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Last Name	Rosmar Jr
First Name	Raymond W.
Specialty	Internist
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Page 1

1 IN THE COURT OF COMMON PLEAS
2 OF CUYAHOGA COUNTY, OHIO
3 -----
4 WILLIAM J. GILL, III, Executor
5 of the Estate of
6 DANIEL P. GILL, deceased,
7 Plaintiff,
8 vs Case No. 457639
9 Judge Russo
10
11 ROGER A. MANSNERUS, M.D.,
12 et al.,
13 Defendants.
14 -----
15 DEPOSITION OF RAYMOND L. ROZMAN, M.D.
16 FRIDAY, AUGUST 22, 2003
17 -----
18 Deposition of RAYMOND L. ROZMAN, M.D., a
19 Witness herein, called by counsel on behalf of
20 the Plaintiff for examination under the statute,
21 taken before me, Vivian L. Gordon, a Registered
22 Diplomate Reporter and Notary Public in and for
23 the State of Ohio, pursuant to agreement of
24 counsel, at the offices of University Suburban
25 Health Center, 1611 South Green Road, Cleveland,
Ohio, commencing at 2:00 o'clock p.m. on the day
and date above set forth.

Page 2

1 APPEARANCES:
2 On behalf of the Plaintiff
3 Becker & Mishkind
4 HOWARD D. MISHKIND, ESQ.
5 Skylight Office Tower Suite 660
6 1220 W. 2nd Street
7 Cleveland, Ohio 44113
8 241-2600
9
10 On behalf of the Defendant
11 Reminger & Reminger
12 ROBERT D. WARNER, ESQ.
13 1400 Midland Building
14 Cleveland, Ohio 44115
15 687-1311
16
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18 -----
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Page 3

1 -----
2 (Thereupon, ROZMAN Deposition
3 Exhibits 1 and 2 were marked for
4 purposes of identification.)
5 -----
6
7 RAYMOND L. ROZMAN, M.D., a witness herein,
8 called for examination, as provided by the Ohio
9 Rules of Civil Procedure, being by me first duly
10 sworn, as hereinafter certified, was deposed and
11 said as follows:
12 EXAMINATION OF RAYMOND L. ROZMAN, M.D.
13 BY MR. MISHKIND:
14 Q. Would you please state your name for
15 the record.
16 A. Raymond William Rozman, Jr.
17 Q. You are a physician; is that correct?
18 A. Yes.
19 Q. I understand that you are board
20 certified in internal medicine; is that correct?
21 A. Yes.
22 Q. And you have a subspecialty in
23 gastroenterology?
24 A. Yes.
25 Q. Your patient population that you see,

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1 a substantial portion of it is in the geriatric
2 population; true?
3 A. I see patients probably starting from
4 late teens through adulthood. The majority of
5 my patients are adults, probably over the age of
6 50.
7 Q. Just so I have a definition of that,
8 when you say the majority of your patients are
9 50 and older, how would you quantify that
10 percentage-wise?
11 A. I would estimate -- I have never
12 counted them -- I would estimate that probably
13 60 percent or so of my patients are 50 years or
14 older.
15 Q. What percentage of your patients do
16 you see for general internal medicine issues as
17 opposed to GI symptomatology?
18 A. About 80 to 85 percent of my patients
19 are my internal medicine patients and the other
20 15 to 20 percent of my practice is
21 gastroenterology. There is some overlap between
22 those groups, but that would be an estimate.
23 Q. Who are you currently affiliated with
24 in your practice?
25 A. I am a member of what's called

<p style="text-align: right;">Page 5</p> <p>1 Cleveland Physicians Incorporated, which is a 2 group of internal medicine physicians. 3 Currently we have approximately 20 members. 4 Q. How long have you been affiliated 5 with this group? 6 A. Since I started practice, 14 years 7 ago. 8 Q. Plaintiff's Exhibit 2 is a copy of 9 your CV that you were kind enough to provide to 10 me before the deposition. Is this current? 11 A. The only change in the CV would be 12 the fact that I'm no longer a director of 13 medical education at this facility. There was a 14 reorganization of the educational program here 15 about a year and a half, two years ago, and I no 16 longer hold that position. Other than that, it 17 is accurate. 18 Q. The publications that are on the 19 second page that number four, is that the extent 20 of your publications? 21 A. Yes. 22 Q. It looks like one of the publications 23 has to do with cancer, and the others appear not 24 to have anything to do with cancer; true? 25 A. Correct. Those four publications</p>	<p style="text-align: right;">Page 7</p> <p>1 time that you prepared your report but didn't 2 for whatever reason comment on having reviewed 3 it? 4 A. No. 5 Q. So what you considered for purposes 6 of your opinion letter are the medical records 7 outlined, the deposition of Dr. Mansnerus, and 8 the death certificate, for purposes of the 9 report; correct? 10 A. Yes. 11 Q. Since that time, I believe you have 12 received Dr. Steele's deposition transcript? 13 A. Yes. 14 Q. And Dr. Sutherland's transcript? 15 A. Yes. 16 Q. And I think there might be a 17 possibility of a couple other items. 18 A. Yes. 19 Q. What else? 20 A. I also have Dr. Steele's report, as 21 well as some publications that I believe were 22 attached to Dr. Steele's deposition; some 23 articles that he had copied and were actually 24 exhibits in his deposition. 25 Q. And they have just sort of come apart</p>
<p style="text-align: right;">Page 6</p> <p>1 were produced while I was a fellow at The 2 Cleveland Clinic Foundation, a fellow in 3 gastroenterology, so they would have been in 4 '88, and the two that were not dated were in 5 1989. I have not had any publications since 6 then. 7 Q. Does the article from 1988 that you 8 wrote when you were a fellow at CCF on 9 esophageal cancer in your opinion have any 10 relevance, in terms of the subject matter of 11 that article, to the subject matter that we are 12 talking about in Dan Gill? 13 A. No. 14 Q. The report that you wrote, which is 15 marked as Exhibit 1, is dated October 28th, 16 2002. Is this the only report that you have 17 written in this case? 18 A. Yes. 19 Q. I noticed before the deposition 20 started that you have a number of items in 21 addition to those which were represented by the 22 letter of October 28th, 2002. 23 A. Yes. 24 Q. Let me first ask you whether you were 25 provided with any additional information at the</p>	<p style="text-align: right;">Page 8</p> <p>1 from the transcript itself, but those were 2 exhibits to his depo; correct? 3 A. Correct. 4 Q. Have you reviewed those articles? 5 A. No. In addition, there was, I 6 believe, some notes also included with 7 Dr. Steele's deposition, some notes that 8 Dr. Steele had taken on Dr. Mansnerus' 9 deposition, as well as notes that he took on 10 some of the medical records. 11 Q. You have notes inside Dr. Steele's, 12 Dr. Sutherland's, and I think Dr. Mansnerus' 13 deposition transcripts; is that true? 14 A. Notes written by me? 15 Q. Yes, sir. 16 A. Yes. 17 Q. And that's your normal process when 18 you go through this type of work, to jot down 19 notes at or near the time that you are reviewing 20 transcripts; correct? 21 A. Correct. And what those consist of 22 are my recording of that person's testimony on 23 that numbered page. They don't contain any 24 impressions of mine or any conclusions that I 25 have made.</p>

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1 Q. So while we may have you read your
2 notes into the record, or the option that you
3 extended before to have you transcribe them, is
4 it fair to say that there are no opinions that
5 you have expressed in any of those notes when
6 you went through the deposition transcripts?
7 A. Correct.
8 Q. Okay. At the very least, what we
9 will do is we will mark those as exhibits at
10 some appropriate time and I will let you know
11 how we want to handle the transcription or your
12 reading them into the transcript.
13 A. Yes.
14 Q. Are there any other items that you
15 have before you, other than the two additional
16 depositions, the exhibits from Dr. Steele's
17 deposition that you have reviewed since October
18 28th, 2002?
19 A. I have a copy of Dr. Levitan's report
20 from October 22nd, 2002, which I received a copy
21 of today and briefly reviewed today.
22 Q. And you have Dr. Steele's report?
23 A. Correct. As well as another exhibit
24 from Dr. Steele's deposition, his page from the
25 textbook regarding staging.

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1 Q. Have you reviewed any of the
2 literature that Dr. Steele provided in
3 conjunction with his deposition?
4 A. I read briefly through his notes on
5 Dr. Mansnerus' deposition, as well as the
6 comments on Dr. Botham's report and his comments
7 on my report.
8 Q. Okay. Taking them one at a time, the
9 notes with regard to Dr. Mansnerus' deposition,
10 you have read over what Dr. Steele noted
11 relative to Dr. Mansnerus' testimony; correct?
12 A. Yes.
13 Q. Is there anything that you picked up
14 on as you read over those notes that you take
15 issue with?
16 MR. WARNER: Objection.
17 A. I do disagree with some of the
18 opinions expressed by Dr. Steele.
19 Q. Can you tell me specifically which
20 ones you disagree with?
21 A. My major disagreement with
22 Dr. Steele's opinions is with his statement that
23 a follow-up chest x-ray was indicated in this
24 patient.
25 Q. Are there any other areas in

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

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1 Q. Actually, let me give you the report
2 because I have a few notes that I would rather
3 you not take a look at. It's my work product
4 there.
5 (Discussion off the record.)
6 A. My opinion in that area would be that
7 even if a chest x-ray had been performed early
8 in the year 2000, that it would have unlikely
9 led to any significant change in the outcome of
10 Mr. Gill's illness.
11 Q. So you do intend to provide proximate
12 cause testimony that an x-ray in early 2000
13 would not have altered the outcome?
14 A. Correct.
15 Q. You are not an oncologist; correct?
16 A. Correct.
17 Q. You don't hold yourself out as a
18 specialist in the area of oncology or
19 hematology; correct?
20 A. I do not.
21 Q. You are not a radiologist; correct?
22 A. Correct.
23 Q. You are also not a cardiothoracic
24 surgeon?
25 A. Correct.

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

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1 A. That opinion is based on my review of
2 this case. I believe that as of that period of
3 time, and actually as of the date of the
4 December 1999 chest x-ray, that Mr. Gill already
5 had metastatic disease and that even if the
6 diagnosis had been made sooner, perhaps early in
7 2000, in February or March of 2000, that because
8 of the presence of metastatic disease that the
9 date of diagnosis would have been made earlier,
10 but it would not have favorably affected his
11 outcome.
12 Q. What is it in December of 1999 or
13 even January of 2000 that you are able to point
14 to in this case that causes you to say that
15 Mr. Gill had metastatic cancer at that time?
16 A. I would look at, for example, in June
17 of 2000, when he presented with some neck
18 discomfort, and then July of 2000, when he had a
19 neck mass, at that point the metastases to his
20 neck were clinically apparent, and I believe
21 that based on the clinical appearance of
22 metastatic disease in June of 2000, that it was
23 present six months earlier.
24 Q. Well, can you cite me to any articles
25 or literature or studies that would support that

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

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1 nodes or any involvement of the femur in
2 December or January; correct?
3 A. Correct.
4 Q. In fact, do you see any evidence that
5 Dr. Mansnerus palpated the neck or the arm or
6 the abdomen on this patient, either during early
7 December, end of December, or early January,
8 when he saw him again?
9 A. No.
10 Q. And is your opinion that he had
11 metastatic disease in the femur and in the neck
12 based upon the fact that he had metastatic
13 disease in the femur and the neck in June and
14 July?
15 A. Yes.
16 Q. Therefore, you conclude that he must
17 have had it in December and January?
18 A. Yes.
19 Q. Now, do you have enough expertise to
20 be able to differentiate for me the growth of
21 nonsmall cell versus small cell lung cancer?
22 A. As an internist and primary care
23 doctor, it's my understanding that small cell
24 cancer is a more aggressive tumor and grows more
25 quickly than nonsmall cell cancer. I am not

<p style="text-align: right;">Page 17</p> <p>1 able to comment on that with any degree of 2 specificity in terms of quoting articles. 3 The growth rate of tumors also varies 4 with their differentiation, and generally a 5 poorly differentiated tumor tends to be more 6 aggressive than a well differentiated tumor. 7 Q. At the time that this diagnosis was 8 made, what was the differentiation of his tumor? 9 A. I believe it was a poorly 10 differentiated carcinoma. 11 Q. I will wait until you get to the 12 record. Are you there now? 13 A. I do have a path report from January 14 of '01. I have not yet put my finger on the 15 earlier path report. 16 I don't have that in front of me. As 17 I stated, those opinions are based on my 18 knowledge of the natural history of cancer from 19 a primary care doctor, internal medicine 20 specialist knowledge. 21 Q. In terms of the staging of the 22 cancer, other than what we know he had at the 23 time of diagnosis, that being Stage 4, would you 24 defer to an oncologist as it relates to the back 25 peddling, if you will, the movement back in time</p>	<p style="text-align: right;">Page 19</p> <p>1 which was present in a microscopic state at the 2 time of staging was done later becomes 3 clinically evident. 4 Q. A patient that has Stage 1 cancer 5 that has cancer cells that get into the 6 bloodstream, is that defined as micrometastasis? 7 A. My definition of micrometastasis 8 would be a patient that has cancer cells which 9 have spread from a primary site which have moved 10 to another site in the body and are not yet 11 detectable by either physical examination or by 12 x-ray tests or blood tests. 13 Q. Do you recall reading in Dr. Steele's 14 testimony where he indicated that you or I may 15 have a certain number of cancer cells in our 16 body, but that it takes literally billions of 17 cancer cells to form what is known as a 18 clinically significant metastasis? 19 A. Yes, I remember reading that. 20 Q. And is that consistent with what you 21 understand from your knowledge, training and 22 experience? 23 MR. WARNER: Objection. 24 A. Let me refer to that page in his 25 deposition and see exactly what he said.</p>
<p style="text-align: right;">Page 18</p> <p>1 as to at what time he was a Stage 3, at what 2 time he was a Stage 2, and at what time he was a 3 Stage 1? 4 A. Yes, I would. 5 Q. Can we agree that if Mr. Gill had 6 been diagnosed when he was a Stage 1, non-small 7 cell lung cancer, that to a reasonable degree of 8 medical certainty, at least a degree of a 9 probability, he would have survived? 10 MR. WARNER: Objection. Go ahead. 11 A. Yes. I would state, though, that my 12 view of staging is that staging is based on 13 studies such as radiologic studies, which are 14 not able to detect the presence of cancer cells 15 until they are present in a certain number or 16 the lesion is a certain size. 17 So that someone who initially appears 18 to be a Stage 1 because the x-ray or the CAT 19 scan is negative, it's been my experience that 20 quite often as time goes along, the metastatic 21 disease or the nodal involvement which was not 22 radiologically apparent or clinically apparent 23 at the time staging was done, it later becomes 24 evident. So that a Stage 1 may later turn into 25 Stage 4 because perhaps the metastatic disease</p>	<p style="text-align: right;">Page 20</p> <p>1 Q. Okay. I will try to help you out as 2 well, if you don't get right to it. 3 It's probably page 33, 34. 4 A. To answer your question, I don't 5 think that he implies here on page 33 that, as 6 you say, you or I have metastatic cells floating 7 around our bodies. 8 Q. Hopefully we don't. 9 A. I believe what he says here is that 10 in a patient who has a primary tumor, that that 11 tumor sheds millions of cells and then 12 eventually some of those cells set up and form a 13 metastasis. I don't disagree with that. But I 14 would disagree with his statement in here that 15 that process didn't start until May or June. 16 Q. I understand. I suspected that that 17 was your opinion based upon your knowledge and 18 training and experience as you have set forth 19 before as there was metastasis even before 20 December of 1999; correct? 21 A. Yes. 22 Q. But there aren't any clinical factors 23 that you are able to point to me in Mr. Gill's 24 case that supports that conclusion, other than 25 what you understand to be the evolution of this</p>

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1 type of cancer; true?
2 A. Correct.
3 Q. In arriving at the opinions that you
4 have that we have started to talk about, did you
5 feel as if you had sufficient information to
6 arrive at the opinions that you have expressed?
7 A. Yes.
8 Q. And are your opinions after reading
9 the deposition transcripts of Dr. Sutherland,
10 Dr. Steele, and then perhaps using some of the
11 articles, have your opinions changed at all?
12 A. No.
13 Q. Have you arrived at any new opinions?
14 A. No.
15 Q. I take it in your practice from time
16 to time you have the occasion in an adult
17 patient to suspect that upper respiratory
18 symptoms or even lower respiratory symptoms are
19 related to a potential pneumonia?
20 A. Yes.
21 Q. And you use x-rays, certainly, as a
22 diagnostic tool to aid you in arriving at or
23 ruling out pneumonia; correct?
24 A. Yes.
25 Q. Do you read your films or do you

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

Page 23

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

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1 Q. So right from the very beginning, you
2 were told by the attorney for Dr. Mansnerus that
3 the issue in this case was, or the allegation
4 was that there was a failure to diagnose a Stage
5 4 nonsmall cell carcinoma at an earlier period
6 of time; correct?
7 A. That was in the letter, yes. When I
8 review a case, I always try to review based on
9 what is known at the time that that patient sees
10 that doctor and try to look at the case
11 prospectively.
12 Q. You recently testified in a nonsmall
13 cell carcinoma case, correct, in June or so of
14 this year?
15 A. Can you remind me of that?
16 Q. A Cuyahoga County case. I didn't
17 bring my entire file with me, but you were an
18 expert, as was Dr. Levitan, and attorney Brian
19 Eisen was plaintiff's attorney.
20 A. Yes. I believe that was actually
21 earlier this year than June, yes.
22 Q. Your depo was taken in March, and it
23 may have been maybe May. You lose track of time
24 after a while.
25 A. Yes.

Page 25

1 Q. That was a nonsmall cell cancer case;
2 correct?
3 A. I don't recall the specific
4 diagnosis, but it was a lung cancer case, yes.
5 Q. Now, in that particular case, you
6 were only providing opinions as it relates to
7 standard of care for the defendant doctor;
8 correct?
9 A. I don't recall the scope of my
10 opinions in that case.
11 Q. I have your deposition and I have
12 read it over, so I'll ask you to accept, at
13 least for purposes of this question, that the
14 scope of your testimony was limited to standard
15 of care and you weren't providing opinions as to
16 whether an earlier diagnosis would have made a
17 difference.
18 In this case you are providing both
19 standard of care as well as proximate cause
20 testimony; correct?
21 A. Yes.
22 Q. But yet, in terms of the detail of
23 staging and the progression of the cancer, you
24 readily admit that you would defer to an
25 oncologist?

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

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1 you can give to me; correct?
2 A. Correct.
3 Q. Have you ever kept track of your work
4 history in this area?
5 A. No.
6 Q. How long have you been doing
7 medical/legal work?
8 A. Approximately ten years. Probably
9 early '90s I started.
10 Q. You currently get some cases from
11 Saponaro and Associates; correct?
12 A. I have gotten cases from
13 Mr. Saponaro's firm. I have not gotten any
14 recently within the past several months.
15 Q. And Saponaro, for my purposes, is a
16 company that provides names or identification of
17 experts to attorneys. It's like a service
18 company that they introduce to you an attorney
19 for purposes of reviewing a case; correct?
20 A. My experience with Mr. Saponaro's
21 firm is that Guy Saponaro will call me and ask
22 me if I am interested in reviewing a case and
23 then the attorney will either contact me by
24 phone or will send me that case in the mail.
25 Q. Besides Saponaro and Associates, are

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1 there any other companies that provide expert
2 witnesses to attorneys that you are currently
3 affiliated with in any way?
4 A. I'm not sure that I'm affiliated with
5 Mr. Saponaro's firm.
6 Q. Maybe it's a poor choice. But I mean
7 that you have agreed to allow Mr. Saponaro to
8 contact you and introduce you to an attorney for
9 purposes of a review. Any other firms that have
10 the same kind of affiliation?
11 A. No.
12 Q. Have you ever been -- I'll use the
13 same term again -- affiliated with any expert
14 witness or any expert search firms other than
15 Saponaro at any time?
16 A. No.
17 Q. Have you ever advertised?
18 A. No.
19 Q. Have you worked at the request of
20 Mr. Warner on any cases before the Gill case?
21 A. I believe I reviewed one other case
22 for Mr. Warner in the past. I met Mr. Warner
23 for the first time earlier today.
24 Q. What did you think? I am putting you
25 on the spot. I'm kidding you.

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

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1 four years, it's been five to ten per year.
2 Q. And this year it's even increased
3 more; correct?
4 A. I have not counted them. It may be
5 less than ten. I don't think it's more than
6 ten.
7 Q. How many times have you testified at
8 trial?
9 A. I would estimate perhaps ten times.
10 That again is a rough estimate.
11 Q. Who is your malpractice carrier?
12 A. Currently we are with ProAssurance, I
13 believe. We had been with the Doctor's Company
14 but recently changed to ProAssurance.
15 Q. Do you happen to know who
16 Dr. Mansnerus is insured with?
17 A. No.
18 Q. Do you know Dr. Mansnerus?
19 A. No.
20 Q. You have never met him?
21 A. No.
22 Q. Have you talked to him in connection
23 with this case?
24 A. No.
25 Q. Dr. Levitan you know professionally?

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1 A. Yes.
2 Q. Do you know him also socially?
3 A. No.
4 Q. You refer some of your patients to
5 Dr. Levitan?
6 A. Yes.
7 Q. And that's been going on for a number
8 of years?
9 A. Yes.
10 Q. I would take it, without identifying
11 the names of any patients, you currently have
12 some of your patients that Dr. Levitan is
13 seeing?
14 A. Yes.
15 Q. How about Dr. Botham, do you know
16 Dr. Botham?
17 A. I have never met Dr. Botham. I
18 believe that he had taken care of one of my
19 patients in the past when he was still with the
20 University System.
21 Q. Tell me before I forget to ask you
22 this how much you charge for a deposition.
23 A. \$400 per hour.
24 Q. And the charge that you have for
25 reviewing cases?

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1 A. \$375 per hour.
2 Q. And how much will you charge
3 Mr. Warner when you testify at the trial of this
4 case?
5 A. For the time spent on the stand, \$500
6 per hour.
7 Q. How about for the time spent off the
8 stand?
9 A. Any preparation or review of records
10 would be the \$375 per hour.
11 Q. Have you been consulted on any cases
12 as an expert outside of the State of Ohio?
13 A. Yes.
14 Q. Give me an idea of how many.
15 A. Perhaps a dozen cases.
16 Q. So most of your medical/legal work
17 over the course of time has been Ohio cases?
18 A. Yes.
19 Q. And have most of them been
20 Northeastern Ohio cases?
21 A. I would estimate the majority of them
22 are from Northeastern Ohio.
23 Q. Do you have any cases currently in
24 your inventory that are outside of the State of
25 Ohio?

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1 A. Yes.
2 Q. How many would you say?
3 A. Less than five.
4 Q. Are you currently serving as an
5 expert witness at the request of any plaintiff's
6 attorneys?
7 A. Yes.
8 Q. How many?
9 A. How many different plaintiff's
10 attorneys?
11 Q. Yes.
12 A. I would estimate ten to 15.
13 Q. Any in Ohio?
14 A. Yes.
15 Q. Who are some of the plaintiff's
16 attorneys?
17 A. Kerry Volsky, Steven Charms, Peter
18 Marmaros, Stephen Crandall, Jay Kelley, James
19 Casey. Those are the ones I can recall right
20 now.
21 Q. All former defense attorneys.
22 A. Is that right?
23 Q. Yes. Except for Kerry Volsky and he
24 has done a little bit of both.
25 MR. WARNER: Note my objection.

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

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1 The second case was a patient of mine
2 who alleged that I did not diagnose an oral
3 cancer in a timely fashion. She was a patient
4 who told me that she had a lesion in her mouth.
5 I referred her to an ear, nose and throat doctor
6 where eventually the diagnosis of cancer was
7 made and I was one of several defendants named
8 in that suit for delay in diagnosis. And I was
9 dismissed without payment.
10 Q. Were your depositions taken in those
11 cases?
12 A. Yes.
13 Q. How long ago would you say those
14 cases were?
15 A. The first one was early '90, perhaps
16 1993 or 1994. Then the second case was perhaps
17 1998 or 1999.
18 Q. Have you ever testified at trial in
19 Ohio on behalf of a plaintiff suing a doctor?
20 A. No.
21 Q. Have you ever testified at deposition
22 in a case in Ohio on behalf of a patient suing a
23 doctor?
24 A. Yes.
25 Q. On how many occasions?

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1 A. As an estimate, perhaps ten cases.
2 Five to ten.
3 Q. Are any of those cases currently
4 pending?
5 A. Yes.
6 Q. Which of the attorneys that you have
7 identified would fall within that category?
8 A. I believe I have a case pending for
9 Mr. Kelley, as well as a case for Mr. Crandall,
10 and a case for Mr. Marmaros and Mr. Charms.
11 Q. Can you tell me when you were last
12 deposed?
13 A. Early July.
14 Q. In a defense case?
15 A. Yes.
16 Q. Was that a Reminger & Reminger case?
17 A. Yes.
18 Q. Who was the attorney?
19 A. James Malone.
20 Q. When are you scheduled to give your
21 next deposition?
22 A. September.
23 Q. Defense case?
24 A. Yes.
25 Q. Reminger & Reminger?

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

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1 95 percent of your medical/legal reviews over
2 the years have been for or at the request of an
3 attorney representing a doctor?
4 A. Yes. My testimony is that and has
5 been that I don't have a particular preference
6 plaintiff versus defense; that the balance of
7 cases, plaintiff versus defense, that I reviewed
8 reflect entirely of the cases that come my way.
9 Early in the years that I reviewed
10 cases it was entirely for the defense. In
11 recent years there have been more plaintiff's
12 cases. And as a result, that number, I believe,
13 has shifted over time.
14 Had you asked me the question eight
15 years ago, I would say it's 100 percent for the
16 defense and zero percent for the plaintiff. As
17 time has gone along and shifted, I still review
18 more cases for the defense than the plaintiff,
19 but that doesn't reflect any particular
20 preference on my part, it's entirely who has
21 sent me cases. I don't turn down any cases for
22 review.
23 Q. Even though it used to be 100
24 percent, in terms of the cases that are coming
25 to you, is it still at or near 95 percent for

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

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

<p style="text-align: right;">Page 41</p> <p>1 or accept Dr. Mansnerus' testimony as to what he 2 told the patient, correct, in terms of follow up 3 after that visit? 4 A. Yes. In his note from January 6, 5 2000, when it says will not repeat chest x-ray 6 unless cough fails to resolve, I would conclude 7 that that statement was based on a discussion 8 with the patient that if your cough doesn't 9 resolve, please come back or call me back. 10 Q. But it doesn't say will see patient 11 in X number of weeks to confirm resolution of 12 pneumonia, does it? 13 A. Correct. 14 Q. And in fact, it doesn't say 15 specifically that he would see the patient in 16 follow up for the pneumonia at any particular 17 time in the future? 18 A. Correct. 19 Q. You are aware, are you not, that 20 there are certain guidelines for the management 21 of adults with a community acquired pneumonia? 22 A. Yes. 23 Q. And in your practice, doctor, when 24 you have a -- strike that. 25 Was Mr. Gill at increased risk of</p>	<p style="text-align: right;">Page 43</p> <p>1 A. I believe that whether or not a 2 follow-up chest x-ray in a patient with 3 pneumonia is indicated is a clinical decision 4 based on a number of factors, including the 5 patient's age, the patient's smoking history, 6 the description of the infiltrate by the 7 radiologist on the chest x-ray, and whether or 8 not the patient's symptoms persist or whether 9 they resolve. 10 For example, in this patient, in a 11 42-year-old man with perhaps a 20 to 25 year, 20 12 to 25 pack year smoking history, not having 13 smoked in 12 years, who had on chest x-ray, what 14 was described as a patchy infiltrate of density, 15 I do not believe that a follow-up chest x-ray 16 was indicated. 17 Q. Is it your testimony that you would 18 not have ordered a follow-up chest x-ray if this 19 had been your patient? 20 A. Correct. 21 Q. Are you aware of any guidelines or 22 protocols with regard to the management of 23 adults with community acquired pneumonia that 24 indicate that a repeat chest x-ray is not 25 necessary or not recommended to establish a new</p>
<p style="text-align: right;">Page 42</p> <p>1 lung cancer because he had a history of smoking 2 than you or I that hopefully are nonsmokers? 3 A. Yes. One's degree of risk of lung 4 cancer related to smoking increases with the 5 number of pack years smoked. 6 Q. In terms of the guidelines for the 7 management of adults with community acquired 8 pneumonia, do you in your practice implement any 9 treatment protocol as it relates to the follow 10 up of and management of patients with community 11 acquired pneumonia? 12 A. I don't follow any specific protocol. 13 I have a strategy that I use in my own practice, 14 which I believe is within the standard of care, 15 but it's not based on a specific published 16 protocol. 17 Q. Tell me what your practice is when 18 you have a patient in their early 40s, presents 19 with a pneumonia, is put on Zithromax, the 20 radiologist interpretation indicates patching 21 infiltrate in the left upper lung suggestive of 22 pneumonia, suggests follow-up radiographic to 23 document clearing. 24 Tell me what your practice is in 25 terms of how you managed that type of patient.</p>	<p style="text-align: right;">Page 44</p> <p>1 radiographic baseline and to exclude the 2 possibility of malignancy? 3 A. I'm aware of that recommendation in 4 some protocols or guidelines. 5 I do get follow-up chest x-rays in 6 some of my patients, but not in all of them. 7 And in this specific patient, I do not believe 8 that I would have ordered a follow-up chest 9 x-ray unless his cough failed to resolve. 10 Q. It's incumbent upon the physician to 11 advise the patient, if your cough does not 12 resolve, I want you to come back and we will do 13 further diagnostic studies; correct? 14 A. Yes. 15 Q. Can we agree that at least from the 16 standpoint of the printed guidelines that are 17 out there -- and there is a number of them -- 18 but that generally speaking, the follow-up x-ray 19 after the initial film is usually in the four to 20 six week range? 21 A. Yes. 22 Q. And in a patient that you feel has 23 pneumonia and feel that there needs to be 24 evidence of a resolution of that pneumonia, do 25 you normally follow that four to six week</p>

<p style="text-align: right;">Page 45</p> <p>1 regimen? 2 A. Yes, I do. 3 Q. Now, of what significance, if any, do 4 you apply to the language of the radiologist 5 that says, suggests follow-up radiographic to 6 document clearing? 7 A. I'm aware of that the language in 8 that x-ray report from December 30th, 1999. My 9 reading of this x-ray report and my evaluation 10 of it in terms of whether or not a follow-up 11 chest x-ray is necessary is based on the 12 description of the infiltrate as being a patchy 13 infiltrate of density. 14 As I mentioned, one of the factors I 15 take into account in my own mind in whether I 16 order a follow-up chest x-ray is the 17 radiologist's description of infiltrate. If the 18 radiologist describes the infiltrate in a way 19 that makes me suspicious of there being a cancer 20 present, for example, if it's described as a 21 nodular infiltrate, or a mass-like density, if 22 the wording is suggestive of the possibility of 23 a cancer being present, then I would indeed 24 order a follow-up chest x-ray, even in someone 25 who is 42 years old.</p>	<p style="text-align: right;">Page 47</p> <p>1 crowded perihilar bronchovascular markings. 2 Q. But in the impression, can we say, 3 under number one, the prominence of the 4 perihilar bronchovascular markings may be due to 5 the depth of inspiration? 6 A. Yes, that is stated there. 7 Q. Okay. One of the reasons that there 8 are recommendations in internal medicine and in 9 other protocols that are widely published to do 10 follow-up radiographic to document resolution of 11 infiltrates is to exclude underlying diseases 12 that may be masked or camouflaged by a 13 pneumonia; correct? 14 A. Yes. 15 Q. And those underlying diseases that 16 you look for include neoplasms, potential 17 tumors; correct? 18 A. Yes. 19 Q. And can we agree that the literature 20 supports the proposition that follow-up 21 radiographic to document resolution of 22 infiltrates to exclude underlying disease such 23 as neoplasm are advocated for selected patients 24 who are over 40 years of age and are smokers? 25 MR. WARNER: Objection.</p>
<p style="text-align: right;">Page 46</p> <p>1 If the radiologist describes a patchy 2 infiltrate of density, as the radiologist did in 3 this report, to me that is not suggestive of the 4 presence of a cancer, and based on that, I would 5 not be likely to order a follow-up chest x-ray. 6 Q. Of what significance is the 7 radiologist's impression that there is some 8 prominence of the perihilar bronchovascular 9 markings? 10 A. The radiologist states that it 11 appears as if that finding or that appearance 12 was the result of a poor respiratory volume. If 13 a patient doesn't take a large deep breath when 14 the chest x-ray is taken, overall the lung 15 markings tend to look more prominent. They tend 16 to on the x-ray look whiter, and it appears as 17 if the radiologist here feels that that finding 18 was related to the depth of inspiration. 19 Q. I think you used the term may be 20 related; correct? 21 A. Well, I'll read exactly what the 22 radiologist stated. Both views demonstrate a 23 poor respiratory volume with probable crowding 24 of perihilar bronchovascular markings. The 25 radiologist seems to relate that finding of</p>	<p style="text-align: right;">Page 48</p> <p>1 A. I'm aware of recommendations to that 2 regard and some of the protocols and guidelines, 3 yes. 4 Q. If you had ordered a chest x-ray -- 5 and I understand that what you are saying is 6 that certainly in your report you are saying 7 then in January that one week follow-up visit a 8 chest x-ray was not indicated; correct? 9 A. Correct. 10 Q. And the reason that you would not 11 have ordered a chest x-ray at that point was 12 that there wouldn't have been enough time to 13 allow sufficient resolution of the pneumonia to 14 be able to appreciate any other pathology that 15 might be lurking? 16 A. Correct. 17 Q. Do you see any note at all by way of 18 an action plan as to when Dr. Mansnerus was 19 considering doing a follow-up x-ray if the 20 patient's cough did not resolve? 21 MR. WARNER: Objection. Asked and 22 answered. Go ahead. 23 A. No. His note states he would not 24 repeat the chest x-ray unless the cough fails to 25 resolve, but there is no time frame associated</p>

<p style="text-align: right;">Page 49</p> <p>1 with that. 2 Q. Now, can we agree in your report that 3 you do not comment at all about the decision on 4 the part of Dr. Mansnerus not to schedule 5 Mr. Gill for a repeat chest x-ray at some point 6 after the one week follow-up visit? 7 A. In my report I state the standard of 8 care did not require that Dr. Mansnerus order 9 another chest x-ray at the follow-up visit one 10 week later. By that statement I mean that the 11 standard of care did not require that he order 12 it for that day or that he order it, for 13 example, give the patient a requisition at that 14 visit for some point in the future. 15 Q. But specifically, we know that he was 16 seen January 2nd or 3rd or whatever the date 17 was, maybe January 6th. 18 A. January 6th. 19 Q. And your testimony is that on January 20 6th, Dr. Mansnerus, to comply with the standard 21 of care, did not need to order another chest 22 x-ray at that follow-up visit on January 6th; 23 correct? 24 A. Correct. And let me elaborate on 25 what I mean by that statement.</p>	<p style="text-align: right;">Page 51</p> <p>1 recommendations that are out in the 2 literature -- 3 MR. WARNER: Objection. 4 Q. -- is that what you are referring to? 5 A. Yes. 6 Q. Can we agree that there would have 7 been an increased likelihood that if a follow-up 8 film had been done four to six weeks after the 9 December 30, 1999 film, that that x-ray would 10 have shown, number one, some resolution of the 11 underlying pneumonia? 12 A. Correct. 13 Q. And given what we know was diagnosed 14 in July, do you have an opinion to a probability 15 as to whether or not that x-ray taken four to 16 six weeks after the December film would likely 17 have shown or raised an index of suspicion that 18 there might be some neoplasm evident on chest 19 x-ray? 20 A. I don't have an opinion to a 21 reasonable degree of medical certainty regarding 22 that issue. I believe that it's possible that 23 that follow-up chest x-ray would have shown a 24 persistent infiltrate without any suggestion of 25 cancer. It's also possible that the x-ray would</p>
<p style="text-align: right;">Page 50</p> <p>1 At that January 6th visit, 2 Dr. Mansnerus stated that he would not repeat a 3 chest x-ray unless the cough fails to resolve. 4 I don't believe that standard of care required 5 him to order an x-ray to be done on January 6th. 6 I don't believe the standard of care required 7 him to on January 6th give Mr. Gill a 8 requisition for four weeks or six weeks. I 9 believe that his plan as outlined on January 10 6th, 2000, was within the standard of care. 11 Q. Would it have been reasonable for 12 Dr. Mansnerus to have scheduled Mr. Gill for a 13 repeat visit four weeks later to come back to 14 examine him and then to make a decision at that 15 point whether or not a follow-up film was 16 necessary to show resolution of the pneumonia? 17 A. It would have been reasonable, but 18 not required by the standard of care. 19 Q. Now, you go on to say that even if 20 another chest x-ray had been performed in early 21 2000 -- do you see that? 22 A. Yes. 23 Q. I presume what you are referring to 24 is that the four to six week follow-up x-ray 25 that we have talked about in terms of the</p>	<p style="text-align: right;">Page 52</p> <p>1 have shown some resolution of infiltrate and may 2 have shown some signs of a cancer. 3 Q. If the latter were the case, and 4 there was at least an evidence of some neoplasm 5 or some suspicion of that, what would the 6 standard of care have required of the internist 7 under those circumstances? 8 A. At that point the standard of care 9 would require that a CAT scan of the chest be 10 performed. 11 Q. Would the CAT scan of the chest have 12 been something that could have been done just on 13 a routine basis or is this something that you 14 would want to get done as soon as possible? 15 A. Had the follow-up chest x-ray been 16 done and if it was suggestive of the presence of 17 a cancer, then the standard of care would 18 require that a CAT scan of the chest be done as 19 the next step in the evaluation. 20 Q. As quickly as one could get it 21 scheduled; correct? 22 A. Correct. It is not the sort of study 23 that would need to be done that day or the next 24 day, but within a short period of time. 25 Q. Within maybe 48 to -- a two to three</p>

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

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

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1 diagnosed?
2 A. I'm looking at a bone scan from
3 August 18th of 2000, which describes a finding
4 in his left femur and the radiologist mentioned
5 he was not able to differentiate between stress
6 fracture or metastasis based on that bone scan.
7 On a plain x-ray from August 18th,
8 2000, the radiologist describes minimal smooth
9 periosteal thickening or reaction along the
10 medial aspect of the mid shaft of the left
11 femur. And then on lateral view it's described
12 as a very small focal lucency in the central
13 region.
14 So it appears around the time it was
15 diagnosed in August of 2000, it was a small
16 lesion in the femur.
17 Q. Are you able to state to any degree
18 of certainty, given the size and the nature of
19 that metastatic cancer in the femur, to what
20 extent, if any, metastatic disease in the femur
21 existed seven or eight months earlier?
22 MR. WARNER: Objection.
23 A. I testified earlier that I believe
24 there was metastatic disease present at the time
25 he was diagnosed with pneumonia in December of

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

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

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

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1 his chance of survival would have still been
2 five percent?
3 A. Correct.
4 Q. The statement, the standard of care
5 in patients over the age of 35 to 40 who have a
6 history of cigarette smoking that have
7 pneumonia -- strike that.
8 Do you agree with the statement that
9 standard of care in patients over the age of 35
10 to 40, who have a history of cigarette smoking,
11 that have pneumonia, require repeat chest x-rays
12 because often pneumonia is precipitated by an
13 underlying cause?
14 A. I agree that pneumonia can be
15 precipitated by an underlying cause. As I
16 testified earlier, I don't believe that, for
17 example, this patient at age 42, his smoking
18 history required a follow-up chest x-ray. I
19 believe that that's an issue where a reasonable
20 physician can have different opinions.
21 I would not disagree with somebody
22 who would send, for example, this patient for a
23 chest x-ray as a follow up. But I personally
24 believe a follow up was not required in this man
25 in this situation.

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

<p style="text-align: right;">Page 61</p> <p>1 Q. Are you able to tell me in this case 2 based upon your knowledge, training and 3 experience as to when Mr. Gill developed nodal 4 involvement? 5 A. No. 6 Q. Again, you would defer to an 7 oncologist? 8 A. Yes. 9 Q. I think we are wrapping up. You've 10 indicated to criticism of Dr. Mansnerus on 11 December 30th and no criticism of him on January 12 6th; correct? 13 A. Correct. 14 Q. And you have told me the reasons why 15 different doctors would approach the issue of 16 follow-up x-rays in this particular patient. 17 Some would and some would not order a follow-up 18 chest x-ray, but in your opinion, Dr. Mansnerus 19 didn't deviate from what you considered to be an 20 accepted standard of care by not ordering the 21 chest x-ray? 22 A. Correct. 23 Q. Does that pretty much cover your 24 opinions as it relates to standard of care in 25 this case?</p>	<p style="text-align: right;">Page 63</p> <p>1 I have seen patients who when I send them for 2 their follow-up x-ray in four weeks the 3 infiltrate is gone. I have seen some patients 4 that take two to three months, sometimes even 5 longer for the infiltrate to finally resolve. 6 Q. So is it fair to say that you can't 7 necessarily say that it takes two to three 8 months to have complete radiological resolution 9 of a pneumonia as a rule of thumb that applies 10 in every case? 11 A. Correct. 12 Q. It depends also in part on the 13 location of the pneumonia, does it not? 14 A. Correct. And also varies with the 15 original size of the infiltrate. 16 Q. Was the infiltrate in your mind, at 17 least from the description on the 18 interpretation, was it significant or was it 19 garden variety, if you will? 20 MR. WARNER: Objection. 21 A. Well, the radiologist characterized 22 it as a patchy infiltrate of density in the left 23 upper lung, suggestive of pneumonia. So that 24 would be the radiologist's evaluation of it. 25 Q. Can you comment any more on the</p>
<p style="text-align: right;">Page 62</p> <p>1 A. Yes. 2 Q. And then as far as the opinions that 3 you are going to provide on proximate cause, 4 they are based in large part on your knowledge, 5 training and experience in following these type 6 of patients as opposed to hands-on, oncological 7 treatment of these patients? 8 A. Correct. 9 Q. Staging, metastasis issues, nodal 10 involvement issues, all of those things you 11 would defer to oncologists in this case? 12 A. Yes. 13 Q. Any other opinions that you have as 14 it relates to proximate cause in this case that 15 we have not covered? 16 A. No. 17 Q. Let me check my notes. I think I may 18 be done. 19 A. Okay. 20 (Pause.) 21 Q. A couple more questions. 22 Do you know how long complete 23 radiological resolution of pneumonia normally 24 takes? 25 A. That varies from patient to patient.</p>	<p style="text-align: right;">Page 64</p> <p>1 significance of it from that description? 2 A. As I testified earlier, that 3 description of a patchy density does not suggest 4 to me that the radiologist was concerned about 5 the presence of or possible presence of a 6 cancer, and when looking at this x-ray report, 7 it would not be a factor that would stimulate me 8 to certainly get a follow-up chest x-ray. 9 Q. Of what significance do you place on 10 the radiologist's language that indicates, 11 suggests follow-up radiographic to document 12 clearing? 13 A. Well, his description of the 14 infiltrate does not suggest to me that the 15 radiologist was concerned about the presence of 16 a cancer. As I mentioned earlier, the decision 17 as to whether or not a follow-up chest x-ray is 18 done is a clinical decision. The radiographic 19 description is part of that equation as far as 20 whether or not a follow-up chest x-ray was done, 21 but it's not the only factor in that equation 22 and not the most important one. 23 There is nothing in this report that 24 would make me, as a primary care doctor, 25 concerned that there was an underlying cancer.</p>

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

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1 done to document clearing, as a primary care
2 doctor, why is it even necessary for the
3 radiologist to make that kind of suggestion to
4 you as a primary care doctor?
5 A. I would expect that the primary care
6 doctor looking at that recommendation by the
7 radiologist would look at again the body of the
8 report, look at the other factors involved in
9 deciding whether to do a follow-up chest x-ray.
10 As I said, the decision is a clinical one, not a
11 radiographic one, and the clinical one would be
12 based on a number of factors, not only the x-ray
13 report.
14 Q. Certainly what the radiologist is
15 saying in terms of suggesting a follow-up film
16 should be considered by the primary care doctor;
17 correct?
18 A. Correct.
19 Q. It shouldn't just automatically be
20 dismissed and considered to be of no value to
21 the primary care doctor; correct?
22 A. Correct.
23 Q. You don't have any criticism of the
24 radiologist in this case, do you?
25 A. No.

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1 Q. Is there anything that you believe
2 Mr. Gill, the patient, did or failed to do,
3 other than his history of having been a smoker,
4 that caused or contributed in any way to a delay
5 in diagnosis?
6 A. No.
7 Q. Have we now exhausted the opinions
8 that you hold in this case?
9 A. Yes.
10 Q. If you arrive at any new or
11 additional opinions between now and the time of
12 trial, would you please inform Mr. Warner of
13 those so that I could have an opportunity to
14 chat with you again?
15 A. Yes.
16 MR. MISHKIND: Thank you, doctor,
17 for your time. Do you want to read the depo?
18 THE WITNESS: Please.
19 -----
20 (Deposition concluded at 3:45 p.m.)
21 (Signature not waived.)
22 -----
23
24
25

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1 AFFIDAVIT
2 I have read the foregoing transcript from
3 page 1 through 67 and note the following
4 corrections:
5 PAGE LINE REQUESTED CHANGE
6
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16
17
18 RAYMOND L. ROZMAN, M.D.
19 Subscribed and sworn to before me this
20 day of , 2003.
21 Notary Public
22
23 My commission expires .
24
25

1 CERTIFICATE

2
3 State of Ohio,
4 SS:
5 County of Cuyahoga.

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

13
14 I do further certify that this deposition
was taken at the time and place specified and
was completed without adjournment; that I am not
15 a relative or attorney for either party or
otherwise interested in the event of this
16 action. I am not, nor is the court reporting
firm with which I am affiliated, under a
17 contract as defined in Civil Rule 28(D).

18 IN WITNESS WHEREOF, I have hereunto set my
hand and affixed my seal of office at Cleveland,
19 Ohio, on this 2nd day of September, 2003.

20
21 
22

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

<p style="text-align: center;">A</p> <p>abdomen 16:6 able 14:13 16:20 17:1 18:14 20:23 48:14 54:15 55:5 55:17 60:19 61:1 about 4:18 5:15 6:12 13:6 15:20 21:4 22:22 29:22 31:15 32:7 37:20 39:16 49:3 50:25 54:15 64:4,15 65:22 above 1:24 69:11 accept 25:12 41:1 accepted 11:18 61:20 account 45:15 53:6 accurate 5:17 26:16 acquired 41:21 42:7,11 43:23 action 48:18 69:16 activities 54:16,21 actually 7:23 12:1 14:3 24:20 60:15 addition 6:21 8:5 additional 6:25 9:15 67:11 adjournment 69:14 admit 25:24 adult 21:16 adulthood 4:4 adults 4:5 41:21 42:7 43:23 advanced 54:6,12 54:14 advertised 28:17 advise 44:11 advised 34:20 40:20 advocated 47:23 affected 14:10 AFFIDAVIT 68:1 affiliated 4:23 5:4 28:3,4,13 69:16 affiliation 28:10 affixed 69:18 aforesaid 69:11 after 21:8 24:24 40:13 41:3 44:19 49:6 51:8,16 afterwards 69:11 again 13:23 16:8</p>	<p>28:13 30:10 57:22 61:6 66:7 67:14 age 4:5 43:5 47:24 59:5,9,17 aggressive 16:24 17:6 ago 5:7,15 29:23 35:13 38:15 agree 18:5 44:15 47:19 49:2 51:6 59:8,14 60:9,13 agreed 28:7 agreement 1:20 ahead 18:10 48:22 56:22 aid 21:22 al 1:9 allegation 24:3 34:16 allegations 23:21 alleged 35:2 allow 28:7 48:13 along 18:20 38:17 55:9 already 14:4 15:12 15:18 57:16 altered 12:13 always 24:8 and/or 53:24 another 9:23 19:10 29:15 49:9,21 50:20 answer 20:4 26:12 26:21 answered 48:22 answers 26:18 anything 5:24 10:13 65:14,21 67:1 apart 7:25 apparent 14:20 18:22,22 57:20,25 58:1 appear 5:23 appearance 14:21 46:11 APPEARANCES 2:1 appears 11:11 18:17 46:11,16 55:14 applies 63:9 apply 45:4</p>	<p>appointment 40:22 appreciate 48:14 approach 61:15 appropriate 9:10 40:10 approximately 5:3 27:8 40:3 area 11:24 12:6,18 27:4 53:14 areas 10:25 arm 16:5 around 20:7 55:14 57:4,6 arrive 21:6 22:14 57:15 67:10 arrived 13:25 21:13 23:13 arriving 21:3,22 article 6:7,11 15:4 articles 7:23 8:4 14:24 17:2 21:11 asked 11:17 23:11 37:5 38:14 48:21 asking 29:15 aspect 55:10 aspects 11:18 assessment 22:13 associated 48:25 Associates 27:11,25 assumed 53:21 assuming 11:17 attached 7:22 attorney 24:2,18,19 26:23 27:18,23 28:8 36:18 38:3 39:9 69:15 attorneys 26:14 27:17 28:2 33:6 33:10,16,21 36:6 37:11 August 1:13 55:3,7 55:15 56:9 58:13 automatically 66:19 aware 41:19 43:21 44:3 45:7 48:1 53:18</p>	<p>57:21 balance 38:6 based 13:11,13 14:1 14:21 15:6 16:12 17:17 18:12 20:17 24:8 26:15 41:7 42:15 43:4 45:11 46:4 54:9 55:6 57:17 58:7 60:19 61:2 62:4 65:11 66:12 baseline 44:1 bases 13:24 57:14 basis 13:7 29:13,17 52:13 Becker 2:3 becomes 18:23 19:2 before 1:18 5:10 6:19 9:3,15 13:5 20:19,19 22:20 23:7 26:7,11,12 28:20 29:6 31:21 68:18 beginning 24:1 behalf 1:16 2:2,10 34:25 35:19,22 37:8 being 3:9 17:23 34:24 45:12,19,23 57:2 65:15 belief 57:5 believe 7:11,21 8:6 14:2,20 15:11,13 15:18 17:9 20:9 24:20 28:21 29:4 30:13 31:18 36:8 38:12 40:19 42:14 43:1,15 44:7 50:4 50:6,9 51:22 54:4 55:23 56:1,4,11 57:7,21 58:7 59:16,19,24 67:1 Besides 27:25 best 23:7 26:25 better 13:20 56:7 between 4:21 53:16 55:5 56:20 67:11 billions 19:16 bit 22:22 33:24 blood 19:12 bloodstream 19:6 board 3:19 bodies 20:7</p>	<p>body 15:16 19:10 19:16 65:12,20 66:7 bone 55:2,6 56:2 58:3 both 25:18 33:24 46:22 Botham 31:15,16 31:17 Botham's 10:6 breakdown 37:18 breath 46:13 Brian 24:18 briefly 9:21 10:4 bring 24:17 bronchoscopy 53:12 bronchovascular 46:8,24 47:1,4 Buckingham 37:4 Building 2:13 Burroughs 37:4</p> <p style="text-align: center;">C</p> <p>calendar 29:8 call 27:21 34:19 41:9 called 1:16 3:8 4:25 23:11 34:19 came 53:16 camouflaged 47:12 cancer 5:23,24 6:9 13:2,12,14 14:15 15:7,10,19 16:21 16:24,25 17:18,22 18:7,14 19:4,5,8 19:15,17 21:1 25:1,4,23 26:3 34:4 35:3,6 42:1 42:4 45:19,23 46:4 51:25 52:2 52:17 53:20,23,25 54:3,7,9,11,12,13 54:17,17,20 55:19 56:11 57:9,19,23 58:16,21 60:6,12 60:15,22 64:6,16 64:25 65:15,23 cancers 54:13 carcinoma 17:10 23:23 24:5,13 cardiothoracic 12:23 53:24</p>
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