information from them?
A. I do not recall.
Q. While Dan was treating at University Hospitals, were you ever requested to provide any medical records to any doctors that were following his care?
A. I do not recall.
Q. In looking through the records -- which I think you may have provided a copy to me, and certainly if not you, Mr. Warner would have provided a copy -- I don't see any evidence that there was a direct request from University Hospitals or even from the family members for you to send over a copy of your records for the treatment of his pneumonia or any of his other treatment. Is that your recollection, as well?
A. If there was a request for records, it would very likely be documented somewhere in the chart.
Q. Did you ever talk with Dr. Olencki who was one of the doctors?

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A. I do not recall any direct conversations with him. It's possible that he called me and I simply don't remember the details.
Q. Is it fair to say that you don't recall ever providing him with any type of a history, either by way of documents or verbal history on the patient?
A. I don't recall what I may or may not have provided him.
Q. So it would be pure speculation on your part to say that you did provide him with something; is that true?
A. Correct.
Q. I want to back up for a second. I'm not trying to jump all over the place. If I move from one area to another, I'll try not to make it a moving target. I'll let you know where I'm going.
A. Okay.
Q. I want to go back in time and the next topic can sort of be called what have you reviewed for purposes of this deposition. And with that in mind, I take it you have looked at your chart; true?

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A. I have reviewed my office notes from that period.
Q. Have you looked at any of the records, other than those that you were cc'd on from University Hospitals or The Cleveland Clinic?
A. No.
Q. So information that you have in your chart relative to his treatment after June or July of 2000 would consist of consult notes and things that you were kind enough to be copied on by the doctors; true?
A. They routinely provide the referring physicians copies of their notes, which are really quite detailed.
Q. Sure. Have you reviewed any medical literature in preparation for today's deposition?
A. No.
Q. You, I presume, subscribe to journals?
A. I subscribe to some, and I review others in the medical library. I read many abstracts that appear in various publications, medical newsletters.

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Q. Tell me which journals in the area of internal medicine do you subscribe to.
A. I receive regular copies of the Journal of the American Medical Association, and the Archives of Internal Medicine. And I have regularly listened to the Audio Digest Tapes.
Q. Who publishes the Audio Digest Tapes?
A. It's the California Medical Association.
Q. And other publications are available to you?
A. If I wish to locate them, yes.
Q. And you would go to the library as opposed to receiving them on a subscription basis?
A. Correct. Other sources, we have weekly lectures at Lakewood Hospital called medical grand rounds where local experts come or visiting experts also come and lecture on specific topics.
Q. Do you hold yourself out in the community as an expert in the treatment of cancer?
A. No.
Q. Do you have any patients that you

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follow currently in your practice that have confirmed diagnoses of some form of lung cancer?
A. Yes.
Q. It's my understanding that Dan had nonsmall cell carcinoma of the lung?
A. Correct.
Q. Do you have any patients that you follow currently that have nonsmall cell carcinoma of the lung?
A. Yes.
Q. I'm not going to ask you names and medical history, but just give me an idea of how many such patients do you follow?
A. That are currently living?
Q. Yes.
A. I probably have three at the present time.
Q. Any as young as Dan?
A. No.
Q. Are most of these patients in their 60s or 70s?
A. Yes.
Q. Have you ever had a patient in your practice that was as young as Dan with a diagnosis of nonsmall cell carcinoma of the

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lung?
A. Not that I remember.
Q. From your knowledge and reading and experience, is the prognosis for a patient with a diagnosis of nonsmall cell carcinoma, Stage 1, better in a younger patient than an older patient?
A. Can you restate that question again?
Q. Sure, I'd be happy to. In terms of your knowledge base and your experience, is the prognosis for a patient that's diagnosed with a Stage 1 nonsmall cell carcinoma of the lung, is that patient's prognosis better for a younger patient than a patient with the same diagnosis that is older in their 60s or 70s?
A. Not necessarily.
Q. What factors, from your experience, determine the long-term survival of patients that have Stage 1 nonsmall cell carcinoma?
A. One would be whether in fact it is a correct stage. I think many times tumors diagnosed as Stage 1 are, in fact, more advanced.
There would be some commonly young patients who get tumors that are commonly seen

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in older people, and they have some immune deficiency that predisposes them to cancer or impairs their ability to fight it, and they may actually do worse at some times, as a younger woman with breast cancer.
Q. Did Dan have any autoimmune deficiencies or other deficits in his immune system that would negatively affect his prognosis regardless of the stage of his cancer?
A. Well, Dan did have a history of, as I recall, of allergic rhinitis, which is a disorder of the immune system, though not a deficiency.
Q. Is there anything about that that you can state to a reasonable degree of probability that would make his prognosis with his age and any comorbidities that he had worse than any other patient of his age at the stage that his cancer was?
A. I'm not aware of any correlation.
Q. Based upon your knowledge --
(Telephone interruption.)
Q. Are you aware of any studies that you consider to be reliable in the literature that comment on the prognosis for patients that are

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diagnosed with nonsmall cell carcinoma?
A. Well, the prognosis for all forms of lung carcinoma are uniformly poor.
Q. Would you agree that Stage 1 nonsmall cell carcinoma prognosis following resection is more favorable than Stage 2 or Stage 3 or Stage 4?
MR. WARNER: Objection. You can answer if you can.
A. Only if it is, in fact, truly Stage 1.
Q. Again, assuming the diagnosis is made in Stage 1 and there is resection done at Stage 1 and it's confirmed, do you know what the medical literature suggests to be the prognosis for a patient?
A. I do not know the estimated five-year survival figures for that circumstance. Nonsmall cell is not a uniform tumor type either. There's a whole collection of tumors with different prognoses.
Q. Do you know the histological type of nonsmall cell carcinoma that Dan Gill had?
A. They always referred to it simply as nonsmall cell.

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Q. Do you have an opinion as to the prognosis for the type that you are aware, from what you have seen, of his nonsmall cell carcinoma, if, in fact, it had been diagnosed truly in a Stage 1 category?
A. I don't know the exact figures.
Q. Do you know, based upon your knowledge and experience and readings, what the ranges are that are reflected in the literature in terms of survival for Stage 1, nonsmall cell carcinoma?
MR. WARNER: Objection. Go ahead and answer if you know.
A. Again, if we are assuming that this Stage 1 is indeed accurate -- because even one cell having metastasized would be a different prognosis. Stage 1 does not mean it's a limited disease, and therefore I think the five-year survival rate would be different even if a micrometastasis had occurred, perhaps.
I do not know how they use these terms, but if somebody goes five years and no metastatic disease has showed up, that would certainly mean it was indeed the Stage 1. And whether they use those criteria in these

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studies, I don't know, but a tumor that has not metastasized would definitely have a better prognosis for local recurrence from one that had.
Q. And the studies and the source of the information that you have gathered with regard to Stage 1 versus micrometastasis, which would take it out of the Stage 1 category, where have you come up with that information? Is it cancer journals or medical journals?
MR. WARNER: Objection. Go ahead.
A. These figures are widely quoted in different articles. I don't have a single source that I could refer to.
Q. In the course of this case, have you looked back at any medical literature to familiarize yourself with the staging on nonsmall cell lung cancer?
MR. WARNER: Objection.
A. I haven't reviewed that specifically. The staging of most cancers is similar. There are several different ways of staging, but basically there are tumors that are localized, without evidence of spread, there are tumors that have adjacent spread, tumors that have

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nodal spread and tumors that have distant metastasis.
Q. If you wanted to get specific information on the staging criteria for nonsmall cell carcinoma, where would you start your search for that information?
MR. WARNER: Objection. Asked and answered. He already responded to that question. There are many sources.
Q. Go ahead.
A. Staging is a formal system.
Q. Are you able to cite me to any journals or any textbooks that contain the staging criteria?
A. Any textbook discussing the subject of oncology would likely list the staging criteria.
Q. You are familiar with DeVito's Cancer Textbook, are you not?
A. No, I'm not.
Q. Obviously, Harrison's Principles of Internal Medicine?
A. Harrison's I'm familiar with.
Q. I presume you own Harrison's Principles of Internal Medicine?

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A. I own it, though I don't commonly refer to it.
Q. Which other internal medicine books do you own besides Harrison's?
A. I have the Scientific American Medical Textbook, which is a three-volume series that has regular updates. Commonly I would speak with an oncologist if I wanted information in that area.
Q. Short of speaking with an oncologist, is the Scientific American, the three-volume, a fairly reliable source for some of the staging criteria?
MR. WARNER: Objection. Go ahead and answer.
A. For that kind of thing, yes.
Q. And to your knowledge, does Harrison's also have some of the staging criteria?
A. I have never looked it up specifically in Harrison's, but I would assume they all have the same criteria, since those are specified by committees.
Q. Is that the American Cancer Association?

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A. I do not know specifically who makes up the staging for lung cancer, if it's that or the Thoracic Society.
Q. From time to time do you look at Harrison's for information in the area of internal medicine?
MR. WARNER: Objection. Asked and answered. Go ahead and answer again.
A. If I have a specific question available to me, I would look it up there.
Q. And even though there are a number of other internal medicine textbooks, would you agree that Harrison's is a reasonably reliable source of information in the area of internal medicine?
MR. WARNER: Objection.
A. Reasonably reliable, but never completely up to date.
Q. Sure. Obviously, journal articles would be more up to date than a textbook; correct?
A. It would be more current, yes.
Q. But all things being equal, Harrison's is a reasonably reliable source for information in the area of internal medicine?

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A. As a starting point.
Q. Have you discussed any aspect of your medical care provided to Mr. Gill with any physicians after learning about the fact that he was diagnosed with nonsmall cell lung cancer?
A. No.
Q. Since his death, have you personally sat down, other than the conversations with your attorney, and reviewed your medical care with a view toward determining whether or not you did or didn't do what you should have done?
A. No.
Q. As you sit here right now, doctor, are there any journals, abstracts, or portions of any texts that you can cite me to that you believe to be relevant to any of the issues in this particular case?
A. None that I can specifically cite, no.
Q. Are there any guidelines that you follow or protocols that you follow in your practice in terms of follow-up on patients with diagnosis of pneumonia?
A. It is quite variable according to the patient, according to the patient's age, his

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other medical conditions, the type and extent of pneumonia, so I would say there is no one protocol that is appropriate for that.
Q. As an internal medicine specialist, board certified internal medicine doctor, are there any guidelines that you are aware of that are promulgated by any internal medicine groups that provide for standards as it relates to different types of pneumonias in terms of what the clinical signs are, what type of testing should be done, and what type of follow-up is indicated?
MR. WARNER: Objection. Go ahead and answer.
A. Various hospitals have care paths for treatment of pneumonia depending on the pneumonia, community-acquired, nosocomial, recommended antibiotic regimens. The diagnosis is fairly straightforward.
Q. Do you in your practice follow those guidelines or regimens that are used in the hospitals?
MR. WARNER: Objection. Go ahead and answer.
A. They print care plans, pathways for

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pneumonia with suggested regimens for antibiotic therapy. Most commonly when I get a patient admitted, it's through the emergency room and the house physician or the resident writes the initial orders and reviews them with me and they tend to follow whatever care path the hospital recommends.
Q. In your office setting when you are seeing a community type situation with a patient with pneumonia, do you follow a different pathway in terms of the care of a patient that is being seen in your office as opposed to a patient that is admitted to the hospital?
A. What's different is that the people I see in my office are much more likely to be healthier, have milder pneumonias. People who wind up in the emergency room tend to be older and sicker and have more complex pneumonias.
Q. What type of pneumonia did Dan Gill have?
A. A community-acquired pneumonia. You don't normally, in cases of uncomplicated community-acquired pneumonia, do studies to determine the organism. I would assume that most of the time these are pneumococcal or

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mycoplasmal organisms and there are regimens that would cover those possibilities.
Q. As a community-acquired pneumonia, do you have an opinion as to what the inciting organism was in his particular case?
A. Only in the general sense that most community-acquired pneumonias are mycoplasmal or pneumococcal.
Q. Does that fall in the category of bacterial?
A. Yes.
Q. As opposed to viral?
A. Whether viral pneumonias is common is debated. I think the community thinking is viral pneumonias are not as common as they were thought to be, because a lot of the atypical, like Chlamydia and Legionella, which were formally thought to be viral, turned out to be atypical bacterial organisms.
Q. So it's your opinion in this case, that more likely than not, his pneumonia, community-acquired pneumonia was bacterial in origin?
A. Yes, I would treat patients on that assumption.

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Q. And you provided him with Zithromax --
A. Correct.
Q. -- as an antibiotic treatment for bacterial community-acquired pneumonia; true?
A. Correct.
Q. Before we delve into December of '99, January of 2000, and then up to the diagnosis, I want to spend a little bit of time talking with you about Dan before December of '99 --
A. Okay.
Q. -- giving you sort of a road map of where I'm going.
You had treated him for some anxiety related matters over time; true?
A. Yes.
Q. I have your records. I don't need to go through all the visits.
Can you summarize for me as best as you can what the nature of his condition was? I guess starting with what your diagnosis was relative to his mental health.
A. Well, Dan did not have mental disease. I think anxiety is a common symptom and it's a spectrum in the population, and I end

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up diagnosing it and treating it to the extent it bothers the patient enough for them to come in with complaints.
I do not recall the specifics of what I may have given him for anxiety, but I would say he was just generally an anxious person and tended to worry about things more than the average patient, particularly health matters.
Q. Was he disabled in any way in terms of being able to handle his activities of daily living --
A. No.
Q. -- as a result of the anxiety?
A. No.
Q. So the anxiety --
A. Not to my knowledge.
Q. So his anxiety was controlled with medication?
A. Well, I don't recall if he took medication on any sort of a regular basis for it. I tend to think he did not. But he may have required periodic treatment for periods of increased anxiety.
Q. Did you ever refer him to a psychologist or a psychiatrist?

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A. Not that I recall.
Q. So you never felt that his anxiety was to the level that he needed to have mental health intervention; true?
A. No, I feel comfortable treating anxiety on my own.
Q. I take it there are situations where the mental health issue is such that you --
A. Severe anxiety that was not responding to treatment I would refer.
Q. That's not the case with Dan; true?
A. No.
Q. Did you ever prescribe any medication to Dan or for Dan relative to his anxiety?
A. I would have to review the record to answer that.
Q. Do you have a copy of the record with you today?
MR. WARNER: I didn't bring it down.
A. If I have prescribed anything, it would be documented in the progress notes from the office.
Q. All right. Let me ask you this, just to save some time.
Do you have a recollection of Dan

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ever being noncompliant with any aspect of your medical treatment?
A. Dan's treatments were for relatively minor self-limited conditions where compliance wasn't a big issue.
Q. So is it fair to say that there is nothing that stands out in your mind that would suggest that he would be categorized as being noncompliant?
A. Well, with regard to acute or self-limited conditions, no. With regard to chronic conditions, I couldn't comment. It's a different issue when it comes to chronic conditions.
Q. What kind of chronic conditions are you referring to?
A. Treating a patient for hypertension, for elevated lipids, and compliance becomes an issue in the long run, maybe not in the short run. But the very common drop off in compliance among the general population is in treating chronic conditions.
Q. Ativan, is that used to treat anxiety?
A. Yes.

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Q. Would .5 milligrams be a fairly mild dosage?
A. I believe that is the smallest dose they market. It's possible it comes out in a lower dose, but .5 is a low dose.
Q. Selane, S-E-L-A-N-E, is that for --
A. Seldane, perhaps? S-E-L-D-A-N-E?
Q. Perhaps I have it typed wrong.
A. Seldane is a nonstating antihistamine no longer on the market but was widely used to treat allergies.
Q. Was he on any cholesterol lowering medications that you recall?
A. I don't think he was. I recall him asking to have his cholesterol checked at some point, but I don't remember that we treated him with any drug therapy. I may have advised him on diet therapy.
Q. Dan had been a smoker; true?
A. In his younger years.
Q. During the ten plus years that he was in your practice, he was an ex-smoker?
A. I believe he quit a couple years prior to entering my practice.
Q. And as far as you know, from the time

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that he entered your practice through the time of his diagnosis, he didn't carry a history of any current or recurrent smoking; true?
A. Well, he never admitted it to me.
Q. But did you ever get the sense with Dan that he was less than candid with you in connection with any of the complaints that he had, from head to toe?
A. No. Although smokers and drinkers often do not like to volunteer those things. But I have no objective evidence that he was a smoker at the time I cared for him.
Q. And he seemed to be, at least from what I can gather -- and I'm not trying to put words in your mouth, so you tell me if I am misstating things -- but it seemed like he was a patient that was concerned about his medical condition.
For example, coming in and requesting --
A. I would say he was probably more concerned than the average patient.
Q. One example is that when he had a particular sexual partner, I see on a number of occasions, he wanted to have HIV testing done.

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A. Well, many people want that done. That's a lethal condition. I think the fact that he came in relatively frequently for a male of his age would suggest he had maybe more than the average number of concerns about his health, which was basically good.
Q. Prior to December of '99, do you have a recollection of ever treating him for any type of community-acquired pneumonia?
A. I don't recall treating him for that.
Q. Did you ever treat Dan on an inpatient basis?
A. I do not recall treating him in the hospital.
Q. You may or may not be able to answer this question. If you can't, just tell me. If you can, great.
Did Dan, as of December of 1999 or January of 2000, have any medical conditions, diseases, or illnesses that in your opinion would suggest his life expectancy, absent cancer, would have been less than a normal life expectancy?
A. Probably not.
Q. Just a couple general questions and

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

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

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

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

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by physical effort. He was able to do physical activity without symptoms.

I reiterated the smoking history. He quit in 1987; that he did not have other risk factors for heart problems, such as cholesterol or family history.

The exam essentially was normal of the heart and lungs, and I diagnosed him with noncardiac symptoms, likely related to anxiety and overuse.

Q. Overuse of what?

A. Apparently that applies overuse of the muscles of the upper trunk and upper extremity as you would see in an athlete or a weightlifter like Dan.

Q. What else did you have within your differential to explain this symptom complex?

A. That was my differential at the time. There wasn't much to suggest other possibilities at that time.

Q. In looking back at his records prior to December of '99, I don't see that he had presented at any time with the symptom complex of chest pain, numbness on the left side, pinching in the left side of the chest or left

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side of the neck.

A. Claudia, my assistant, stated the pinching feeling on the left side of the chest. That's apparently quoting his term for it. I did not use that term myself in writing the progress note.

Q. I guess my question was, in looking at what's noted in December of '99, and going back in history of your treatment of Dan, I didn't see that he had ever presented with that symptom complex.

A. He may not have, although anxious people are very frequent office visitors with those symptoms, because they elicit worries about possible coronary disease, and I think as patients get older they tend to fret about that more if somebody they know has had a heart problem or they read an article. It doesn't take much to bring them in with these things.

Q. So your differential was pretty limited at that time?

A. At that time, yes.

Q. And it was noncardiac and just sort of a muscular strain?

A. And symptoms fairly typical of

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anxiety.

Q. But yet in Dan's situation, if my statement is correct, he hadn't presented with these symptoms all grouped together before, his anxiety --

A. He did not come to my office complaining of those specific symptoms, to my recollection.

Q. But in any event, you did attribute them, at least in part, to the anxiety and part to perhaps him being a very active individual?

A. Yes. I said likely related to anxiety and overuse.

Q. Now, the complaint of left-sided chest pain with numbness of the arm, did that --

A. That's very nonspecific. Chest pain of any cause may be referred to the arm due to the way the peripheral nervous system is constructed.

Q. What else would be within your differential as a potential cause of that type of --

MR. WARNER: Note my objection. You said overuse and anxiety and he has covered that three or four times. Note my objection.

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Q. Go ahead.

A. In the absence of respiratory symptoms, pulmonary symptoms are not a significant concern with those particular symptoms. Lungs do not experience -- there are not any pain receptors in the lung proper; they are in the pleura and require a pulmonary process, something that would extend to the periphery of the lung and the pleura of the chest. Pleural pain would be experienced. His pain was really not pleuritic either. It sounded primarily musculoskeletal.

Q. Did he also have some occasional shortness of breath at rest?

A. At rest, but not with activity, which again would divert attention away from cardiac and pulmonary symptoms to, you know, noncardiac, nonpulmonary.

Q. And again within the differential, other than anxiety related, or muscle strain, what else would explain dyspnea at rest?

MR. WARNER: Note my objection. You asked this question about the fourth or fifth time and he has given the answer. He said he didn't have any more differentials and you are

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

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

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

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

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

A. No. Lung cancer does not cause chest

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

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

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

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

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

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

A. Correct.

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

A. I did not write that down.

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Q. I understand.

A. But I do emphasize that to the patient.

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

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

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

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

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

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

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

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

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

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

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

Q. Okay.

A. Other than my medical assistant's.

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

A. Claudia Conforto.

Q. Is Claudia still with you?

A. Yes.

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

A. She does not have a formal training certificate.

Q. On-the-job training?

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

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the best in the group.
Q. And is she assigned to your patients or does she see --
A. She sees primarily my patients.
Q. Why did you note in the chart on December 9 no reason for stress test? What was your thought process?
A. Just what I was going through in my mind with regard to these complaints, were they or were they not suggestive of myocardiac ischemia. I think I would say I probably gave some consideration suggested by a stress test and my answer at that time was they were not sufficiently indicative of myocardial ischemia to do a stress test.
Q. Is it fair to say that your thought process on December 9, 1999 did not include the possibility of any pulmonary involvement?
A. That was not a significant concern at that time.
Q. Let's forget about the word significant. Was pulmonary involvement a consideration in your mind?
A. I considered it to the extent that I stated he had dyspnea at rest, but not with

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strenuous activity.
Q. From the standpoint of there being any potential serious pulmonary condition being causative of the dyspnea on exertion, did you consider that?
A. I considered it, but I rejected the possibility, because he did not have shortness of breath with exertion.
Q. In order to have gotten to that point where you would have seriously considered it, you would have needed shortness of breath on exertion?
A. If a patient comes in with symptoms in a certain anatomic region, you have to give consideration to all the things that could cause symptoms in that region, but you don't necessarily do it consciously, it's sort of a subconscious sorting process you go through any time you see a patient. These are categorized in terms of probabilities worth following up and probabilities that are not worth following up at that time.
Q. You saw Dan on December 30th; true?
A. Yes, on December 30th, 1999.
Q. Was he returning for a scheduled

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follow-up from the December 9th visit, or was this a return on his own for other reasons?
A. That was, I'm certain, a return on his own for his acute symptoms.
Q. At the time he had cough and sore throat and chest congestion; true?
A. Claudia stated he had cough, sore throat and chest congestion. I stated a history of four-day cough with yellow-green sputum; nonpleuritic substernal chest soreness; sore throat, fatigue, malaise, felt short of breath taking the stairs.
Q. Did you do a sputum culture?
A. No.
Q. Why?
A. I do not routinely do sputum cultures on community-acquired pneumonias because they are not of much help.
Q. Had you already concluded before doing a chest x-ray that this was a community-acquired pneumonia?
A. No. Because I stated under the impression, viral bronchitis or upper respiratory infection, rule out influenza or pneumonia.

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Q. Having not arrived at a diagnosis of community-acquired pneumonia, why didn't you do a sputum culture where he presented with productive sputum?
A. Because a sputum culture is not informative in that situation.
Q. Under what circumstances is a sputum culture --
A. If someone came into the hospital with a pneumonia, they would probably get a sputum culture, although more often than not the results are not helpful.
The one thing, they don't come back for two or three days, by which time you have already selected a course of treatment and it is not really the standard of practice to do routine sputum cultures in this situation.
Q. Under your impressions on that day, would that constitute your differential diagnosis on the patient?
A. Those were the leading possibilities. I mean, the differential diagnosis could be 20 things, but that's the ones that are worth consideration at the time of the visit.
Q. The ones that would be higher up on

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

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

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

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A. Yes.
Q. And was that a scheduled follow-up on his pneumonia?
A. Yes, that would have been scheduled.
Q. And at that time, did you have the interpretation on the x-ray from December 30th?
A. I could not be sure if I had the typewritten one, but I had the phone report certainly.

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(Thereupon, Plaintiff's Deposition Exhibit No. 1 was marked for purposes of identification.)

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Q. I'm going to show you a copy of what I believe to be the radiology interpretation from December 30th, '99 and it's marked as Plaintiff's Exhibit 1.
Just for the record, would you confirm the fact that Exhibit 1 is a copy of the radiology interpretation from December 30, 1999?
A. I will confirm that.
Q. And the radiologist -- who is the radiologist on that film?
A. I don't see his name here. It should

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be somewhere in the record.
Q. In any event, whoever that radiologist is, your practice is to rely on their interpretations and impressions relative to the x-rays; true?
A. Correct. We go by their interpretation of the findings.
Q. And on that interpretation, do you see that the radiologist suggested a follow-up?
A. Yes, he suggested it.
Q. If I can borrow that to quote, it suggests follow-up radiographs to document clearing. And above that it says patchy infiltrate in the left upper lung suggestive of pneumonia.
You don't dispute that you received this?
A. No, I don't dispute that.
Q. Is it more likely than not that you would have had this interpretation when you saw Dan on January 6th, 2000?
MR. WARNER: Objection. Asked and answered, but go ahead and answer again.
A. Could you state it again?
Q. Is it more likely than not when you

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saw Dan on January 6th that you would have received the interpretation, the written interpretation that's marked as Plaintiff's Exhibit 1?
MR. WARNER: Note my objection. Asked and answered. He already responded to that, but respond again, doctor.
A. It is likely, but I have no way of determining that.
Q. On January 6th, you examined Dan and why don't you tell me what your findings were.
A. Well, according to the note, the history stated that he had been seen a week earlier with pneumonia, treated with a Z-Pak and mostly back to normal except for a lingering cough.
On the physical exam, lungs clear to auscultation, and no coughing, meaning the patient was not observed to cough while I was in the room with him. Clear to auscultation means I am listening to the chest with a stethoscope. I had no abnormal sounds that would indicate pneumonia or other pulmonary problems.
Q. And your plan?
A. I stated will not repeat chest x-ray

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unless cough fails to resolve, and then I would also observe the blood pressure, which was in the borderline range.
Q. Now, the radiologist suggested follow-up to document clearing of the pneumonia.
A. He suggested it, yes.
Q. You emphasized the word suggest. Tell me whether you interpret that to mean that his suggestion was, I guess, optional.
A. Well, the radiologist basically makes an interpretation. They do not usually have many, if any, clinical parameters about the patient.
They know how old the patient is, they know the chief reason they were sent over, but they do not know if the patient is a smoker typically, they don't know their medical history, so they are not prepared to make any very specific recommendations, so they made the general suggestion that chest x-ray be repeated to document clearing.
Q. When you are following a patient that has a community-acquired pneumonia, is there, to your knowledge, a standard of care that requires a follow-up chest x-ray to document resolution

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of the infiltrate?
A. No, I don't think there is a standard of care on medical grounds that would require that. It's a clinical decision based on the nature of the patient, the nature of the pneumonia.
Q. So your testimony is that the standard of care for follow-up on an adult patient with a community-acquired pneumonia does not require a chest x-ray to document resolution?
A. I think that's a clinical decision that the clinician makes.
Q. Again, just so we are using the same language, your testimony would be, Mr. Mishkind, the standard of care does not require, as an absolute statement, does not require a follow-up x-ray to document resolution of pneumonia?
A. That is my opinion.
Q. Are you aware of any medical literature or studies or articles or sections of any texts that you deem reliable that would support the proposition that a follow-up x-ray to document resolution of the infiltrate secondary to a pneumonia is not required?

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A. I do not recall seeing anything one way or another in that respect.
Q. Now, in your plan, you don't indicate when, if at all, Dan is to return to your office; true?
A. Correct.
Q. In your plan, you don't indicate how long Dan was to wait to get back in touch with you if, in fact, the cough failed to resolve; true?
A. I did not state a specific interval on the progress note, but my general practice is to tell the patient if the cough continues to improve and clears up in a reasonable time, meaning within a few weeks, there is no need to return regarding that particular episode.
Q. All right. Back in January, I take it, you had a full-time clinical practice?
A. Yes.
Q. 9:00 to 5:00?
A. I don't recall what my office hours were at that time, but they varied from day-to-day.
Q. But you had a full-time clinical practice?

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A. Correct, between hospital rounds and office hours.
Q. And you would see a number of patients, both in the hospital, as well as in your office; true?
A. Yes.
Q. Do you recall specifically seeing Dan on December 30th when he presented with the pneumonia?
A. It's hard to say what I recall from that specific visit as to what I might recall from rereading the progress note. The progress note is usually my trigger for recalling encounters.
Q. Do you recall anything specific about the January 6th office visit other than what's noted in your handwritten note?
A. No. I don't recall any details beyond what is documented on the note there.
Q. It looks like, as I am looking at your note on January 6th, that other than an indication that if the cough failed to resolve, that you would repeat the chest x-ray, there was no time interval for him to return for any reason to the office; true?

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MR. WARNER: Objection. Asked and answered. He already talked about that.
MR. MISHKIND: Your objection is noted.
A. He was to return if he had symptoms or concerns for another visit.
Q. When it said observe BP, what does that mean?
A. That means we are certainly not going to treat it, but we should repeat it in a reasonable interval to make sure it wasn't going up.
I don't remember what I told him specifically. It was basically I think a note to myself that we were to keep an eye on the blood pressure, but we weren't going to be treating it at that time.
Q. If we jump ahead, is it fair to say the next encounter you had with Dan was when he came into the office for the Kenalog shot in May?
A. I didn't see him myself on that occasion. He came in and got an injection from my medical assistant. Had I seen him other than maybe in the hallway to say hello, I would have

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entered a note in the chart.
Q. She did indicate that you were in the office, true?
A. That is a requirement of the group, is that no injections can be given without a physician in the office.
Q. Got it. But as far as you actually seeing him, other than perhaps saying hello --
A. Had I seen him, I would have written a note.
Q. The chest x-ray, Exhibit 1, I guess my first question to you is, do you have any basis to criticize what the radiologist has indicated in his interpretation and impressions on that document?
A. As far as what he saw or his recommendation?
Q. Both.
A. I do not have any issue with the interpretation. He said probable pneumonia, which was consistent with the clinical impression and the clinical response to treatment. With regard to suggestion of follow-up radiograph, I think we discussed that previous, and --

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Q. And again, that's a suggestion but the ultimate decision is a clinical one?
A. It's a blanket suggestion. It's not intended to refer to this specific patient.
Q. But the fact that he says suggests follow-up, you are not critical of him for making such a suggestion, are you?
A. Not for writing it down, no.
Q. Ultimately, as to whether or not it's required in order to comply with the standard of care, that really falls within the clinician's purview?
A. That's not the radiologist's area of expertise, what should be done to follow-up on conditions.
Q. The presence of the infiltrate that Dan had was in the upper lobe; true?
A. Left upper lobe is I believe where he placed it. He says left upper lung. He does not say left upper lobe, though.
Q. Do you know whether it was in the left upper lobe or just -- strike that.
When pneumonia is diagnosed on x-ray, and an infiltrate is seen, is an infiltrate normally seen in the lower or the upper lobe

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when it's related to pneumonia?
A. Well, an infiltrate can be seen in any of the various lobes of the lung. On the left side it could be the upper lobe, the lower lobe, the linguinal.
Q. Is it more common in a community-acquired pneumonia that is bacterial in origin to see the infiltrate in the upper or lower lobe, in your experience?
A. You know, I don't think there is a wide difference. Statistically one may be more common than the other, but I'm not aware of a strong tendency toward one lobe or the other.
Q. I understand what you have said to me about January 6th.
My question to you is, when you noted will not repeat the chest x-ray unless the cough fails to resolve, was there any downside from your perspective as Dan's physician in terms of ordering a chest x-ray in two or three weeks or that day to document resolution of the pneumonia?
MR. WARNER: Note my objection. One day, two or three weeks?
MR. MISHKIND: I'll break it down. I

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finally agree with one of your objections.
Q. Was there any downside to you ordering some time in the future for the patient to have a chest x-ray to document resolution of the pneumonia?
A. Well, there would be a downside to ordering the day of the follow-up visit or within a couple weeks, because pneumonias are slow to improve on x-ray, slower than they are clinically.
Q. Let me stop you for one second.
MR. WARNER: I object to you stopping him. I would like to have him finish it and then you can go ahead. Unless you were done, doctor.
THE WITNESS: I guess I was done.
MR. WARNER: I apologize.
MR. MISHKIND: My stopping him wasn't intending to stop him from finishing.
Q. So on January 6th, and correct me if I am wrong, to have ordered a chest x-ray to document resolution of the community-acquired pneumonia in your opinion would have been useless?
A. Well, it would have been clinically

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inappropriate, because it is likely that the x-ray would not have cleared by that time, and you would not get to document clearing. You might as well wait to at least an interval where you anticipate clearing.
Q. Why schedule him for a follow-up visit so close in time?
A. Because the clinical response to treatment is the most important thing. You want to make sure that the patient is improving; that the physical exam is satisfactory; that he is not lost to follow-up.
Q. Why not schedule him after January 6th for further follow-up to be able to --
A. Well, because he clinically almost completely resolved and that was actually a quicker response than one would commonly see in community-acquired pneumonia. So due to the excellent clinical response, I did not feel it was necessary to bring him back for further visits unless he had ongoing or continuing problems.
Q. Well, he did have the lingering cough.
A. Well, he had a lingering history of

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some persistent cough a week after he began treatment, but he did not cough while I saw him. And I told him if the cough did not resolve, he indeed should return.

Q. Well, you may have said that to him, but we can agree that your note does not indicate for him to return; true?

MR. WARNER: Objection. The note speaks for itself.

Q. Well, does the note indicate that the patient is to return to the office if the cough does not resolve?

A. Well, it implies that he is to contact me, whether in the office or by phone, because I said will not repeat the chest x-ray unless cough fails to resolve. He would have to communicate with me in some fashion to get an office visit for a repeat chest x-ray.

Q. If the cough did not resolve in a week or two, would you have ordered a repeat chest x-ray?

A. Not in a week. Two weeks possibly I would have had him back to the office to take a look at him.

Q. Is it your normal practice, doctor,

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when following a patient for a community-acquired pneumonia, that a follow-up visit to examine the patient to document resolution of the symptoms with or without an x-ray, just to document seeing the patient for resolution of symptoms is not required?

MR. WARNER: Objection. Do you understand the question?

A. Rephrase that one more time.

Q. Sure. This is the context in which the question is being asked. You saw him on January 6th and your plan was to repeat the chest x-ray only if the cough failed to resolve.

A. Correct.

Q. My question is, is it your opinion that the standard of care does not require a follow-up visit to document resolution of the symptoms of the pneumonia?

A. It does not necessarily require that, no.

Q. Now, you saw Mr. Gill, it looks like, June 22nd; is that true?

A. That was the next time which I saw him, yes.

Q. And at that time, on June 22nd, you

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documented that he had had pneumonia. Read me what --

A. He had pneumonia in January. Just recapitulating what the previous visits were for. Stated for the past month he complained of some mild shortness of breath, dyspnea on exertion, shortness of breath with effort, and pain in the left pectoral area. He had a slight cough. He had by his own estimate stated that his exercise capacity was decreased by approximately 30 percent.

I found him on exam to have some tenderness over the left sternal mastoid muscle, which is the strap muscle here in the neck, but no tenderness over the pectoral muscles or the ribs in that vicinity. Normal heart exam. Lungs were clear.

My impression was fibromyalgia, which is a common form of muscular pain, possibly asthmatic bronchitis, and stated I doubted if any of this was due to coronary artery disease.

Plan was for observation, trial of Accolate, which is an oral asthma drug, and to consider doing a chest x-ray and a stress test, and H&H, essentially a hemoglobin and

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hematocrit, to essentially determine if anemia might be present which could also cause shortness of breath, if not better in the next two weeks.

Q. You didn't order a stat chest x-ray?

A. No.

Q. Did you consider within your differential on June 22nd the possibility that he may have some type of neoplasm or pulmonary --

A. Well, I can't tell you what all I possibly might have consciously entertained, but I think I was aware at that time that his symptoms had become more significant; that if he didn't respond to treatment for asthma, we would be required to do further testing within a two-week interval.

Q. Is it fair to say that within your differential at that time would have been the possibility that the patient had some lung pathology as being causative of these symptoms?

MR. WARNER: Note my objection to the word possibility. Go ahead.

A. Well, I think shortness of breath, decrease in exercise capacity and shortness of

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breath on exertion would in this situation point to the possibility of some abnormality of lung function.
Q. And certainly within that parameter, would you agree that lung cancer could not be ruled out?
A. Well, to say it could not be ruled out does not say that it's a likely possibility. Even in a person in this situation, it would still be an unlikely possibility. It would be something that would probably be picked up if the x-ray were obtained.
Q. What about a CAT scan, did you consider that?
A. Not a CAT scan. That would be done if the chest x-ray were abnormal.
Q. Did you review at all with Mr. Gill, other than 30 percent decrease in exercise capacity, what his physical activities had been over the preceding months between January, when you last saw him, and June?
A. I do not recall the details of what specifics we discussed.
Q. You saw him on July 19th; is that true?

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A. I seem to be missing a page or it's probably out of sequence here.
Q. Probably out of sequence. Let me save you time.
A. That's correct, I saw the patient in the office on July 19th.
Q. And he had some swelling on the left side of his neck; true?
A. That was his presenting complaint.
Q. And continued shortness of breath?
A. Still had shortness of breath, correct.
Q. And it was your impression at that time that the swelling on the left side of the neck was an inflammatory node?
A. Well, let's see, what did I state here? I stated there was a firm tender mass in the neck. I said probably large inflammatory node, as well as persistent dyspnea, recent pneumonia by history, and consider atypical infection, such as fungal infection or a noninfectious process such as tumor or sarcoid.
Q. When you saw him in July and you said recent pneumonia by history --
A. Recent meaning six months. Six

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months ago.
Q. I understand. Did you feel that the symptoms that he presented with in July had any connection to the pneumonia that he had been diagnosed with back in December of '99?
A. I'm certain that that crossed my mind that there might be a linkage.
Q. On July 19th, did you order a CAT scan or a chest x-ray?
A. According to my note, I ordered a CT scan of the chest and the neck. I treated him on an antibiotic, Augmentin.
Q. Were these tests ordered on a stat basis?
A. I couldn't tell you. I would have to look and see when they were done. Normally a test like that would be done within a day or two if it were ordered.
Q. Stat would probably not be indicated since he was in no acute distress.
So if the CAT scan and chest x-rays were performed on the 25th, about six days later, would that be consistent with what you felt to be a reasonable period to do these tests, given what you --

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A. I don't think the health of the patient would be strongly influenced by a few days sooner or later, although sometimes one likes to get those as quickly as possible just to try to alleviate anxiety. I don't know what day of the week that was either.
Q. Based upon the results, he was diagnosed with a Stage 4 nonsmall cell cancer of the lung; true?
A. Correct.
Q. Prognosis for Stage 4 nonsmall cell cancer of the lung?
A. Very poor.
Q. Statistically, can you give me any ranges for a patient otherwise, with his --
A. I'm sure the five-year survival would be well under five percent.
Q. Do you agree that early detection of cancer directly correlates with a better prognosis?
A. Not necessarily.
Q. Would you agree that the earlier one diagnoses cancer, the better?
A. Not necessarily.
Q. As a general rule, would you agree

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that the earlier one diagnoses cancer, the better it is? I'm not saying in all cases, but as a general rule, when one -- you may still object -- as a general rule, if you will, would you agree that when one is faced with lung cancer, that early detection of lung cancer is first the goal when you are working a patient up?
A. I think that is truer of other cancers than it is of lung cancer.
Q. So you would disagree with that statement?
A. I would respond that routine chest x-rays, for example, have not been recommended in screening smokers for lung cancer, because they do not pick up lung cancer sufficiently early to be of any real benefit.
Q. Is it your opinion that his lung cancer -- or do you have an opinion as to whether his lung cancer was caused by his history of smoking?
A. It's the only risk factor that we can identify.
Q. I recognize that that may be a risk factor, but do you hold an opinion in this case

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as to whether or not his --
A. I think it likely had a connection.
Q. And is that opinion to a reasonable degree of probability that his smoking caused the cancer or are you not able to state it to a probability?
A. By probability, more likely than not, I would say yes.
Q. Even though his smoking may have caused his cancer, certainly you would agree that if the smoking caused the cancer and the cancer was diagnosable at an early stage, Stage 1, that's better than diagnosing it at Stage 4; true?
A. If it is in fact truly Stage 1, it is better to diagnose Stage 1 than Stage 4.
Q. And can we agree also that if the lung cancer, which more likely than not is caused by smoking, is diagnosed at Stage 2, that the prognosis for the patient is better than diagnosing it at Stage 4?
MR. WARNER: Objection.
A. In a large group of patients with cancers that are not necessarily all the same, there is the general tendency for survival to be

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better in the lower stages.
Q. And the same question in terms of diagnosing a patient with lung cancer that's more likely than not caused by smoking, is the prognosis for that patient better if it's diagnosed at Stage 3 as opposed to at Stage 4?
A. I doubt there is much difference.
Q. Are you able to state to a reasonable degree of probability that there is no difference between the long-term survival between Stage 3 --
A. I would say the prognosis is quite poor in both situations, but I cannot give you a quantitative estimate.
Q. Would you agree that it's worse in Stage 4 than it is in Stage 3?
MR. WARNER: Objection. He has answered that question twice now and you keep asking the question repetitively.
Doctor, answer the question again for the third time.
MR. MISHKIND: I wish you would listen to the question because it isn't the third time, but I do appreciate hearing from you ever once and a while, Rob, but go ahead.

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A. Repeat the question.
Q. You really want me to?
A. You want me to repeat the answer, I would like you to repeat the question.
Q. Are you saying that the prognosis for survival in a patient with Stage 4 lung cancer is no different than prognosis for a patient with Stage 3?
A. Well, prognosis is really a doctor's estimate of the outcome. For a given patient with lung cancer staged correctly, no, in terms of just simply clinical evidence. But if in fact the cancer is truly Stage 1, the prognosis is better than Stage 2.
The problem is that we often do not know the cancer is truly Stage 1. The clinical tools for staging cancer are rather crude and can only detect tumor at distant sites which has reached a certain size, which means it metastasized there well in advance of when it was found.
Q. All things being equal, staging being accurately performed and consistently performed, is it your testimony that the long-term survival for the same patient is no different whether

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they are diagnosed accurately at Stage 3 as opposed to being diagnosed accurately at Stage 4?
A. I think a patient with Stage 4 would have a worse prognosis, because their tumor has progressed farther.
Q. If a chest x-ray had been repeated by you in January, do you have an opinion to a reasonable degree of probability what it would have demonstrated, knowing what you know as of July in terms of the diagnosis of the nonsmall cell carcinoma?
MR. WARNER: Objection. Asked and answered. You went through a whole thing as to why didn't he do one in January and what would it show, but go ahead.
MR. MISHKIND: Rob, I have never asked this question.
Q. If a chest x-ray had been ordered in January, do you have an opinion, knowing what the diagnosis was in July when the chest x-ray and CAT scan were done, do you have an opinion as to what it would have shown?
A. It probably would have shown an infiltrate in the left upper lobe or the left

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upper lung.
Q. And if it had shown infiltrate in the left upper lobe or left upper lung, would you more likely than not have ordered any further diagnostic studies at that time, including, but perhaps not limited to a CAT scan?
A. No. I probably would repeat the x-ray in a more reasonable interval.
Q. And that being?
A. Maybe a month.
Q. Let's go to February.
A. Assuming that the second rather inappropriate x-ray were abnormal, I would wait at least a month before doing another one.
Q. So you would say that it would be inappropriate to have done one in January?
A. In January, I think so.
Q. Fair enough. I hear you. Let's go to February.
A. Okay.
Q. Again, having the benefit of knowing what the diagnosis was in July, if an x-ray had been done in February, what is your opinion more likely than not as to what the chest x-ray would have shown?

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A. You know, I have not seen subsequent x-rays since the initial one taken and I do not know for a fact that what we saw on the initial x-ray in December was the same infiltrate that they saw later on. I have no way of determining that.
Q. Is it fair to say that based upon what knowledge you have at this particular point that you do not know as of February what a chest x-ray would have shown?
A. No, because I do not know if what we saw on the initial x-ray was a pneumonia resulting from bronchial obstruction by a tumor, or whether the infiltrate was tumor itself.
Q. How would one go about differentiating bronchial obstruction due to tumor versus just an infiltrate from pneumonia?
A. Ultimately, you need a bronchoscopy.
Q. Do you have an opinion based upon the stage of Dan's cancer, Stage 4, in July, as to how long he likely had this bronchogenic carcinoma?
A. I would imagine it has probably been there for a year or more.
Q. And do you have an opinion, assuming

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it was subject to being diagnosed in December or January, how that would have impacted, if at all, his likelihood of survival?
A. I doubt it would have a significant influence.
Q. Tell me why you say that.
A. I think he had a highly malignant, aggressive tumor that metastasized quite early in the game, and that metastasis is often determined more by the biologic nature of the tumor and the patient's immune system than it is by simple size or what is often inaccurate staging of the tumor.
Q. Is it fair to say then that if you had done things that you believe were not indicated, but had you done a repeat chest x-ray, or a CAT scan, and came upon the diagnosis of bronchogenic carcinoma in January, is it your opinion, and correct me if I am wrong, that he more likely than not would have had metastatic disease at that time?
A. I think he likely had metastatic disease at that time.
Q. And do you have an opinion as to what likely would have been the stage of his

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bronchogenic carcinoma if it had been diagnosed in January?
A. Well, the stage again is a clinical evaluation which requires metastatic tumor reaching a certain size to be demonstrable, so I don't have an opinion on that.
I have the opinion on a biologic basis that cells had metastasized by that time. Whether they would have been clinical apparent on the current staging tools which are rather crude, I don't know.
Q. And in terms of, for lack of better terminology, his likelihood or his chance of survival comparing July to January, if the bronchogenic cancer had been detected in January, irrespective of the staging issue, is it your opinion, and correct me if I am wrong, that he likely would have had the same morbidity and mortality in January?
A. I believe that the tumor had already spread to the sites where it became apparent and that any resection of the primary tumor would have simply added more morbidity without any real benefit.
Q. Those opinions that you are providing

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to me are based upon your clinical experience?
A. My clinical experience, and just reading the general history on the treatment of lung cancer.
Q. Did you read the general literature on the treatment of lung cancer in connection with this case?
A. No.
Q. Are you able to cite me to any articles in the general medical literature on the treatment of lung cancer that you believe to be supportive of what you have just told me?
A. Not at this time.
MR. MISHKIND: Let me check my notes. I may be done.
(Discussion off the record.)
Q. Just a couple final questions.
I understand what you have told me in terms of to a probability that Dan's lung cancer was caused by his history of having been a smoker. Is there anything that you believe Dan did beginning in December of 1999 and January of 2000 with regard to the follow-up for the diagnosis of pneumonia that caused or contributed in any way to his outcome?

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A. No. I think he had no control over the outcome at that time.
Q. So if his cancer was caused by the smoking, that's one thing, but in terms of him causing or contributing to the outcome once he was seen in December or January, you are not critical of him for that period of time after December or January; true?
A. Well, I do not know what Dan did during that interval. I don't know what symptoms he might have had that he did not report, because there was a big gap from early January until, what was it, June or July before he saw me. He may have had symptoms that he perhaps denied or was afraid to report. He may have felt fine. I don't know what took place during that interval, so it's very hard to comment on what actions he might have taken, what difference it might have made, but likely very little.
Q. I guess your last point is, irrespective of his symptoms, it's your opinion that --
A. I think the horse was out of the barn in December.

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Q. As you were getting progress notes, were you monitoring what he was going through, even though you weren't calling and seeing him, but were you keeping up to date?
A. Not specifically, but I get these on many of my patients, I get stacks every day on reports from specialists and I read through them and file them in the chart.
Q. I guess what I'm trying to understand is, here is a man that had been your patient for ten plus years, who has a diagnosis of cancer, and then you are getting copies of reports back. Did you no longer consider him to be your patient at that time?
A. I think Dan no longer considered me to be his doctor at that time.
Q. Tell me why you say that.
A. He switched his treatment. When people get serious diseases like that and they are being treated at a specialty center, they tend to just concentrate there.
Q. Did you have any conversations with him where you and he discussed any aspect of the diagnosis?
A. I don't recall. If it's not

documented in the chart that I saw him, then I didn't, but I would have to look through the chart about any subsequent visits.
Q. Looking at the notes for his treatment and what have you, do you have enough understanding of what a cancer patient goes through with the type of treatment?
A. Oh, yes, I know all too well.
Q. Is this a personal situation?
A. Well, my father died of lung cancer or he had lung cancer and died of cancer of unknown cause about three years ago, but I have had many, many of my patients die with terminal cancer.
Q. So you know?
A. I am well familiar with what they go through and the toxicity of treatment and the myriad of ways that they can make you miserable.
Q. From what you can tell, looking at the records, was his course, if you will, from the time the cancer was diagnosed through his treatment, was this a man that went through a lot of suffering?
MR. WARNER: Objection. If you know.
A. I think he did. I think all cancer

patients go through a lot of suffering.
Q. Is there anything else relative to his treatment after he left you and was under the care of, first, consultation of the Clinic and then at UH that you have personal knowledge of other than copies of consults?
A. No.
Q. And after his death, you have never discussed the case with any family members or physicians?
MR. WARNER: Objection. Asked and answered.
A. No.
Q. Is there anything about any of the visits in December, the two visits in December of '99, the visit in January, the passing, perhaps, in the hall when the Kenalog shot was given in May, and then the visits in June and July that you recall that we haven't already talked about?
A. No.
MR. MISHKIND: Doctor, I have no further questions for you. Thank you for your time.
Do you want to reserve signature?

MR. WARNER: I will have him read it.
- - - - -
(Deposition concluded at 4:40 p.m.)
(Signature not waived.)
- - - - -

AFFIDAVIT

I have read the foregoing transcript from page 1 through 107 and note the following corrections:

PAGE	LINE	REQUESTED CHANGE

ROGER A. MANSNERUS, M.D.

Subscribed and sworn to before me this day of , 2002.

Notary Public

My commission expires .

CERTIFICATE

State of Ohio,
SS:
County of Cuyahoga.

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

I do further certify that this deposition was taken at the time and place specified and was completed without adjournment; that I am not a relative or attorney for either party or otherwise interested in the event of this action. I am not, nor is the court reporting firm with which I am affiliated, under a contract as defined in Civil Rule 28 (D).

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 8th day of July, 2002.

Vivian L. Gordon

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

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DEPOSITION OF ROGER A. MANSNERUS, M.D.