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Last Name	Lorman Jr
First Name	Raymond E. W.
Specialty	Internist
Party	Plaintiff D
Date (format =99/99/9999)	8/22/03
Type of Document	Articles Depo
Type of Injury	Lung cancer
Type of Case	MMC
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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
Judge Russo

ROGER A. MANSNERUS, M.D.,
et al.,
Defendants.
- - - - -
DEPOSITION OF RAYMOND L. ROZMAN, M.D.
FRIDAY, AUGUST 22, 2003
- - - - -
Deposition of RAYMOND L. ROZMAN, M.D., a Witness herein, called by counsel on behalf of the Plaintiff for examination under the statute, taken before me, Vivian L. Gordon, a Registered Diplomate Reporter and Notary Public in and for the State of Ohio, pursuant to agreement of counsel, at the offices of University Suburban Health Center, 1611 South Green Road, 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.
Skylight Office Tower Suite 660
1220 W. 2nd Street
Cleveland, Ohio 44113
241-2600

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

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

RAYMOND L. ROZMAN, 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 RAYMOND L. ROZMAN, M.D.
BY MR. MISHKIND:

Q. Would you please state your name for the record.
A. Raymond William Rozman, Jr.
Q. You are a physician; is that correct?
A. Yes.
Q. I understand that you are board certified in internal medicine; is that correct?
A. Yes.
Q. And you have a subspecialty in gastroenterology?
A. Yes.
Q. Your patient population that you see,

a substantial portion of it is in the geriatric population; true?
A. I see patients probably starting from late teens through adulthood. The majority of my patients are adults, probably over the age of 50.
Q. Just so I have a definition of that, when you say the majority of your patients are 50 and older, how would you quantify that percentage-wise?
A. I would estimate -- I have never counted them -- I would estimate that probably 60 percent or so of my patients are 50 years or older.
Q. What percentage of your patients do you see for general internal medicine issues as opposed to GI symptomatology?
A. About 80 to 85 percent of my patients are my internal medicine patients and the other 15 to 20 percent of my practice is gastroenterology. There is some overlap between those groups, but that would be an estimate.
Q. Who are you currently affiliated with in your practice?
A. I am a member of what's called

Page 5

Cleveland Physicians Incorporated, which is a group of internal medicine physicians. Currently we have approximately 20 members.
Q. How long have you been affiliated with this group?
A. Since I started practice, 14 years ago.
Q. Plaintiff's Exhibit 2 is a copy of your CV that you were kind enough to provide to me before the deposition. Is this current?
A. The only change in the CV would be the fact that I'm no longer a director of medical education at this facility. There was a reorganization of the educational program here about a year and a half, two years ago, and I no longer hold that position. Other than that, it is accurate.
Q. The publications that are on the second page that number four, is that the extent of your publications?
A. Yes.
Q. It looks like one of the publications has to do with cancer, and the others appear not to have anything to do with cancer; true?
A. Correct. Those four publications

Page 6

were produced while I was a fellow at The Cleveland Clinic Foundation, a fellow in gastroenterology, so they would have been in '88, and the two that were not dated were in 1989. I have not had any publications since then.
Q. Does the article from 1988 that you wrote when you were a fellow at CCF on esophageal cancer in your opinion have any relevance, in terms of the subject matter of that article, to the subject matter that we are talking about in Dan Gill?
A. No.
Q. The report that you wrote, which is marked as Exhibit 1, is dated October 28th, 2002. Is this the only report that you have written in this case?
A. Yes.
Q. I noticed before the deposition started that you have a number of items in addition to those which were represented by the letter of October 28th, 2002.
A. Yes.
Q. Let me first ask you whether you were provided with any additional information at the

Page 7

time that you prepared your report but didn't for whatever reason comment on having reviewed it?
A. No.
Q. So what you considered for purposes of your opinion letter are the medical records outlined, the deposition of Dr. Mansnerus, and the death certificate, for purposes of the report; correct?
A. Yes.
Q. Since that time, I believe you have received Dr. Steele's deposition transcript?
A. Yes.
Q. And Dr. Sutherland's transcript?
A. Yes.
Q. And I think there might be a possibility of a couple other items.
A. Yes.
Q. What else?
A. I also have Dr. Steele's report, as well as some publications that I believe were attached to Dr. Steele's deposition; some articles that he had copied and were actually exhibits in his deposition.
Q. And they have just sort of come apart

Page 8

from the transcript itself, but those were exhibits to his depo; correct?
A. Correct.
Q. Have you reviewed those articles?
A. No. In addition, there was, I believe, some notes also included with Dr. Steele's deposition, some notes that Dr. Steele had taken on Dr. Mansnerus' deposition, as well as notes that he took on some of the medical records.
Q. You have notes inside Dr. Steele's, Dr. Sutherland's, and I think Dr. Mansnerus' deposition transcripts; is that true?
A. Notes written by me?
Q. Yes, sir.
A. Yes.
Q. And that's your normal process when you go through this type of work, to jot down notes at or near the time that you are reviewing transcripts; correct?
A. Correct. And what those consist of are my recording of that person's testimony on that numbered page. They don't contain any impressions of mine or any conclusions that I have made.

Page 9

Q. So while we may have you read your notes into the record, or the option that you extended before to have you transcribe them, is it fair to say that there are no opinions that you have expressed in any of those notes when you went through the deposition transcripts?
A. Correct.
Q. Okay. At the very least, what we will do is we will mark those as exhibits at some appropriate time and I will let you know how we want to handle the transcription or your reading them into the transcript.
A. Yes.
Q. Are there any other items that you have before you, other than the two additional depositions, the exhibits from Dr. Steele's deposition that you have reviewed since October 28th, 2002?
A. I have a copy of Dr. Levitan's report from October 22nd, 2002, which I received a copy of today and briefly reviewed today.
Q. And you have Dr. Steele's report?
A. Correct. As well as another exhibit from Dr. Steele's deposition, his page from the textbook regarding staging.

Page 10

Q. Have you reviewed any of the literature that Dr. Steele provided in conjunction with his deposition?
A. I read briefly through his notes on Dr. Mansnerus' deposition, as well as the comments on Dr. Botham's report and his comments on my report.
Q. Okay. Taking them one at a time, the notes with regard to Dr. Mansnerus' deposition, you have read over what Dr. Steele noted relative to Dr. Mansnerus' testimony; correct?
A. Yes.
Q. Is there anything that you picked up on as you read over those notes that you take issue with?
MR. WARNER: Objection.
A. I do disagree with some of the opinions expressed by Dr. Steele.
Q. Can you tell me specifically which ones you disagree with?
A. My major disagreement with Dr. Steele's opinions is with his statement that a follow-up chest x-ray was indicated in this patient.
Q. Are there any other areas in

Page 11

connection with Dr. Steele's comments, either responding to Dr. Mansnerus' deposition or in general that you have gathered that you take issue with concerning Dr. Steele's opinions?
A. There may be other disagreements, but that would be the major one.
Q. Now, I want to try to get a framework for the scope of your testimony in this case, and then we will plow forward as quickly as we can.
In reviewing your report, it appears as if you have certain opinions as to the level of care provided by Dr. Mansnerus to Mr. Gill; correct?
A. Yes.
Q. And it's your intention to testify, assuming the right questions are asked of you, that certain aspects of his care met accepted standards, in your professional opinion; true?
A. Yes.
Q. Do you also intend to provide testimony as it relates to the issue of proximate cause?
A. My opinion in that area as expressed in the report --

Page 12

Q. Actually, let me give you the report because I have a few notes that I would rather you not take a look at. It's my work product there.
(Discussion off the record.)
A. My opinion in that area would be that even if a chest x-ray had been performed early in the year 2000, that it would have unlikely led to any significant change in the outcome of Mr. Gill's illness.
Q. So you do intend to provide proximate cause testimony that an x-ray in early 2000 would not have altered the outcome?
A. Correct.
Q. You are not an oncologist; correct?
A. Correct.
Q. You don't hold yourself out as a specialist in the area of oncology or hematology; correct?
A. I do not.
Q. You are not a radiologist; correct?
A. Correct.
Q. You are also not a cardiothoracic surgeon?
A. Correct.

Page 13

Q. When you have patients that are diagnosed with lung cancer, do you treat those patients or do you refer them to specialists?
A. I refer them to specialists.
Q. What I want to find out before we talk about your standard of care opinions are, what is the basis upon which you are intending to provide opinions that it's unlikely that this would have led to any significant change in his eventual outcome?
A. That opinion would be based on my general knowledge of lung cancer as an internist and based on my experience with my own patients diagnosed with lung cancer.
Q. Now, you state that it's unlikely that it would have led to any significant change in the outcome. Is it your intention to say that a diagnosis in early 2000 in your professional opinion would not have increased the chance of Mr. Gill having a better outcome than what occurred in this case?
A. Correct.
Q. And again, other than what you have just said, is there any other bases upon which you have arrived at that opinion?

Page 14

A. That opinion is based on my review of this case. I believe that as of that period of time, and actually as of the date of the December 1999 chest x-ray, that Mr. Gill already had metastatic disease and that even if the diagnosis had been made sooner, perhaps early in 2000, in February or March of 2000, that because of the presence of metastatic disease that the date of diagnosis would have been made earlier, but it would not have favorably affected his outcome.
Q. What is it in December of 1999 or even January of 2000 that you are able to point to in this case that causes you to say that Mr. Gill had metastatic cancer at that time?
A. I would look at, for example, in June of 2000, when he presented with some neck discomfort, and then July of 2000, when he had a neck mass, at that point the metastases to his neck were clinically apparent, and I believe that based on the clinical appearance of metastatic disease in June of 2000, that it was present six months earlier.
Q. Well, can you cite me to any articles or literature or studies that would support that

Page 15

conclusion that because he had metastatic disease in June or July that he most likely had it in December of 1999 or January of 2000?
A. I can't quote any particular article or any particular publication. That's just based on my general knowledge of the natural history of lung cancer.
Q. Do you have an opinion as to what stage Mr. Gill likely was at back in December or early January with regard to his lung cancer?
A. I believe that at that point in time he already had metastatic disease, which I believe would make him a Stage 4 patient at that time.
Q. And where was the metastatic disease in his body at that time?
A. It's my opinion that it was at least already present in his neck. I believe he had cancer cells in his nodes and also in his femur.
Q. Are you talking about in December, January?
A. Yes.
Q. Clinically Dr. Mansnerus made no mention at all of any symptomatology that would be consistent with any involvement of the lymph

Page 16

nodes or any involvement of the femur in December or January; correct?
A. Correct.
Q. In fact, do you see any evidence that Dr. Mansnerus palpated the neck or the arm or the abdomen on this patient, either during early December, end of December, or early January, when he saw him again?
A. No.
Q. And is your opinion that he had metastatic disease in the femur and in the neck based upon the fact that he had metastatic disease in the femur and the neck in June and July?
A. Yes.
Q. Therefore, you conclude that he must have had it in December and January?
A. Yes.
Q. Now, do you have enough expertise to be able to differentiate for me the growth of nonsmall cell versus small cell lung cancer?
A. As an internist and primary care doctor, it's my understanding that small cell cancer is a more aggressive tumor and grows more quickly than nonsmall cell cancer. I am not

Page 17

able to comment on that with any degree of specificity in terms of quoting articles.
The growth rate of tumors also varies with their differentiation, and generally a poorly differentiated tumor tends to be more aggressive than a well differentiated tumor.
Q. At the time that this diagnosis was made, what was the differentiation of his tumor?
A. I believe it was a poorly differentiated carcinoma.
Q. I will wait until you get to the record. Are you there now?
A. I do have a path report from January of '01. I have not yet put my finger on the earlier path report.
I don't have that in front of me. As I stated, those opinions are based on my knowledge of the natural history of cancer from a primary care doctor, internal medicine specialist knowledge.
Q. In terms of the staging of the cancer, other than what we know he had at the time of diagnosis, that being Stage 4, would you defer to an oncologist as it relates to the back peddling, if you will, the movement back in time

Page 18

as to at what time he was a Stage 3, at what time he was a Stage 2, and at what time he was a Stage 1?
A. Yes, I would.
Q. Can we agree that if Mr. Gill had been diagnosed when he was a Stage 1, nonsmall cell lung cancer, that to a reasonable degree of medical certainty, at least a degree of a probability, he would have survived?
MR. WARNER: Objection. Go ahead.
A. Yes. I would state, though, that my view of staging is that staging is based on studies such as radiologic studies, which are not able to detect the presence of cancer cells until they are present in a certain number or the lesion is a certain size.
So that someone who initially appears to be a Stage 1 because the x-ray or the CAT scan is negative, it's been my experience that quite often as time goes along, the metastatic disease or the nodal involvement which was not radiologically apparent or clinically apparent at the time staging was done, it later becomes evident. So that a Stage 1 may later turn into Stage 4 because perhaps the metastatic disease

Page 19

which was present in a microscopic state at the time of staging was done later becomes clinically evident.
Q. A patient that has Stage 1 cancer that has cancer cells that get into the bloodstream, is that defined as micrometastasis?
A. My definition of micrometastasis would be a patient that has cancer cells which have spread from a primary site which have moved to another site in the body and are not yet detectable by either physical examination or by x-ray tests or blood tests.
Q. Do you recall reading in Dr. Steele's testimony where he indicated that you or I may have a certain number of cancer cells in our body, but that it takes literally billions of cancer cells to form what is known as a clinically significant metastasis?
A. Yes, I remember reading that.
Q. And is that consistent with what you understand from your knowledge, training and experience?
MR. WARNER: Objection.
A. Let me refer to that page in his deposition and see exactly what he said.

Page 20

Q. Okay. I will try to help you out as well, if you don't get right to it.
It's probably page 33, 34.
A. To answer your question, I don't think that he implies here on page 33 that, as you say, you or I have metastatic cells floating around our bodies.
Q. Hopefully we don't.
A. I believe what he says here is that in a patient who has a primary tumor, that that tumor sheds millions of cells and then eventually some of those cells set up and form a metastasis. I don't disagree with that. But I would disagree with his statement in here that that process didn't start until May or June.
Q. I understand. I suspected that that was your opinion based upon your knowledge and training and experience as you have set forth before as there was metastasis even before December of 1999; correct?
A. Yes.
Q. But there aren't any clinical factors that you are able to point to me in Mr. Gill's case that supports that conclusion, other than what you understand to be the evolution of this

Page 21

type of cancer; true?
A. Correct.
Q. In arriving at the opinions that you have that we have started to talk about, did you feel as if you had sufficient information to arrive at the opinions that you have expressed?
A. Yes.
Q. And are your opinions after reading the deposition transcripts of Dr. Sutherland, Dr. Steele, and then perhaps using some of the articles, have your opinions changed at all?
A. No.
Q. Have you arrived at any new opinions?
A. No.
Q. I take it in your practice from time to time you have the occasion in an adult patient to suspect that upper respiratory symptoms or even lower respiratory symptoms are related to a potential pneumonia?
A. Yes.
Q. And you use x-rays, certainly, as a diagnostic tool to aid you in arriving at or ruling out pneumonia; correct?
A. Yes.
Q. Do you read your films or do you

Page 22

typically rely on the radiologist for purposes of the interpretation?
A. I do not read my own films.
Q. And, in fact, Dr. Mansnerus in this case, I think, if memory serves me correct, also relied on the interpretation of the radiologist as to that December film. Do you remember him saying that in his deposition?
A. Yes.
Q. And that certainly is common practice, is it not, to look at the radiology interpretation and read it in conjunction with your clinical assessment of the patient and then arrive at a diagnosis?
A. Yes.
Q. I want to back up for a moment and then plow back into your opinions.
I never can keep on the same track, so you will have to forgive me. You and I have never met before, have we?
A. No.
Q. I want to ask you a little bit about your medical/legal experience and then hopefully we will get back into the opinions and wrap things up, okay?

Page 23

A. Yes.
Q. The letter that you first received from Mr. Warner concerning this case was dated what?
A. September 27th, 2002.
Q. And had you talked to Mr. Warner, as best as you can recall, before you received this letter, or did it just come to you with here are records and take a look at this case?
A. I don't recall. I suspect he may have called, asked if I was interested in reviewing a case. I said yes and then the records arrived with this letter on top.
Q. And I presume, even though there isn't a lot written in this letter, you would have looked at the cover letter just to see what he was pointing out and then started your review; correct?
A. Yes.
Q. And in his letter, he told you that he represents Dr. Mansnerus as to allegations, failure to diagnose a Stage 4 nonsmall cell carcinoma of the lung, most likely related to the patient's history of smoking; correct?
A. That's stated in the letter, yes.

Page 24

Q. So right from the very beginning, you were told by the attorney for Dr. Mansnerus that the issue in this case was, or the allegation was that there was a failure to diagnose a Stage 4 nonsmall cell carcinoma at an earlier period of time; correct?
A. That was in the letter, yes. When I review a case, I always try to review based on what is known at the time that that patient sees that doctor and try to look at the case prospectively.
Q. You recently testified in a nonsmall cell carcinoma case, correct, in June or so of this year?
A. Can you remind me of that?
Q. A Cuyahoga County case. I didn't bring my entire file with me, but you were an expert, as was Dr. Levitan, and attorney Brian Eisen was plaintiff's attorney.
A. Yes. I believe that was actually earlier this year than June, yes.
Q. Your depo was taken in March, and it may have been maybe May. You lose track of time after a while.
A. Yes.

Page 25

Q. That was a nonsmall cell cancer case; correct?
A. I don't recall the specific diagnosis, but it was a lung cancer case, yes.
Q. Now, in that particular case, you were only providing opinions as it relates to standard of care for the defendant doctor; correct?
A. I don't recall the scope of my opinions in that case.
Q. I have your deposition and I have read it over, so I'll ask you to accept, at least for purposes of this question, that the scope of your testimony was limited to standard of care and you weren't providing opinions as to whether an earlier diagnosis would have made a difference.
In this case you are providing both standard of care as well as proximate cause testimony; correct?
A. Yes.
Q. But yet, in terms of the detail of staging and the progression of the cancer, you readily admit that you would defer to an oncologist?

Page 26

A. Yes.
Q. Have you ever testified in any other nonsmall cell cancer cases?
A. I may have. I don't recall the specifics.
Q. You have reviewed cases for the Reminger & Reminger firm before?
A. Yes.
Q. The following series of questions are going to sound very similar to what you heard before, so I'll warn you, if you want to take a nap, you will probably know the answer before you hear the question.
You have been hired by attorneys from that firm, based upon information I have, in excess of 50 times. Does that sound accurate?
A. Yes. Let me say that any of the answers regarding numbers of cases, either over time or per year, et cetera, would be estimates on my part. I don't keep track of my cases, I don't count them, so any answer I give you as far as how many cases I have reviewed for an attorney or firm or plaintiff versus defense would be purely estimates.
Q. But they are the best estimates that you can give to me; correct?

Page 27

A. Correct.
Q. Have you ever kept track of your work history in this area?
A. No.
Q. How long have you been doing medical/legal work?
A. Approximately ten years. Probably early '90s I started.
Q. You currently get some cases from Saponaro and Associates; correct?
A. I have gotten cases from Mr. Saponaro's firm. I have not gotten any recently within the past several months.
Q. And Saponaro, for my purposes, is a company that provides names or identification of experts to attorneys. It's like a service company that they introduce to you an attorney for purposes of reviewing a case; correct?
A. My experience with Mr. Saponaro's firm is that Guy Saponaro will call me and ask me if I am interested in reviewing a case and then the attorney will either contact me by phone or will send me that case in the mail.
Q. Besides Saponaro and Associates, are there any other companies that provide expert witnesses to attorneys that you are currently affiliated with in any way?

Page 28

A. I'm not sure that I'm affiliated with Mr. Saponaro's firm.
Q. Maybe it's a poor choice. But I mean that you have agreed to allow Mr. Saponaro to contact you and introduce you to an attorney for purposes of a review. Any other firms that have the same kind of affiliation?
A. No.
Q. Have you ever been -- I'll use the same term again -- affiliated with any expert witness or any expert search firms other than Saponaro at any time?
A. No.
Q. Have you ever advertised?
A. No.
Q. Have you worked at the request of Mr. Warner on any cases before the Gill case?
A. I believe I reviewed one other case for Mr. Warner in the past. I met Mr. Warner for the first time earlier today.
Q. What did you think? I am putting you on the spot. I'm kidding you.

Page 29

(Discussion off the record.)
Q. This is the first time you have met him, but you reviewed other cases for him?
A. I believe I reviewed one other case for Mr. Warner.
Q. You have been deposed before?
A. Yes.
Q. In this calendar year, which is quickly leaving us, eight months into it now, how many times have you been deposed?
A. As a rough estimate, perhaps ten times.
Q. So on a yearly basis, giving an estimate, how many times would you say to someone or another lawyer asking this question how many depositions you give in medical malpractice cases on a yearly basis?
A. The number has changed over time. Over the past probably two to three years, I reviewed more cases, and as a result, I have given more depositions.
I started reviewing cases about ten years ago and in the first probably five years, I would do maybe one or two depositions per year. I would say that in the past three to

Page 30

four years, it's been five to ten per year.
Q. And this year it's even increased more; correct?
A. I have not counted them. It may be less than ten. I don't think it's more than ten.
Q. How many times have you testified at trial?
A. I would estimate perhaps ten times. That again is a rough estimate.
Q. Who is your malpractice carrier?
A. Currently we are with ProAssurance, I believe. We had been with the Doctor's Company but recently changed to ProAssurance.
Q. Do you happen to know who Dr. Mansnerus is insured with?
A. No.
Q. Do you know Dr. Mansnerus?
A. No.
Q. You have never met him?
A. No.
Q. Have you talked to him in connection with this case?
A. No.
Q. Dr. Levitan you know professionally?

Page 31

A. Yes.
Q. Do you know him also socially?
A. No.
Q. You refer some of your patients to Dr. Levitan?
A. Yes.
Q. And that's been going on for a number of years?
A. Yes.
Q. I would take it, without identifying the names of any patients, you currently have some of your patients that Dr. Levitan is seeing?
A. Yes.
Q. How about Dr. Botham, do you know Dr. Botham?
A. I have never met Dr. Botham. I believe that he had taken care of one of my patients in the past when he was still with the University System.
Q. Tell me before I forget to ask you this how much you charge for a deposition.
A. $400 per hour.
Q. And the charge that you have for reviewing cases?

Page 32

A. $375 per hour.
Q. And how much will you charge Mr. Warner when you testify at the trial of this case?
A. For the time spent on the stand, $500 per hour.
Q. How about for the time spent off the stand?
A. Any preparation or review of records would be the $375 per hour.
Q. Have you been consulted on any cases as an expert outside of the State of Ohio?
A. Yes.
Q. Give me an idea of how many.
A. Perhaps a dozen cases.
Q. So most of your medical/legal work over the course of time has been Ohio cases?
A. Yes.
Q. And have most of them been Northeastern Ohio cases?
A. I would estimate the majority of them are from Northeastern Ohio.
Q. Do you have any cases currently in your inventory that are outside of the State of Ohio?

Page 33

A. Yes.
Q. How many would you say?
A. Less than five.
Q. Are you currently serving as an expert witness at the request of any plaintiff's attorneys?
A. Yes.
Q. How many?
A. How many different plaintiff's attorneys?
Q. Yes.
A. I would estimate ten to 15.
Q. Any in Ohio?
A. Yes.
Q. Who are some of the plaintiff's attorneys?
A. Kerry Volsky, Steven Charms, Peter Marmaros, Stephen Crandall, Jay Kelley, James Casey. Those are the ones I can recall right now.
Q. All former defense attorneys.
A. Is that right?
Q. Yes. Except for Kerry Volsky and he has done a little bit of both.
MR. WARNER: Note my objection.

Page 34

Q. Any of those cases that you are working on with Steve or Pete or Steve Crandall, et cetera, involve issues concerning diagnosis and treatment of lung cancer?
A. Not that I recall.
(Discussion off the record.)
Q. Have you ever been a defendant in a medical malpractice case?
A. Yes.
Q. On how many occasions?
A. Two occasions.
Q. Any currently pending?
A. No.
Q. What was the subject matter and the result of those cases?
A. The first case the allegation was that there was a delay in diagnosis of myocardial infarction. A patient of a colleague of mine called me when I was on call on a Sunday complaining of chest pain. I advised that patient to go to our urgent care center. He was evaluated there, sent home and later that day suffered a myocardial infarction. I was dismissed from that case without payment being made on my behalf.

Page 35

The second case was a patient of mine who alleged that I did not diagnose an oral cancer in a timely fashion. She was a patient who told me that she had a lesion in her mouth. I referred her to an ear, nose and throat doctor where eventually the diagnosis of cancer was made and I was one of several defendants named in that suit for delay in diagnosis. And I was dismissed without payment.
Q. Were your depositions taken in those cases?
A. Yes.
Q. How long ago would you say those cases were?
A. The first one was early '90, perhaps 1993 or 1994. Then the second case was perhaps 1998 or 1999.
Q. Have you ever testified at trial in Ohio on behalf of a plaintiff suing a doctor?
A. No.
Q. Have you ever testified at deposition in a case in Ohio on behalf of a patient suing a doctor?
A. Yes.
Q. On how many occasions?

Page 36

A. As an estimate, perhaps ten cases. Five to ten.
Q. Are any of those cases currently pending?
A. Yes.
Q. Which of the attorneys that you have identified would fall within that category?
A. I believe I have a case pending for Mr. Kelley, as well as a case for Mr. Crandall, and a case for Mr. Marmaros and Mr. Charms.
Q. Can you tell me when you were last deposed?
A. Early July.
Q. In a defense case?
A. Yes.
Q. Was that a Reminger & Reminger case?
A. Yes.
Q. Who was the attorney?
A. James Malone.
Q. When are you scheduled to give your next deposition?
A. September.
Q. Defense case?
A. Yes.
Q. Reminger & Reminger?

Page 37

A. No.
Q. Who is that for?
A. That's for Mr. Riemschneider at Buckingham, Doolittle & Burroughs.
Q. I may have asked this of you, but just so I'm clear, in terms of testifying experience, you have never testified in a courtroom on behalf of a patient that we have established; correct?
A. That's correct. I have reviewed a number of cases for plaintiff's attorneys and in those cases I have given opinions that the doctor failed to comply with the standard of care and I have given that testimony in deposition, but none of those cases have reached the point of trial.
Q. Then as far as the percentage breakdown relative to deposition testimony that you have given over the course of your career, is that about 80 percent defense, 20 percent plaintiff? Is that a fair estimate?
A. That would be a fair estimate, yes.
Q. Have you previously given testimony that in terms of your medical/legal reviews, all told, looking at cases, providing opinions, that

Page 38

95 percent of your medical/legal reviews over the years have been for or at the request of an attorney representing a doctor?
A. Yes. My testimony is that and has been that I don't have a particular preference plaintiff versus defense; that the balance of cases, plaintiff versus defense, that I reviewed reflect entirely of the cases that come my way.
Early in the years that I reviewed cases it was entirely for the defense. In recent years there have been more plaintiff's cases. And as a result, that number, I believe, has shifted over time.
Had you asked me the question eight years ago, I would say it's 100 percent for the defense and zero percent for the plaintiff. As time has gone along and shifted, I still review more cases for the defense than the plaintiff, but that doesn't reflect any particular preference on my part, it's entirely who has sent me cases. I don't turn down any cases for review.
Q. Even though it used to be 100 percent, in terms of the cases that are coming to you, is it still at or near 95 percent for

Page 39

the defense and five percent for the plaintiff?
A. Looking at the new cases coming my way, it's not 95 percent. I would estimate perhaps 75, 80 percent defense and 20 to 25 percent plaintiff. And that number varies over time. That would be my current estimate.
Q. In the cases that you were named as a defendant, were you also represented by an attorney from the Reminger firm?
A. Yes.
Q. Was that Jim Malone?
A. Mr. Malone defended me in the first case and Mr. Groedel in the second case.
Q. On standard of care you have expressed several opinions in your report and I want to talk about those now.
December 30th, 1999, I think you indicate -- I'm looking at the second page of your report -- you indicate that his presenting symptoms, physical findings, chest x-ray results, and the prescription of Zithromax all on December 30th, 1999 in your opinion complied with the standard of care; correct?
A. Yes.
Q. Do you know as you sit here right now

Page 40

how long Mr. Gill had been a patient of Dr. Mansnerus?
A. Approximately ten years.
Q. Your next comment was that when Mr. Gill was seen in follow up one week later, Dr. Mansnerus did not order a chest x-ray at that time; correct?
A. Correct.
Q. And you felt that that was appropriate?
A. Correct.
Q. Now, was the patient scheduled for any follow up after that one week as it relates to his pneumonia?
A. No. There was no specific scheduled follow up. In his note from January 6, 2000, Dr. Mansnerus' plan was to not repeat a chest x-ray unless the cough fails to resolve. I believe in his testimony he stated that he advised the patient if the cough did not resolve, that he come back for follow up. But there was no scheduled appointment for follow up.
Q. Since Mr. Gill is dead, we have to do one of two things; look to Dr. Mansnerus' record

Page 41

or accept Dr. Mansnerus' testimony as to what he told the patient, correct, in terms of follow up after that visit?
A. Yes. In his note from January 6, 2000, when it says will not repeat chest x-ray unless cough fails to resolve, I would conclude that that statement was based on a discussion with the patient that if your cough doesn't resolve, please come back or call me back.
Q. But it doesn't say will see patient in X number of weeks to confirm resolution of pneumonia, does it?
A. Correct.
Q. And in fact, it doesn't say specifically that he would see the patient in follow up for the pneumonia at any particular time in the future?
A. Correct.
Q. You are aware, are you not, that there are certain guidelines for the management of adults with a community acquired pneumonia?
A. Yes.
Q. And in your practice, doctor, when you have a -- strike that.
Was Mr. Gill at increased risk of

Page 42

lung cancer because he had a history of smoking than you or I that hopefully are nonsmokers?
A. Yes. One's degree of risk of lung cancer related to smoking increases with the number of pack years smoked.
Q. In terms of the guidelines for the management of adults with community acquired pneumonia, do you in your practice implement any treatment protocol as it relates to the follow up of and management of patients with community acquired pneumonia?
A. I don't follow any specific protocol. I have a strategy that I use in my own practice, which I believe is within the standard of care, but it's not based on a specific published protocol.
Q. Tell me what your practice is when you have a patient in their early 40s, presents with a pneumonia, is put on Zithromax, the radiologist interpretation indicates patching infiltrate in the left upper lung suggestive of pneumonia, suggests follow-up radiographic to document clearing.
Tell me what your practice is in terms of how you managed that type of patient.

Page 43

A. I believe that whether or not a follow-up chest x-ray in a patient with pneumonia is indicated is a clinical decision based on a number of factors, including the patient's age, the patient's smoking history, the description of the infiltrate by the radiologist on the chest x-ray, and whether or not the patient's symptoms persist or whether they resolve.
For example, in this patient, in a 42-year-old man with perhaps a 20 to 25 year, 20 to 25 pack year smoking history, not having smoked in 12 years, who had on chest x-ray, what was described as a patchy infiltrate of density, I do not believe that a follow-up chest x-ray was indicated.
Q. Is it your testimony that you would not have ordered a follow-up chest x-ray if this had been your patient?
A. Correct.
Q. Are you aware of any guidelines or protocols with regard to the management of adults with community acquired pneumonia that indicate that a repeat chest x-ray is not necessary or not recommended to establish a new

Page 44

radiographic baseline and to exclude the possibility of malignancy?
A. I'm aware of that recommendation in some protocols or guidelines.
I do get follow-up chest x-rays in some of my patients, but not in all of them. And in this specific patient, I do not believe that I would have ordered a follow-up chest x-ray unless his cough failed to resolve.
Q. It's incumbent upon the physician to advise the patient, if your cough does not resolve, I want you to come back and we will do further diagnostic studies; correct?
A. Yes.
Q. Can we agree that at least from the standpoint of the printed guidelines that are out there -- and there is a number of them -- but that generally speaking, the follow-up x-ray after the initial film is usually in the four to six week range?
A. Yes.
Q. And in a patient that you feel has pneumonia and feel that there needs to be evidence of a resolution of that pneumonia, do you normally follow that four to six week

Page 45

regimen?
A. Yes, I do.
Q. Now, of what significance, if any, do you apply to the language of the radiologist that says, suggests follow-up radiographic to document clearing?
A. I'm aware of that the language in that x-ray report from December 30th, 1999. My reading of this x-ray report and my evaluation of it in terms of whether or not a follow-up chest x-ray is necessary is based on the description of the infiltrate as being a patchy infiltrate of density.
As I mentioned, one of the factors I take into account in my own mind in whether I order a follow-up chest x-ray is the radiologist's description of infiltrate. If the radiologist describes the infiltrate in a way that makes me suspicious of there being a cancer present, for example, if it's described as a nodular infiltrate, or a mass-like density, if the wording is suggestive of the possibility of a cancer being present, then I would indeed order a follow-up chest x-ray, even in someone who is 42 years old.

Page 46

If the radiologist describes a patchy infiltrate of density, as the radiologist did in this report, to me that is not suggestive of the presence of a cancer, and based on that, I would not be likely to order a follow-up chest x-ray.
Q. Of what significance is the radiologist's impression that there is some prominence of the perihilar bronchovascular markings?
A. The radiologist states that it appears as if that finding or that appearance was the result of a poor respiratory volume. If a patient doesn't take a large deep breath when the chest x-ray is taken, overall the lung markings tend to look more prominent. They tend to on the x-ray look whiter, and it appears as if the radiologist here feels that that finding was related to the depth of inspiration.
Q. I think you used the term may be related; correct?
A. Well, I'll read exactly what the radiologist stated. Both views demonstrate a poor respiratory volume with probable crowding of perihilar bronchovascular markings. The radiologist seems to relate that finding of

Page 47

crowded perihilar bronchovascular markings.
Q. But in the impression, can we say, under number one, the prominence of the perihilar bronchovascular markings may be due to the depth of inspiration?
A. Yes, that is stated there.
Q. Okay. One of the reasons that there are recommendations in internal medicine and in other protocols that are widely published to do follow-up radiographic to document resolution of infiltrates is to exclude underlying diseases that may be masked or camouflaged by a pneumonia; correct?
A. Yes.
Q. And those underlying diseases that you look for include neoplasms, potential tumors; correct?
A. Yes.
Q. And can we agree that the literature supports the proposition that follow-up radiographic to document resolution of infiltrates to exclude underlying disease such as neoplasm are advocated for selected patients who are over 40 years of age and are smokers?
MR. WARNER: Objection.

Page 48

A. I'm aware of recommendations to that regard and some of the protocols and guidelines, yes.
Q. If you had ordered a chest x-ray -- and I understand that what you are saying is that certainly in your report you are saying then in January that one week follow-up visit a chest x-ray was not indicated; correct?
A. Correct.
Q. And the reason that you would not have ordered a chest x-ray at that point was that there wouldn't have been enough time to allow sufficient resolution of the pneumonia to be able to appreciate any other pathology that might be lurking?
A. Correct.
Q. Do you see any note at all by way of an action plan as to when Dr. Mansnerus was considering doing a follow-up x-ray if the patient's cough did not resolve?
MR. WARNER: Objection. Asked and answered. Go ahead.
A. No. His note states he would not repeat the chest x-ray unless the cough fails to resolve, but there is no time frame associated

Page 49

with that.
Q. Now, can we agree in your report that you do not comment at all about the decision on the part of Dr. Mansnerus not to schedule Mr. Gill for a repeat chest x-ray at some point after the one week follow-up visit?
A. In my report I state the standard of care did not require that Dr. Mansnerus order another chest x-ray at the follow-up visit one week later. By that statement I mean that the standard of care did not require that he order it for that day or that he order it, for example, give the patient a requisition at that visit for some point in the future.
Q. But specifically, we know that he was seen January 2nd or 3rd or whatever the date was, maybe January 6th.
A. January 6th.
Q. And your testimony is that on January 6th, Dr. Mansnerus, to comply with the standard of care, did not need to order another chest x-ray at that follow-up visit on January 6th; correct?
A. Correct. And let me elaborate on what I mean by that statement.

Page 50

At that January 6th visit, Dr. Mansnerus stated that he would not repeat a chest x-ray unless the cough fails to resolve. I don't believe that standard of care required him to order an x-ray to be done on January 6th. I don't believe the standard of care required him to on January 6th give Mr. Gill a requisition for four weeks or six weeks. I believe that his plan as outlined on January 6th, 2000, was within the standard of care.
Q. Would it have been reasonable for Dr. Mansnerus to have scheduled Mr. Gill for a repeat visit four weeks later to come back to examine him and then to make a decision at that point whether or not a follow-up film was necessary to show resolution of the pneumonia?
A. It would have been reasonable, but not required by the standard of care.
Q. Now, you go on to say that even if another chest x-ray had been performed in early 2000 -- do you see that?
A. Yes.
Q. I presume what you are referring to is that the four to six week follow-up x-ray that we have talked about in terms of the

Page 51

recommendations that are out in the literature --
MR. WARNER: Objection.
Q. -- is that what you are referring to?
A. Yes.
Q. Can we agree that there would have been an increased likelihood that if a follow-up film had been done four to six weeks after the December 30, 1999 film, that that x-ray would have shown, number one, some resolution of the underlying pneumonia?
A. Correct.
Q. And given what we know was diagnosed in July, do you have an opinion to a probability as to whether or not that x-ray taken four to six weeks after the December film would likely have shown or raised an index of suspicion that there might be some neoplasm evident on chest x-ray?
A. I don't have an opinion to a reasonable degree of medical certainty regarding that issue. I believe that it's possible that that follow-up chest x-ray would have shown a persistent infiltrate without any suggestion of cancer. It's also possible that the x-ray would

Page 52

have shown some resolution of infiltrate and may have shown some signs of a cancer.
Q. If the latter were the case, and there was at least an evidence of some neoplasm or some suspicion of that, what would the standard of care have required of the internist under those circumstances?
A. At that point the standard of care would require that a CAT scan of the chest be performed.
Q. Would the CAT scan of the chest have been something that could have been done just on a routine basis or is this something that you would want to get done as soon as possible?
A. Had the follow-up chest x-ray been done and if it was suggestive of the presence of a cancer, then the standard of care would require that a CAT scan of the chest be done as the next step in the evaluation.
Q. As quickly as one could get it scheduled; correct?
A. Correct. It is not the sort of study that would need to be done that day or the next day, but within a short period of time.
Q. Within maybe 48 to -- a two to three

Page 53

day period?
A. Knowing how scheduling goes, I would think within seven to ten days.
Q. And if the CAT scan had been positive, within whatever period would have been reasonable, scheduling taken into account, and it had shown evidence of a neoplasm, what then would the standard of care have required?
A. The standard of care would then require that the mass or the nodule, if it were present, would be sampled, either by needle using CAT scan guidance, or by bronchoscopy, depending on the location and the size of the area.
Q. Was Mr. Gill scheduled for any visits between January and when he came back in June with the complaints in his neck?
A. Not that I'm aware of.
Q. Do you follow your patients that have diagnosis of lung cancer or do you normally have the care assumed by an oncologist?
A. When a patient of mine is diagnosed with lung cancer, I refer them to an oncologist and/or a cardiothoracic surgeon for treatment of the lung cancer. I still follow the patient for

Page 54

their medical problems.
Q. Have you followed Stage 4 metastatic nonsmall cell lung cancer patients?
A. I believe I have, yes.
Q. And are such patients physically limited in any way by virtue of having advanced lung cancer?
A. The degree of limitation would vary based on how much cancer is present, where it's located, whether they have any complications related to the presence of the cancer. I have seen patients with fairly advanced cancer, not only lung cancer, but other cancers, who despite the presence of advanced disease have a good functional status and are able to go about their activities of daily living. Typically as that cancer progresses and as the cancer grows, their level of function can decline.
Q. Would you expect a patient that has metastatic cancer which infected the femur to be limited with regard to normal daily activities?
A. It would depend on the size of the metastatic lesion in the femur.
Q. Do you know what the size was of the metastatic lesion in Mr. Gill when it was

Page 55

diagnosed?
A. I'm looking at a bone scan from August 18th of 2000, which describes a finding in his left femur and the radiologist mentioned he was not able to differentiate between stress fracture or metastasis based on that bone scan.
On a plain x-ray from August 18th, 2000, the radiologist describes minimal smooth periosteal thickening or reaction along the medial aspect of the mid shift of the left femur. And then on lateral view it's described as a very small focal lucency in the central region.
So it appears around the time it was diagnosed in August of 2000, it was a small lesion in the femur.
Q. Are you able to state to any degree of certainty, given the size and the nature of that metastatic cancer in the femur, to what extent, if any, metastatic disease in the femur existed seven or eight months earlier?
MR. WARNER: Objection.
A. I testified earlier that I believe there was metastatic disease present at the time he was diagnosed with pneumonia in December of

Page 56

'99. I believe that had x-rays been done at that time or perhaps even a bone scan been done at that time that it would most likely not have been detectable by those studies, but I believe there were metastatic cells present there at that time.
Q. Would his prognosis have been better back in December from the standpoint of morbidity and mortality than it was in August?
MR. WARNER: Objection.
A. I don't believe that had his cancer been diagnosed at that time that his survival would have been improved at all.
Q. Zero? I mean, not even to a percentage? You think that the prognosis, as well as the degree of disability, that degree of morbidity, if you would, that he was going to go through in terms of chemotherapy and radiation, is it your testimony that there was no change in the prognostic factors at all between December and June or July of the next year?
MR. WARNER: Objection. Go ahead.
A. I think that had he been diagnosed at that time that his treatment would likely have been the same. And that he evidently would have

Page 57

succumbed to his tumor as he did with the diagnosis being made the date that it was.
Q. Are you saying he would have died around the same time or can you not say that?
A. It's my belief he would have died around the same time.
Q. So that you don't believe that a seven to eight month delay in diagnosis of nonsmall cell lung cancer is significant at all?
MR. WARNER: Objection to the number.
A. In this patient with this timing, that's my testimony.
Q. And I want to just make certain that I understand all of the bases upon which you arrive at that opinion to the extent that they are any different than what you already said.
A. That opinion is based on my knowledge as an internist, primary care doctor in the natural history of lung cancer. This man had clinically apparent metastatic disease as of June of 2000, and I believe looking back in time, again, knowing the natural history of lung cancer, that those metastases were present in December of 1999. They may not have been clinically apparent at that time. They may not

Page 58

have been radiographically apparent.
As I said, had he had x-rays done of his femur or bone scan done, it may very well have been read as normal, because the radiographic studies we use, whether it be CAT scans, x-rays, have a certain lower limit of detection, but I believe that based on what subsequently occurred with him developing a mass in his neck, a lesion in his femur, in June and July of 2000, that those metastases were, indeed, present in December of '99.
Q. When he was diagnosed in July or August of 2000, do you have an opinion as to what chance of survival he would have had? We know he ultimately died, but at that particular time, given the stage of cancer that he had, if you were looking at a staging manual or any literature, what would you say is the chance of him surviving at that time?
A. The survival for a Stage 4 lung cancer is very small. It's my understanding it's in the range of five percent or less as a five year survival.
Q. And is it your testimony that had it been diagnosed six or seven months earlier, that

Page 59

his chance of survival would have still been five percent?
A. Correct.
Q. The statement, the standard of care in patients over the age of 35 to 40 who have a history of cigarette smoking that have pneumonia -- strike that.
Do you agree with the statement that standard of care in patients over the age of 35 to 40, who have a history of cigarette smoking, that have pneumonia, require repeat chest x-rays because often pneumonia is precipitated by an underlying cause?
A. I agree that pneumonia can be precipitated by an underlying cause. As I testified earlier, I don't believe that, for example, this patient at age 42, his smoking history required a follow-up chest x-ray. I believe that that's an issue where a reasonable physician can have different opinions.
I would not disagree with somebody who would send, for example, this patient for a chest x-ray as a follow up. But I personally believe a follow up was not required in this man in this situation.

Page 60

Q. So that you wouldn't have criticized Dr. Mansnerus for ordering unnecessary testing had he scheduled him for a four to six week follow up given his smoking history?
A. I would not criticize that.
Q. Is lung cancer family related?
A. Probably some cases are. But I wouldn't say most cases are, no.
Q. You would agree, would you not, that there is an excellent long-term survival in patients who have a Stage 1 nonsmall cell lung cancer?
A. I would agree. As I mentioned earlier, it's been my experience that a Stage 1 cancer may later be determined to have actually been a Stage 4, but indeed if a patient is truly Stage 1 without metastatic disease, then the prognosis is good.
Q. Are you able to tell me based upon your knowledge, training, and experience and your review in this case as to when prior to December of 1999 in your opinion his lung cancer metastasized?
A. No. I would defer to an oncologist for that.

Page 61

Q. Are you able to tell me in this case based upon your knowledge, training and experience as to when Mr. Gill developed nodal involvement?
A. No.
Q. Again, you would defer to an oncologist?
A. Yes.
Q. I think we are wrapping up. You've indicated to criticism of Dr. Mansnerus on December 30th and no criticism of him on January 6th; correct?
A. Correct.
Q. And you have told me the reasons why different doctors would approach the issue of follow-up x-rays in this particular patient. Some would and some would not order a follow-up chest x-ray, but in your opinion, Dr. Mansnerus didn't deviate from what you considered to be an accepted standard of care by not ordering the chest x-ray?
A. Correct.
Q. Does that pretty much cover your opinions as it relates to standard of care in this case?

Page 62

A. Yes.
Q. And then as far as the opinions that you are going to provide on proximate cause, they are based in large part on your knowledge, training and experience in following these type of patients as opposed to hands-on, oncological treatment of these patients?
A. Correct.
Q. Staging, metastasis issues, nodal involvement issues, all of those things you would defer to oncologists in this case?
A. Yes.
Q. Any other opinions that you have as it relates to proximate cause in this case that we have not covered?
A. No.
Q. Let me check my notes. I think I may be done.
A. Okay.
(Pause.)
Q. A couple more questions.
Do you know how long complete radiological resolution of pneumonia normally takes?
A. That varies from patient to patient.

Page 63

I have seen patients who when I send them for their follow-up x-ray in four weeks the infiltrate is gone. I have seen some patients that take two to three months, sometimes even longer for the infiltrate to finally resolve.
Q. So is it fair to say that you can't necessarily say that it takes two to three months to have complete radiological resolution of a pneumonia as a rule of thumb that applies in every case?
A. Correct.
Q. It depends also in part on the location of the pneumonia, does it not?
A. Correct. And also varies with the original size of the infiltrate.
Q. Was the infiltrate in your mind, at least from the description on the interpretation, was it significant or was it garden variety, if you will?
MR. WARNER: Objection.
A. Well, the radiologist characterized it as a patchy infiltrate of density in the left upper lung, suggestive of pneumonia. So that would be the radiologist's evaluation of it.
Q. Can you comment any more on the

Page 64

significance of it from that description?
A. As I testified earlier, that description of a patchy density does not suggest to me that the radiologist was concerned about the presence of or possible presence of a cancer, and when looking at this x-ray report, it would not be a factor that would stimulate me to certainly get a follow-up chest x-ray.
Q. Of what significance do you place on the radiologist's language that indicates, suggests follow-up radiographic to document clearing?
A. Well, his description of the infiltrate does not suggest to me that the radiologist was concerned about the presence of a cancer. As I mentioned earlier, the decision as to whether or not a follow-up chest x-ray is done is a clinical decision. The radiographic description is part of that equation as far as whether or not a follow-up chest x-ray was done, but it's not the only factor in that equation and not the most important one.
There is nothing in this report that would make me, as a primary care doctor, concerned that there was an underlying cancer.

Page 65

Q. So in your opinion, it is reasonable, as a primary care doctor, when given a report from a radiologist that says suggests follow-up radiographic to document clearing, regardless of whether you're thinking pneumonia or some other pathology, it would be reasonable to disregard the radiologist's suggestion?
MR. WARNER: Objection.
A. I wouldn't say that the primary care doctor would disregard that recommendation. Based on that recommendation, I would carefully read the body of the report, and, as I testified earlier, see if the radiologist describes anything that sounds like the possibility of a cancer being present; did they describe a nodular density or a presence of a possible mass.
So a statement such as the radiologist made there as far as follow up would really make me focus on the body of the report to see if there was anything described that makes me concerned about the presence of a cancer.
Q. When you see a statement by radiologists suggesting that a radiographic be

Page 66

done to document clearing, as a primary care doctor, why is it even necessary for the radiologist to make that kind of suggestion to you as a primary care doctor?
A. I would expect that the primary care doctor looking at that recommendation by the radiologist would look at again the body of the report, look at the other factors involved in deciding whether to do a follow-up chest x-ray. As I said, the decision is a clinical one, not a radiographic one, and the clinical one would be based on a number of factors, not only the x-ray report.
Q. Certainly what the radiologist is saying in terms of suggesting a follow-up film should be considered by the primary care doctor; correct?
A. Correct.
Q. It shouldn't just automatically be dismissed and considered to be of no value to the primary care doctor; correct?
A. Correct.
Q. You don't have any criticism of the radiologist in this case, do you?
A. No.

Page 67

Q. Is there anything that you believe Mr. Gill, the patient, did or failed to do, other than his history of having been a smoker, that caused or contributed in any way to a delay in diagnosis?
A. No.
Q. Have we now exhausted the opinions that you hold in this case?
A. Yes.
Q. If you arrive at any new or additional opinions between now and the time of trial, would you please inform Mr. Warner of those so that I could have an opportunity to chat with you again?
A. Yes.
MR. MISHKIND: Thank you, doctor, for your time. Do you want to read the depo?
THE WITNESS: Please.
- - - - -
(Deposition concluded at 3:45 p.m.)
(Signature not waived.)
- - - - -

Page 68

AFFIDAVIT
I have read the foregoing transcript from page 1 through 67 and note the following corrections:

PAGE	LINE	REQUESTED CHANGE

RAYMOND L. ROZMAN, M.D.

Subscribed and sworn to before me this day of , 2003.

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 RAYMOND L. ROZMAN, 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 2nd day of September, 2003.

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