

1                   IN THE COURT OF COMMON PLEAS

2                   SUMMIT COUNTY, OHIO

3           KAREN WILSON,

4                   Plaintiff,

5                               JUDGE MURPHY

5                   -vs-

5                               CASE NO. CV-2002-06-3340

6           YOUN PARK, M.D., et al.,

7                   Defendants.

8                   - - - -

9                   Deposition of DAVID W. STEPNIK, M.D., taken  
10           as if upon cross-examination before Tami A.  
11           Mitchell, a Registered Professional Reporter and  
12           Notary Public within and for the State of Ohio,  
13           at University Hospitals of Cleveland, 11100  
14           Euclid Avenue, Cleveland, Ohio, at 3:08 p.m. on  
15           Friday, August 22, 2003, pursuant to notice  
16           and/or stipulations of counsel, on behalf of the  
17           Plaintiffs in this cause.

18                   - - - -

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

W I T N E S S I N D E XPAGE

CROSS-EXAMINATION  
DAVID W. STEPNIK, M.D.  
BY MS. TAYLOR-KOLIS..... 4

E X H I B I T I N D E XEXHIBITMARKED

Plaintiffs' Exhibit A..... 35  
Plaintiffs' Exhibit B..... 39  
Plaintiffs' Exhibit C..... 70

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

7                    CROSS-EXAMINATION OF DAVID W. STEPNIICK, M.D.

8                    BY MS. TAYLOR-KOLIS:

9                    Q.    Doctor, for the record, let me state my name is  
10                    Donna Kolis. We were just briefly introduced  
11                    before the start of the deposition.

12                    As you are probably aware from multiple  
13                    correspondence from Mr. Griffin, I represent the  
14                    estate of Geraldine Bailes. My understanding is  
15                    you are going to serve as an expert witness at  
16                    trial of the lawsuit. Is that a fair  
17                    understanding?

18                    A.    That's correct.

19                    Q.    I received an expert report that was apparently  
20                    authored by yourself dated April 18, 2003.

21                    Doctor, to the best of your knowledge, is this  
22                    the only report you authored in this matter?

23                    A.    To the best of my knowledge, yes.

24                    Q.    I guess what we are going to do, you had an  
25                    opportunity to testify on occasions other than

1           today, correct?

2   A.   Correct.

3   Q.   You have a pretty basic understanding of the  
4       deposition rules.  You know you have to answer  
5       all my questions verbally; is that correct?

6   A.   Yes.

7   Q.   My purpose today, honestly, is find out what  
8       you're going to testify to at trial, both as to  
9       the issue of standard of care and proximate  
10      causation.

11           As you are undoubtedly aware, I'm not a  
12      physician, or at least not to your knowledge.  
13      Having said that, occasionally I ask questions  
14      that don't make sense.  It's not purposeful.  I  
15      may ask a question and it may not sound correct  
16      medically.  If that occurs, would you extend me  
17      the courtesy of indicating you don't know what  
18      I'm asking you?

19   A.   Yes.

20   Q.   I would appreciate that.  If you have something  
21      more pressing than answering my question, as in  
22      you receive a page, simply let us know.  I don't  
23      have any great plans for the evening; however  
24      long this takes us that is fine with me.

25   A.   I will do so.

1 Q. Have you on any occasion prior to this particular  
2 piece of litigation worked for Mr. Griffin or any  
3 of the members of his law firm, Buckingham  
4 Doolittle?

5 A. Not to my knowledge.

6 Q. How frequently do you review medical legal  
7 matters?

8 A. Probably on the average about one case per year,  
9 perhaps two.

10 Q. And generally speaking, we'll start with general,  
11 what kinds of cases are you contacted to review?

12 A. Most of the cases probably relate to head and  
13 neck cancer, a few sinus surgery cases. To my  
14 recollection those are the primary ones.

15 Q. My guess was going to be it would have to be  
16 oncology related because of your CV. But would  
17 you say that's the majority of the cases you look  
18 at?

19 A. Yes.

20 Q. How many times have you given a deposition?

21 A. I would estimate six to eight.

22 Q. Okay. Have you ever testified for a patient?

23 A. As in a deposition?

24 Q. Yes.

25 A. Yes.

1 Q. Okay. And did you do so in your capacity as a  
2 subsequent treating physician or expert witness?

3 A. I'm sorry. You asked if I testified for the  
4 patient. You mean if there is a lawsuit,  
5 testifying for the attorney representing the  
6 patient?

7 Q. Yes.

8 A. Yes.

9 Q. We got a yes, yes?

10 A. Yes.

11 THE WITNESS: Could you read back  
12 the last part of her question, please?

13 - - - -

14 (Thereupon, the requested portion of  
15 the record was read by the Notary.)

16 - - - -

17 Q. As an expert witness?

18 A. As an expert witness.

19 Q. How many occasions, please?

20 A. Of the depositions probably three-quarters of  
21 those on the basis of the patient.

22 Q. Okay. And have you ever rendered testimony in  
23 Cuyahoga County on behalf of a patient as an  
24 expert witness?

25 A. Yes, I have.

1 Q. What plaintiffs attorneys have you worked with?

2 A. Plaintiffs attorneys?

3 Q. Plaintiffs, attorney representing the patient.

4 A. I don't recall the names to be honest.

5 Q. When is the last time you testified, either by  
6 deposition or in a court of law, on behalf of a  
7 patient?

8 A. I would say by deposition maybe two years ago on  
9 behalf -- in a court of law it's been many more  
10 years than that.

11 Q. When is the last time you testified in a trial?

12 A. The trial was about ten years ago, if I remember.

13 Q. Okay. At present how many cases are you  
14 currently reviewing?

15 A. This one and then there's another case that's on  
16 behalf of the plaintiff that's representing the  
17 patient which I'm the treating physician.

18 Q. You're the treating physician. What attorney is  
19 representing the patient?

20 A. I don't recall.

21 Q. Okay. You know Dr. Lavertu, correct?

22 A. I do.

23 Q. During the course of your analysis of this case  
24 were you provided with a copy of the expert  
25 report that was written by Pierre?

1 A. No.

2 Q. For purposes of brevity, I will state for the  
3 record in reviewing your CV I have no doubt  
4 you're qualified as an expert witness in this  
5 matter. Just to make certain, you're currently  
6 licensed in the state of Ohio, correct?

7 A. Yes, I am.

8 Q. I would assume from what I'm able to glean from  
9 these numerous pages, at least 50 percent of your  
10 professional time is in the active, clinical  
11 practice of medicine?

12 A. Yes.

13 Q. You also teach?

14 A. I do.

15 Q. Are you teaching at the medical school or by way  
16 of rounding the residents here?

17 A. Primarily the residents.

18 Q. Do you teach any classes at the medical school?

19 A. No.

20 Q. What textbooks do you refer your residents to in  
21 terms of supplementing their hands-on learning in  
22 otolaryngology?

23 A. It depends on the specific area of otolaryngology  
24 and also depends on the specific procedure. In  
25 the area of facioplastic, if it's a face lift,

1       one text; if it's eyes, it's another. So a  
2       variety of different textbooks.

3   Q. Can you name those textbooks for me?

4   A. All of them?

5   Q. Well, let's make it easy. Would there be a  
6       particular textbook that you would commend to the  
7       reading of your residents? Are you involved in  
8       any fellowship training programs?

9   A. No, I'm not.

10   Q. Would there be a textbook you would commend to  
11       their reading relative to the basic understand of  
12       nasal vestibular or nasoseptal cancer?

13   A. Probably not a single textbook, no.

14   Q. How many multiple textbooks would you ask them to  
15       look at for the material?

16   A. As you know it's a rather unusual entity.

17   Q. Yes.

18   A. And I think as you also know the textbooks  
19       represent the opinions of the person writing  
20       them. So probably if I were going to ask the --  
21       if the residents were interested in knowing about  
22       that, I would ask them to do a literature search  
23       to see what was new and relevant in the area, if  
24       anything had been published recently.

25   Q. Had you done a literature search in anticipation

1 of my deposition to find out what is new and  
2 relevant in the area?

3 A. No.

4 Q. Did you do any literature search relative to the  
5 issues that present themselves in this case?

6 A. No.

7 Q. Unrelated but social question, you are acquainted  
8 with my expert Dr. Barry Wenig?

9 A. I know who he is. If he walked down the hall, I  
10 would not know who he was.

11 Q. Have you heard him lecture or read his published  
12 material?

13 A. I have not heard him lecture. I don't know if I  
14 read his published material.

15 Q. Let's talk about what you do for a living. You  
16 have an office in Beachwood?

17 A. That's correct.

18 Q. Is that your primary place of practice you see  
19 patients?

20 A. No. I have many actually.

21 Q. Tell me where all your offices are.

22 A. Probably would be easier to tell you what I do on  
23 a week. Monday I operate at University  
24 Hospitals. On Tuesdays I operate at the VA,  
25 Cleveland VA. On Wednesdays I'm here for

1 conference in the morning and go to the office I  
2 think you're referring to, Beachwood or Chagrin  
3 Highlands, and see patient there. Thursdays I'm  
4 in Westlake at University Hospitals Westlake, OR  
5 in the morning, seeing patients in the afternoon.  
6 On Friday after our head and neck tumor  
7 conference in the morning I either go to the  
8 University Suburban office which is in South  
9 Euclid, unless it's the second Friday of the  
10 month in which case I'm here for the Bolwell  
11 Clinic.

12 Q. Now, I think I know where you spend your time.  
13 What does the majority of your practice consist  
14 of at this point? What are you doing when you're  
15 doing these surgeries?

16 A. Is the question the majority of my practice when  
17 I'm seeing patients?

18 Q. Or doing surgeries...

19 A. Majority of the patients I see have head and neck  
20 tumors.

21 Q. To put it different and quicker to the point,  
22 hopefully a spin on it, your practice of  
23 otolaryngology is specialized into what appears  
24 to me to be operations on head and neck tumors.  
25 That's what you spend the majority of your time

1           doing, am I correct?

2   A.   Correct.

3   Q.   I always do a double negative.  It wouldn't  
4       appear you have a general ENT practice seeing 60  
5       people for a sundry of complaints, wax in the  
6       ears, runny noses?

7   A.   Correct.  Some of those patients will wind up in  
8       my office.  That's not generally whom I'm  
9       supposed to be seeing.

10  Q.   Are the majority of patients you treat  
11       professionally referred to you by other  
12       physicians who have ascertained there may be an  
13       issue regarding head and neck tumor?

14  A.   Yes.

15  Q.   Doctor, from your point of view as the  
16       otolaryngologist, I love saying that word, is  
17       there a difference between a sore nose and a sore  
18       in the nose?

19  A.   I am big on semantics.  And to me those would  
20       mean different things.  Probably to most people  
21       they wouldn't.  To me a sore in the nose refers  
22       to a thing or a sore, where a sore nose is a  
23       symptom.

24  Q.   Okay.  Prior to rendering your written report in  
25       this matter, can you tell me what materials you

1           actually reviewed, everything that is yours on  
2           the table, I believe?

3   A.   Could I see the -- see the report that I  
4           authored?  It's in the pile here somewhere.

5   Q.   I didn't take it.

6                           MS. TAYLOR-KOLIS:  These are my  
7                           folders.  These are his.

8   A.   I would have stated in that report what I had  
9           reviewed.

10   Q.   Just to make this -- so we don't stay here all  
11           day, this is the report that I received.  Of  
12           course, my copy is highlighted.

13                           MR. GRIFFIN:  I have an  
14                           unhighlighted copy.

15   A.   Apparently, I'm reading from that report to help  
16           me recall, it says I reviewed office records and  
17           depositions of Drs. Park and Manning, as well as  
18           the opinion of Dr. Wenig provided you regarding  
19           the standard of care.

20   Q.   To the best of your belief, prior to the time you  
21           wrote this report the only thing you then  
22           reviewed was Dr. Park's office notes and  
23           Dr. Manning's office notes, correct, in terms of  
24           medical records?

25   A.   Right.  And some of those I have to go back and

1 look, some of them as part of their office chart  
2 may have had other information, whatever was part  
3 of their chart.

4 Q. Whatever was part of their chart?

5 A. Yes.

6 Q. Subsequent to the time you have reviewed  
7 additional medical records of any sort?

8 A. Yes, I have.

9 Q. Can you tell me what you subsequently reviewed?

10 MR. GRIFFIN: There's an index to  
11 all the records. I don't know when you  
12 reviewed them.

13 A. I reviewed -- re-reviewed some of these,  
14 Dr. Park's, Dr. Manning's records, records from  
15 Gary Williams, pathology and radiology from Summa  
16 Health Systems reports, certain records from  
17 St. Thomas Medical Center, office chart from  
18 Paragon Health Associates, records from Edwin  
19 Shaw Hospital, records from Dr. Sieder/Sieder,  
20 additional things from Summit Oncology,  
21 Dr. Steinberger, Dr. Trantri's records, records  
22 from The Cleveland Clinic Foundation, additional  
23 things from Summa, that's probably most of them.  
24 I did also review Dr. Wenig's deposition.

25 Q. His deposition this past week, Wednesday?

1 A. Yes.

2 Q. And the deposition of Dr. -- the pathologist  
3 Dr. Makk?

4 MR. GRIFFIN: M-a-k-k.

5 Q. Has the reading or evaluation of the additional  
6 materials that you just discussed with me changed  
7 any opinion that you initially rendered?

8 A. No.

9 Q. Has it caused you to have additional opinions  
10 other than listed in this report?

11 A. Just that I think I agree with what I said there  
12 more.

13 Q. All right. Doctor, have you ever been sued?

14 A. Yes.

15 MS. TAYLOR-KOLIS: Objection for  
16 the record, of course.

17 Q. How many times have you been sued?

18 A. Perhaps half a dozen, six.

19 Q. And of those half dozen or six did any of them  
20 have to do with failure to diagnose nasal  
21 vestibular cancer?

22 A. No.

23 Q. Were payments made on your behalf of any of those  
24 six cases?

25 A. No.

1 Q. Who is your insurance carrier?

2 A. This week?

3 Q. Yeah, this week.

4 A. I think Mutual Assurance but I could be wrong.

5 Q. Are you a member of a group?

6 A. I'm a member of the group here at University  
7 Hospitals which is University Faculty Practice  
8 Associates which has a carrier.

9 Q. Did you go to the lecture which Jim Malone gave?  
10 You might have, you may not have. I thought he  
11 did that, gave a big lecture to the University  
12 Family Group not long ago regarding who your  
13 carrier was.

14 Prior to this litigation did you know  
15 Dr. Park?

16 A. I knew of him.

17 Q. How did you know of Dr. Park?

18 A. I have taken care of patients he's taken care of.  
19 He's referred some patients.

20 Q. He referred patients to you?

21 A. Yes.

22 Q. Okay. Dr. Park I assume, to the best of your  
23 knowledge, does not do surgery on head and neck  
24 tumors?

25 A. He may well.

1 Q. But you don't know that one way or the other?

2 A. I don't know that one way or the other.

3 Q. Why did he end up referring the patients to you,  
4 to the best of your knowledge?

5 A. Community physicians will often take care of head  
6 and neck cancer patients. If they feel that it  
7 is a cancer that requires more expertise, because  
8 that's what training you receive as an  
9 otolaryngologist, on occasion if someone feels  
10 they need more expertise on other occasions when  
11 somebody wants to deal with the intricacies of  
12 the treatment, radiation, chemotherapy and  
13 whatnot or some patients -- some physicians  
14 simply will refer because they're not interested  
15 in dealing with the patient.

16 I don't know why specifically Dr. Park. My  
17 recollection is that he's probably referred again  
18 about half dozen patients so it's not a large  
19 number. Typically these would be somebody that  
20 he's identified a problem that he thought could  
21 be better taken care of at an institution we have  
22 a team approach towards tumor.

23 Q. Describe your team approach towards tumor.

24 A. University Hospitals has the Ireland Cancer  
25 Center which is a National Cancer Institute

1       Accredited cancer center. As part of head and  
2       neck there is a multidisciplinary team that  
3       consists of otolaryngologists which would be, as  
4       I would often say to patients, surgical  
5       oncologists because there is no specialty of  
6       surgical oncology as you're aware, radiation  
7       oncologist, actually several medical, several  
8       medical oncologists, social workers, dentists,  
9       radiologists, pathologists. So typically what  
10      would happen is almost all cancer patients  
11      presented as part of this multidisciplinary  
12      conference that I referred to earlier in the  
13      testimony to, number one, educate the residents  
14      about the different treatment modalities and also  
15      as an education conference to help get varying  
16      opinions from the physicians in the room as to  
17      what they believe is the best treatment modality,  
18      to establish if a patient is eligible for any  
19      experimental protocols, et cetera. And  
20      university has as its main campus where we are  
21      here, all of its satellite locations and that we  
22      end up working together and caring for these  
23      patients and they're treated as required.

24    Q.   Okay. Before we get into the most important  
25      stuff, we are going to work a little backwards.

1 After you reviewed the initial materials and then  
2 the subsequent medical materials that you  
3 received and/or depositions did you reach a  
4 conclusion that anyone subsequent to the  
5 diagnosis of Mrs. Bails' cancer in January of  
6 2001 was below the standard of care?

7 A. I thought that as I reviewed the records that  
8 when her cancer recurred, which again  
9 semantically it didn't recur, it regrew, that it  
10 struck me there were some irregularities that  
11 could potentially be considered below the  
12 standard of care.

13 Q. Dr. Wenig used the word persistence versus  
14 recurrences. Do you have an objection to his use  
15 of the word persistence of her cancer?

16 A. Again, as I alluded to, I'm big on semantics.  
17 And recurrences in my mind is something that  
18 means the tumor was gone and then it came back.  
19 And the reason that that's probably an accurate  
20 term it's not a new cancer, that when the tumor  
21 is rediscovered it is simply regrown. Tumors  
22 that completely disappear and show up in the same  
23 place at another time truly haven't recurred.  
24 Probably 99 percent of all physicians would  
25 consider that recurrence, regrowth or persistence

1           which means the tumor was microscopic in size  
2           where it was not visible and undetectable to a  
3           point the tumor can be detected.    I would not  
4           have an objection to that terminology.

5   Q.   Once again, this is, I don't want to call it a  
6       red herring, these were mentioned during  
7       cross-examination.   I wanted to take a look at  
8       them.

9           Would you agree with me subsequent to the  
10       conclusion of Mrs. Bails' radiation treatment in  
11       April that there wasn't a second biopsy within  
12       three months to determine the cancer had  
13       completely disappeared?

14   A.   Can you read that back?

15   Q.   I talk fast.

16                               -   -   -   -

17                               (Thereupon, the requested portion of  
18                               the record was read by the Notary.)

19                               -   -   -   -

20   A.   I would specifically have to look at the dates in  
21       the records.    As what I alluded to, as I was  
22       reading through the records and noticing some  
23       signs perhaps the tumor was regrowing it seemed  
24       there was some delay when that biopsy was  
25       performed.

1 Q. I will represent the biopsy didn't occur, the  
2 next biopsy until October of 2001. Is that your  
3 recollection?

4 A. Roughly, yes.

5 Q. Having said you felt there were irregularities,  
6 you felt that sometime in July of 2001 when there  
7 was now the appearance of, I think what's been  
8 described as a satellite lesion, perhaps a biopsy  
9 should have been done at that point?

10 A. I would have done so and I think most physicians  
11 would have.

12 Q. Do you have an opinion, to a reasonable degree of  
13 medical probability, as to whether or not those,  
14 what you've termed them. Irregularities caused  
15 or contributed to Mrs. Bailes' death in January  
16 of 2002?

17 A. I think that's difficult to say because the tumor  
18 was originally, as you're aware, a small tumor  
19 that was staged as a T-1 tumor. She then  
20 underwent her radiation therapy and thereafter  
21 it's apparent the growth rate changed.

22 Q. I hate to let myself do that. Tell me why the  
23 growth rate changed to you. What are you basing  
24 that opinion on?

25 A. I'm basing that on the description of what her

1 physical exam was when the radiation oncologist  
2 and others had seen her following the completion  
3 of radiation therapy.

4 Q. You're not basing it on histology as contained in  
5 the pathology slides saying it changed?

6 A. Correct.

7 Q. In fact, the first biopsy and second biopsy  
8 described the same type of cancer, correct?

9 A. That's my recollection, yes.

10 Q. Same characteristics?

11 A. That is my recollection, yes.

12 Q. Including that's what Dr. Makk testified to,  
13 correct?

14 A. As far as I recall.

15 Q. You haven't independently looked at that  
16 pathology slide?

17 A. I have not.

18 Q. Would it do you any good if you did?

19 A. Probably not.

20 Q. You're assertion her growth rate changed in this  
21 particular cancer is based upon physical  
22 findings; is that right?

23 A. Yes.

24 Q. And because I don't do this for a living, what  
25 about the physical changes indicate to you that

1 her growth rate changed?

2 A. Probably the most obvious one as I recall was the  
3 general plastic surgeon Dr. Trochelman, Tantri,  
4 I'm not looking at his note, but from my  
5 recollection it was him that described in an  
6 exam, if I recall, about one week apart where at  
7 one point she didn't have something and then a  
8 week later that she had multiple satellite  
9 nodules.

10 Q. What would account for that, Dr. Stepnick,  
11 assuming the accuracy of the doctor's observation  
12 and examination which I'm not challenging?

13 A. Are you asking what the nodules came from?

14 Q. What would account for the difference in that one  
15 week examination?

16 A. Without having seen the patient, I'm sort of  
17 speaking generally. Generally when you have  
18 tumor recurrences that is seen as multiple  
19 nodules throughout the skin that is considered  
20 dermal metastasis. Dermal metastasis traveled  
21 through the -- travels in the dermis and implants  
22 in other areas of the dermis and grow. If  
23 something grows in that period of time that is  
24 not characteristic of squamous cell carcinoma in  
25 general that would be considered very rapid.

1 Q. Could that occurrence, that event you and are you  
2 discussing and we don't need to be specific of  
3 the date, we know what note we are talking about,  
4 those notes that are a week apart, this sudden,  
5 dramatic appearance of additional satellite kinds  
6 of abnormalities not be a direct product, the  
7 fact cancer had been seeding through the dermis  
8 for some period of time and was now full-blown  
9 metastatic disease?

10 A. I think that's very unlikely. I think that the  
11 most likely thing is that the biologic behavior  
12 of the tumor changed during radiation therapy and  
13 following the radiation that the cells started to  
14 travel and then the growth rate accelerated to  
15 the point you could see physical signs changing  
16 in a very short period of time.

17 Q. Is radiation -- okay. Let me withdraw, starting  
18 of the question with an ending part.

19 This change in the biological behavior of  
20 this particular cancer as a result of radiation  
21 therapy is a known entity?

22 A. Yes.

23 Q. Do you agree that it was true? I'm trying to do  
24 my years and not think of any other cases. In  
25 2001 there was no preference for a Stage 1

1 cancer, such as Mrs. Bailes, had between  
2 radiation therapy and surgical treatment?

3 A. I heard what you said so I'm not going to ask to  
4 read that back.

5 Could you please rephrase that?

6 Q. At that point the data available to a person  
7 treating a person with vestibular or septal  
8 cancer that's been called stage 1, we'll talk  
9 about that in a second, could you elect to do  
10 radiation therapy or surgical treatment?

11 A. I think from the standpoint of cure, the cure  
12 rates would be similar. From the standpoint of  
13 overall patient care such as how do you  
14 reconstruct that, that the -- my understanding of  
15 probably why that was chosen was that it was  
16 decided that radiation therapy probably had an  
17 equal chance of cure as surgery but could leave  
18 the patient more intact than surgery would.

19 Q. You didn't have any objection to that choice  
20 being made in consultation with The Cleveland  
21 Clinic, I gather?

22 A. Correct.

23 Q. Let's talk about staging just for a second. Is  
24 there truly an agreed upon staging for vestibular  
25 and septal cancer?

1 A. There currently is a staging system that includes  
2 nasal cavity.

3 Q. I have a bad Internet searcher and reader. Tell  
4 me who has the staging system for those.

5 A. There's a group that's called the AJCC, American  
6 Joint Committee on Cancer Staging. And cancer  
7 staging is revised every so often. As more is  
8 known about any particular tumor, that the  
9 descriptions of the specific substages, anatomic  
10 sites will be revised.

11 Q. Can you tell me when they came out with a staging  
12 system that actually included the nasal  
13 vestibular cancer?

14 A. I would have to go back and look. I don't know  
15 that one offhand.

16 Q. You don't have it in your pocket or anything,  
17 right, because I didn't find it. Do you know  
18 whether that staging system was recognized and  
19 available in January of 2001?

20 A. No, I don't. It may or may not have been.

21 Q. Okay. Doctor, do you treat vestibulitis?

22 A. Yes.

23 Q. Give me your definition of vestibulitis.

24 A. I'm trying to tell you my own definition, not  
25 that of Dr. Wenig, which I read two days ago, I

1 believe. Vestib -- nasal vestibule is that  
2 portion of the nose where the skin, as we have on  
3 the outside, whiter skin meets the skin on the  
4 inside, pinker skin and the mucosa that is  
5 considered the nasal vestibule. There are small  
6 hairs and that hair can get inflamed and that  
7 would be vestibulitis.

8 Q. Okay. If a patient has vestibulitis, the  
9 inflammation can be caused by a number of things?

10 A. Yes, it can.

11 Q. One can be an infected hair follicle?

12 A. Correct.

13 Q. Also in that area of the vestibule we have some  
14 sweat glands?

15 A. Yes.

16 Q. Could those get blocked or clogged?

17 A. Yes.

18 Q. If a patient had vestibulitis what would you  
19 expect to see in their nasal vestibule, what  
20 would about the appearance?

21 A. Could be a variety of different things. It's  
22 not just seeing but it could be tender, often  
23 it's tender, usually it's tender, some swelling,  
24 redness, could be some crusting in the area, can  
25 be some excoriation, which means the top layers

1 of skin are abraded or not present, probably a  
2 light form of what might be considered an ulcer.

3 Q. Okay. What would be the treatment for  
4 vestibulitis?

5 A. Depends on the severity and duration of it. If  
6 it was something not particularly bothersome,  
7 it's often local care such as cleaning and using  
8 a topical antibiotic ointment. Something more  
9 pronounced with fair tenderness and whatnot one  
10 may add oral antibiotics and keeping things moist  
11 in the area.

12 Q. And how long would you expect that if there were  
13 an infected hair follicle or blocked sweat gland  
14 with the kind of treatment you described that  
15 that condition would persist?

16 A. It would vary. Some patients seemed to be prone  
17 to it and have recurring episodes of  
18 vestibulitis. There are patients that have it  
19 once in their life and never have it again. If  
20 a patient was being treated and had it for two  
21 weeks and came back and still had it, I probably  
22 wouldn't think that anything was wrong. I may  
23 add an oral antibiotic.

24 To answer your question, it's sort of based  
25 on the whole picture. It's not simply the

1 diagnosis of vestibulitis.

2 Q. If in connection with a diagnosis of vestibulitis  
3 there was present this excoriation that you've  
4 described and that did not go away within, we'll  
5 say, within four weeks, would you have something  
6 else within your differential if you continued to  
7 see a patient who had -- are you calling it  
8 excoriation, the first layer the skin is gone and  
9 you see a sore?

10 A. Again, using semantics, excoriation means the  
11 very top layers of skin are not there. And I  
12 would personally consider an ulcer something  
13 where you have the same type of process but now  
14 you're deeper. So excoriation would be as you  
15 described.

16 Q. So going back to what I was asking you, someone  
17 presented with what you thought was vestibulitis,  
18 they went through the treatment modality you  
19 discussed, we'll give them an oral antibiotic but  
20 it persists with excoriation. Would you have  
21 anything else within your differential at that  
22 point?

23 A. Yes.

24 Q. What would be within your differential?

25 A. Any time you have an ulceration, as obviously

1           you're asking in this case, one has to consider  
2           malignancy. One would look for other signs. If  
3           I saw somebody that came back after four weeks  
4           that still had ulcerations, are there rolled  
5           edges, I would look for not necessarily pain  
6           because that simply is a result of having an  
7           ulceration, bleeding, progression.

8   Q. Doctor, I note you had an opportunity, I don't  
9       think we discussed it, it's my oversight because  
10      it's Friday afternoon, within your material it  
11      appears you looked at some of the family members  
12      depositions in this case; is that right?

13   A. Yes, that's correct.

14   Q. Can you tell us, for the record, what children's  
15      deposition you read?

16   A. I am looking at one that is Karen Wilson and I  
17      assume -- because I haven't looked at these  
18      recently Deborah Ondecker.

19   Q. I believe those are the only two I saw. Are there  
20      any others?

21   A. There's, looks like, Kenneth James and David  
22      Bailes.

23   Q. Did you actually read their depositions?

24   A. I did but it's been -- it couldn't have been too  
25      long ago. Yes, I did.

1 Q. Did reading the family depositions add any  
2 factual information for you to consider?

3 A. I don't believe so. I think that's why I'm not  
4 recalling them right off the top of my head until  
5 I look at the depositions themselves.

6 Q. You are aware that Dr. Manning indicates by his  
7 office note that in November of 1999 he examined  
8 Mrs. Bailes in her nasal vestibule left side and  
9 describes an ulceration. Would you agree with  
10 that?

11 A. That's my recollection, yes.

12 Q. Mrs. Bailes presents to Dr. Park approximately  
13 how many days later? You can look at your notes.  
14 It's not a memory contest.

15 A. Which date was that you just referred to,  
16 Dr. Manning?

17 Q. Dr. Manning's visit of November 8th, 1999.

18 A. I think it would be November 15th if that's what  
19 you're referring to.

20 Q. Yes. November 15th, 1999.

21 A. Do you want to help me find it?

22 Q. Did you want to look at Dr. Manning November  
23 examination or Dr. Park?

24 MR. GRIFFIN: What do you want him  
25 to look at?

1 Q. I asked if he had a recollection of what was  
2 described by Dr. Manning in his November 1999  
3 visit. It's November 8th.

4 A. I'm looking at one page of notes I've taken. It  
5 looks like from my notes that the nurse wrote  
6 sore in nasal passage and Dr. Manning wrote sore  
7 gotten bit better but not completely gone.

8 Q. Okay.

9 A. Scab over lesion nasal septum left. Sore appears  
10 to be improving.

11 Q. He wanted her to see an ENT; is that correct?

12 A. See ENT, yes.

13 Q. He describes it as an ulceration, correct?

14 A. I don't see that.

15 Q. Okay. I guess we'll go backwards. He sees her  
16 on October 11th, 1999, correct?

17 A. Yes.

18 Q. What does he observe in that visit?

19 A. Patient has a sore on left part of the septum of  
20 nose which has been there on and off for about  
21 one year.

22 Q. Okay. That gives you the history of how long the  
23 sore has been there, correct?

24 A. Yes.

25 Q. And then on examination he finds a shallow

1 ulceration in the left septum, correct?

2 A. Correct.

3 Q. He doesn't use the word excoriation?

4 A. No.

5 Q. And then she returns per his instructions in  
6 approximately four weeks. Are we in agreement  
7 with that?

8 A. Yes.

9 Q. Okay. And on that point he doesn't say that it's  
10 gone away. He says it looks better, correct?

11 A. Correct.

12 Q. But it's not gone. Would you agree with that?

13 A. Yes. According to his exam.

14 Q. Okay. Do you think that he didn't know how to  
15 conduct a physical examination of the patient's  
16 nose?

17 A. I don't know Dr. Manning so I don't know his  
18 capabilities. I know I have been asked to see  
19 things from other physicians that sometimes they  
20 have an accurate sense of and other sense not.

21 Q. Is the premise of any opinion you're rendering in  
22 this case Dr. Manning was unable to recognize an  
23 ulceration in the nose?

24 A. No.

25 Q. And Dr. Manning, in fact, filled out a referral

1 form. Have you seen that referral form? I'm  
2 going to ask if you have seen this before. We'll  
3 mark that Plaintiffs' Exhibit A.

4 - - - -

5 (Thereupon, Plaintiffs' Exhibit A  
6 was marked for purposes of identification.)

7 - - - -

8 A. I may have. I don't recall it offhand.

9 Q. Would you agree with me that what it says is  
10 persistent sore on nose, if you can make that  
11 out?

12 A. Persistent sore on nasal or nose, something like  
13 that, yes.

14 Q. Based upon what is contained in his records he's  
15 describing the sore in the vestibule, I call it  
16 left vestibule, if that's all right with you?

17 A. Yes.

18 Q. And by history that sore has been there  
19 approximately a year, correct?

20 A. Well, he said it's been on and off. So the  
21 implication of that would be it's there and then  
22 at times it's not and it's healed up.

23 Q. Okay. If you presume, and we'll do this  
24 hypothetically, if you presume the testimony is  
25 that Mrs. Bailes had a sore for approximately a

1 year that never completely went away, would that  
2 be the kind of sore in the nasal vestibule you  
3 believe would need some evaluation to determine  
4 whether or not perhaps it was a different disease  
5 entity other than vestibulitis?

6 MR. GRIFFIN: Object. Go ahead.

7 A. Again, it would depend on the specific  
8 characteristics which I really don't see. They  
9 described it as a sore but -- I'm sorry  
10 Dr. Manning hasn't referred to any other  
11 descriptors such as rolled edges we talked about  
12 before. If someone has, for instance, a deviated  
13 nasal septum where they're subjected to drying,  
14 it may not be unusual for someone to have a sore  
15 that may be present for a year or more.

16 Q. Can you tell us if that condition you just  
17 suggested was present in the patient and would be  
18 the cause of her to have a sore for more than a  
19 year?

20 A. I can't tell in this particular patient. I'm  
21 simply stating the time in itself is nearly the  
22 thing that would biopsy a sore or ulcer.

23 Q. And Dr. Manning, not being an otolaryngologist,  
24 only describes for you ulceration and doesn't use  
25 any of these other descriptive terms you're

1 looking for?

2 A. Yes.

3 Q. Do you have any doubt in your mind, as you sit  
4 here today, that this particular area that's  
5 being described by Dr. Manning is ultimately  
6 where the cancer was detected?

7 A. It's the same general area, it seems, within a  
8 few couple centimeters, half an inch; could be  
9 the exact same area.

10 Q. Does she describe it to Dr. Steinberger? Does  
11 she tell Dr. STEinberger in the initial  
12 presentation to him this is the sore in that  
13 location that has been there for two years?

14 MR. GRIFFIN: January 22, '01.

15 MS. TAYLOR-KOLIS: I think it's  
16 January 10.

17 MR. GRIFFIN: January 10, '01.

18 A. Dr. Steinberger notes in a letter to Dr. Manning,  
19 which I'm looking at right at the moment, she was  
20 evaluated with regard to a sore in her left nose  
21 that will not heal. Apparently she had seen  
22 Dr. Park for this. She has been on Bactroban for  
23 some time and this has been about six months.

24 Q. Do you recall a note written by Dr. Sieder also  
25 about a sore she had seen Dr. Park about?

1 A. I'm reading what appears to be Dr. Sieder's  
2 consultation note, initial consultation note from  
3 February 14th of 2001 wherein his history he says  
4 Ms. Bailes is 66 year old white female states  
5 approximately two years ago she developed a  
6 pimple in the nose, treated symptomatically over  
7 the next 18 month with topical antibiotics which  
8 helped symptomatically but did not help the mass  
9 go away.

10 Q. Looking at those documents, we'll look at more  
11 before the evening is over, if you've answered  
12 the question completely that's fine. I want to  
13 be clear I heard what you said.

14 Do you dispute that the sore that she  
15 complained about in 1999 in the left vestibule is  
16 ultimately the site where the cancer was  
17 determined to be?

18 MR. GRIFFIN: Object. Go ahead.

19 A. As far as I can tell from these records they're  
20 describing the same general area, yes.

21 Q. Before we get into the particulars of your report  
22 and some other issues, I notice when you gave me  
23 the opportunity to review your chart you actually  
24 had a transcription of Dr. Park's office notes;  
25 is that correct?

1 A. Yes.

2 Q. Do you know when you got that transcription of  
3 his office notes?

4 A. No.

5 Q. Did you request a transcription of the office  
6 notes prior to rendering your opinion because you  
7 could not read his office notes?

8 A. I really don't recall the proximity of when I  
9 received those.

10 MS. TAYLOR-KOLIS: I would like  
11 to mark those Plaintiffs' Exhibit B.

12

- - - -

13 (Thereupon, Plaintiffs' Exhibit B  
14 was marked for purposes of identification.)

15

- - - -

16 Q. Doctor, in looking at Dr. Park's chart could you  
17 actually read what Dr. Park's chart said without  
18 a transcript or his deposition testimony?

19 A. Let me look again. I can read most of it. There  
20 are certainly words here difficult to make out.

21 Q. So I can gather the transcription aided you and  
22 assisted you determining what the sum total of  
23 all those notes said?

24 A. Yes.

25 Q. Do you know who prepared this transcript?

1 A. No.

2 Q. Did it come with a cover letter that you're aware  
3 of? I didn't see one. It might be in your  
4 stack.

5 A. I'm sure it did. As you can see everything has  
6 been separated at this point in time.

7 Q. Dr. Stepnick, how many hours have you spent  
8 evaluating medical records and testimony and  
9 preparing in this case?

10 A. I would have to go back and look. I would guess  
11 12.

12 Q. Okay. Do you think -- I shouldn't you use that  
13 word. To a reasonable degree of medical  
14 probability as of September 1998 through January  
15 of 2001 was there a clear epidemiological  
16 correlation between cigarette smoking and nasal  
17 vestibular cancer?

18 A. I think nasal vestibular cancers are not  
19 considered to be like other sites in the head and  
20 neck in that sites such as oral cavity, tongue,  
21 larynx, pharynx, there's a clear epidemiological  
22 link between cigarette smoking and cancer.

23 Q. If I read my literature correctly, that is the  
24 answer I was looking for. Maybe Dr. Koch is  
25 going to be one of our experts. Do you know

1 Dr. --

2 MR. GRIFFIN: One of yours?

3 MS. TAYLOR-KOLIS: I said he might  
4 turn around to be mine. You never know.

5 MR. GRIFFIN: I highly doubt it.

6 Q. What is the P53 mutation? What bearing does it  
7 have, if any, in terms of what we know about  
8 vestibular cancer and how we are going to treat  
9 them?

10 A. The development of cancer is not an event that  
11 happens at a moment in time. Current theories of  
12 development of cancer, perhaps beyond theory,  
13 we'll use the word theory even though I'm big on  
14 semantics, the current theory about development  
15 of cancer there's a series of abnormalities in  
16 the chromosome that when they accumulate will  
17 eventually lead to uncontrolled growth and  
18 ability of the cells to spread or metastasize in  
19 this uncontrolled local growth and that is  
20 considered the mass.

21 There are a variety of different mutations  
22 which is an abnormality in one of the chromosomes  
23 that have been linked to development of cancer  
24 and P53, which a specific site has been one of  
25 the, if you will, hottest, one of the most looked

1 at areas, have some of the highest correlations  
2 with the development of cancer. So as we try to  
3 understand what it is about the different things  
4 such as tobacco which causes cancer in some  
5 patients but may not cause cancer in another  
6 patient, we are back to looking at chromosomes  
7 and DNA of the patients that get the cancer to  
8 help determine what really is different between  
9 the patient.

10 Q. From what I have been able to absorb, which isn't  
11 all of it, believe me, am I reading this material  
12 about P53 correctly, the theory, and this is  
13 pretty theoretical, cigarette smoking affects or  
14 causes a P53 mutation?

15 MR. GRIFFIN: Objection. Move to  
16 strike.

17 A. It might but it's not known at this point in  
18 time.

19 Q. Okay. Does University Hospitals of Cleveland  
20 have their nasal cancer patients undergo P53  
21 mutation testing?

22 A. No.

23 Q. Let's talk about your report. In the concluding  
24 paragraph the last sentence of your first  
25 paragraph you indicate, quote, unquote, the

1 disease process proved to be particularly  
2 aggressive in her and ultimately led to her  
3 death. I think we already had a brief  
4 conversation about that sentence. But I would  
5 like for you to explain to me the basis of your  
6 opinion. I think you have already done it to  
7 some degree but this is my only chance to talk to  
8 you before trial.

9 A. The staging system is quite admittedly an  
10 imperfect system. Whether it can be applied to  
11 this case or not is probably not relevant. The  
12 staging system is a system by which physicians  
13 can communicate with each other the likelihood  
14 that a particular tumor is going to be curable or  
15 not. So, in general, forehead and neck cancer is  
16 stage 1, stage 2, stage 3, stage 4. Stage 1 most  
17 curable, stage 4 least curable.

18 It becomes important as we look at various  
19 ways to treat cancer, we can understand what is  
20 working and what is not working as we grow  
21 hopefully closer and closer to a cure of cancer.  
22 In addition to that, the stage of a tumor is  
23 something that helps us decide what the therapy  
24 should be. So, again, by way of example that  
25 often a stage 4 cancer will receive radiation

1 surgery and chemotherapy whereas a stage 1 cancer  
2 typically will receive radiation or surgery  
3 alone.

4 So the staging system is something that we  
5 use to communicate with each other and it relies  
6 on statistics that are historical and it also  
7 relies on the, if you will, average behavior of  
8 certain tumors, such that if you have a  
9 particular tumor that the growth rate on the  
10 average is fairly predictable but that's not the  
11 case for every tumor and some tumors may grow  
12 much more slowly and some much more quickly.

13 So for, again, by way of example I have had  
14 patients who refused surgery one would think in 6  
15 to 12 months will be dead and they're still  
16 around five year later. There are other patients  
17 you discovery the recurrence of tumor and within  
18 a matter of four weeks they've died. The growth  
19 rate of tumors is different despite the fact the  
20 staging system is used. So my reference in this  
21 particular case is that she had a tumor which  
22 whether we want to call it a 1,T-1 or stage 1  
23 tumor, whether we want to consider it a tumor  
24 that was a small tumor, a centimeter or so in  
25 size, that statistically should have been able to

1       be cured with either radiation or surgery,  
2       perhaps a 90 percent success rate. That is  
3       largely based on comparisons with other tumors  
4       because, once again, this one is so unusual. As  
5       you know, that isn't the case in her, in  
6       Ms. Bailes. After she received her radiation  
7       therapy, which again statistically in most  
8       patients would have cured this, that she started  
9       to develop signs and symptoms that ultimately  
10      proved was tumor returning and growing in a very  
11      rapid fashion. The question was asked before if  
12      radiation therapy could cause this to happen and  
13      the answer I said was yes. That's obviously not  
14      typically what happens with radiation therapy  
15      because we are using them to cure cancer not to  
16      make them worse but it can probably occur.

17           The other thing that could have occurred,  
18      which is pure speculation, is that the biologic  
19      behavior of the tumor could have changed during  
20      the radiation therapy, not independent of the  
21      radiation itself. And regardless of how she was  
22      treated, whether it was with radiation or  
23      whatnot, it would have progressed. So when I  
24      say -- when I've use the terms particularly  
25      aggressive, I'm using that based on what one

1           would expect a typical tumor, how one would  
2           expect a tumor this size to respond and the fact  
3           it didn't do so in her.

4   Q.   Prior to the time that this diagnosis was made,  
5       do you believe that the cancer was diagnosable?

6                   MR. GRIFFIN:   Object to form but  
7                   go ahead.

8   A.   At some point in time.   All cancers begin as  
9       single cells that, again, go through the changes  
10      we have discussed before at which point in time  
11      they are not diagnosable.   And if someone had the  
12      most sophisticated imaging studies which probably  
13      today is a PET scan, if somebody even had a  
14      biopsy, if there's only a few cells that have  
15      undergone what we'll call malignant degeneration,  
16      meaning the normal cells changed to cancer cells,  
17      you may not be able to find that.   As that grows  
18      larger it gets to a point where it is diagnosable  
19      by biopsy.

20   Q.   How large does it have to be to be diagnoseable  
21       by biopsy, if there's an answer to that question  
22       and I don't know that there is?

23                   MR. GRIFFIN:   Object.

24   A.   The answer would be that it would be smaller than  
25       one could see because at one point in time when

1 people had small tumors that had already  
2 metastasized to the neck and diagnose was made,  
3 we were trying to figure out where the tumor came  
4 from. It used to be the standard would be  
5 you do a blind biopsy, biopsy normal tissue and  
6 in some cases you would find tumor under the  
7 microscope where you could not see that.

8 I guess the answer to your question is it  
9 doesn't need to be visible to be there. So one  
10 may not notice -- one may not be able to find a  
11 cancer even if it's there unless you do a biopsy.

12 Q. Based upon the sum total of medical information  
13 that you have available to you, the charting, do  
14 you believe that Mrs. Bailes was, first of all,  
15 diagnosable prior to January of 2001?

16 MR. GRIFFIN: Object to form.

17 A. I'm reading -- since you used January 2001. I'm  
18 assuming because Dr. Steinberger made the  
19 diagnosis then.

20 Q. Of course.

21 A. I'm refreshing myself with his notes where he  
22 says there is left anterior septal deviation,  
23 which is I mentioned before one cause you can get  
24 drying and excoriation even ulceration because of  
25 the drying effect the septal deviation. He has

1 with ulceration and granular tissue. Again, just  
2 refreshing my memory, January 10th, 2001, if your  
3 question is if that was biopsied a week before,  
4 two weeks before would it have shown tumor, I  
5 think it would.

6 Q. That wasn't my question. The precise question  
7 I'm asking is based upon symptoms that presented  
8 in any and all medical records you have your  
9 hands on. Was there a point that you believe  
10 that this cancer could have been diagnosed prior  
11 to January 2001? We can take a break for a  
12 second -- shouldn't be that many records in one  
13 notebook.

14 I think you know what I'm asking. Was there  
15 any physical manifestation that would have  
16 suggested at an earlier point a biopsy could have  
17 been done that would have resulted in a  
18 diagnosis?

19 MR. GRIFFIN: Place an objection.

20 A. He describes again ulceration with granular  
21 tissue. If someone had seen that as a physical  
22 sign and was concerned that could be a cancer and  
23 biopsy, yes, it could have resulted in a  
24 diagnosis earlier.

25 Q. What was significance of finding granular tissue

1 at the time of his examination January 10th, I  
2 believe it was, 2001?

3 A. It's part of what we discussed before, that  
4 while, again, I wasn't there to review that, it  
5 sounds to me more when I read granular tissue  
6 there was something else there other than missing  
7 tissue, there was new tissue.

8 Q. If you know, how long would it take for the  
9 formation of granular tissue in the situation of  
10 this particular kind of cancer to develop?

11 A. Well, granular tissue isn't necessarily a sign of  
12 cancer. Although, as we talked before, granular,  
13 heaped edges, et cetera can be a sign of tumor  
14 there is something called granulation tissue  
15 which are simply capillaries, if you look at  
16 them, which is normal healing tissue. So  
17 there's really no answer to your question other  
18 than the fact it could be either tumor or  
19 granulation tissue.

20 Q. What are the signs and symptoms of nasal  
21 vestibular cancer?

22 A. It depends on what point one defines it. If one  
23 looks at what one may see, a mass, can see nasal  
24 obstruction, can have bleeding, can have pain,  
25 can have destruction of tissue, obviously have

1       metastatic disease spread to lymph nodes and  
2       whatnot. As it becomes earlier and earlier it  
3       becomes much more difficult to define and it  
4       simply may be, as we have discussed, ulceration,  
5       rolled edges, those sorts of findings on physical  
6       exam, some local pain and tenderness.

7   Q. Doctor, you made the distinction if one looks  
8       like -- we are looking at nasal obstruction  
9       masses. If one looks early maybe all that there  
10      is an ulceration; is that right?

11   A. Yes.

12   Q. Is it preferable to detect the nasal vestibular  
13      cancer early?

14                   MR. GRIFFIN: Object.

15   A. I think with any cancer, nasal vestibular or  
16      otherwise, that the earlier that you detect a  
17      cancer the better. However, if you push that to  
18      the extreme, one could make the argument I should  
19      line up everybody on this floor and take biopsies  
20      from various parts of their body.

21   Q. You clearly know I'm not asking that argument.  
22       In the face of ulceration at an early state, it's  
23      better to have a diagnosis then at a later state?

24   A. Again, the earlier that one makes the diagnosis,  
25      generally the better that would be but that does

1 not necessarily translate to a different  
2 prognosis.

3 Q. Okay. Let's do it this way. I'm trying to make  
4 this easy so we don't have to stay much past 5:00  
5 hopefully.

6 You have treated nasal vestibular cancer,  
7 would I be fair to guess that?

8 A. Yes.

9 Q. So through your education, extensive training,  
10 your fellowship, and all the good stuff you have  
11 gotten to do here, probably I'm guessing, you can  
12 correct me if I'm wrong, when you are fortunate  
13 enough to get someone who presents with a T-1,  
14 that's the mythical staging --

15 A. Yes.

16 Q. -- you have a conversation with your patients  
17 about prognosis, correct?

18 A. Yes.

19 Q. I don't know what your particular bedside manner  
20 is, whether you wouldn't or would, do you tell  
21 them what the statistical percentages are when  
22 you first have a patient with T-1 tumor?

23 A. I tell them vaguely. I don't talk about specific  
24 numbers. And, in fact, I flip it around if I  
25 somebody who has a very poor prognosis, maybe 10

1           percent chance of survival, I tell that patient  
2           that our goal is to make them those 10 out of  
3           hundred that are going to be cured. So generally  
4           while I don't throw out specific numbers, I  
5           generally say whether this is something that is a  
6           fairly good prognosis or something that is a poor  
7           prognosis that we need to treat more  
8           aggressively.

9   Q. But in speaking as you sit in the office with a  
10   patient and let's just say -- let's make that  
11   patient someone very similar to Mrs. Bailes who  
12   comes in with a certain size area that has been  
13   defined as her lesion.

14   A. Yes.

15   Q. Based upon that using our mythical staging system  
16   she has a T-1 tumor .

17                   MR. GRIFFIN: Object to the form.

18   Q. As you sit there as her physician you know a  
19   certain percentage of people diagnosed with T-1  
20   tumor are not going to survive?

21   A. Yes.

22   Q. And back in January of 2001 approximately,  
23   Doctor, what do you believe the percentages were  
24   of people who would not survive the diagnoses of  
25   T-1 tumor?

1 A. It's by site.

2 Q. Nasal vestibular or nasal septal cancer,  
3 whichever would you prefer to use?

4 A. I don't frankly know there are enough cases one  
5 would come up with a specific number like that.  
6 We used, quote, 12,000 of laryngeal cancer and  
7 there's certainly more sub sites. That's, as you  
8 said, a rare sub site. So our experience in that  
9 area is largely based upon the response of other  
10 T-1 tumors in the head and neck.

11 Q. Would you -- at that point would you have known  
12 what the statistical experience was?

13 A. Can you ask that a different way?

14 Q. Have you read studies within your specialty that  
15 would aid and assist you in knowing what the  
16 approximate statistical survivability was with  
17 the T-1 nasal vestibular or septal cancer?

18 A. Probably in the past. In general, in general a  
19 T-1 cancer carries with it a fair prognosis, 80  
20 to 90 percent chance of cure.

21 Q. Would you suspect that rate of cure would improve  
22 if the person -- let me withdraw the question.

23 If Mrs. Bailes had been diagnosed in November  
24 of 1999 with this particular cancer, that's an  
25 if, do you believe that a diagnosis a year and

1           three months or two months sooner than it was  
2           made would have improved her ability to survive  
3           the cancer?

4   A.   We would like to think so but it's not  
5           necessarily true.

6   Q.   With what you wrote in your report --

7   A.   I think that cancer carries with it an emotional  
8           component, meaning when someone gets diagnosed  
9           with cancer there's a lot emotion and probably  
10          rightfully so. And so most patients when they  
11          find out they have cancer, want it taken care of  
12          tomorrow and even we as physicians would like to  
13          think that a tumor that is present if, again  
14          making the assumption that was diagnosed a year  
15          and a half earlier, would like to think that that  
16          changes the prognosis.

17                If we assume that the tumor was there, that's  
18                purely an assumption, if we assume the tumor was  
19                there a year and a half beforehand and that it's  
20                approximately the same size as it was when it was  
21                actually diagnosed, again, using what I said was  
22                our imperfect staging system, it would not change  
23                the prognosis because it hasn't -- it would have  
24                not have gone, again, we have gone around in  
25                circles whether we can use the staging system or

1 not. It would not have been upstaged. It would  
2 not have gone to state 2 tumor. It would be  
3 something that is the same stage.

4 Q. Do you suspect that a year and a half earlier  
5 year and three months earlier it would have been  
6 the same size as it was as it was in diagnosed in  
7 January of 2001?

8 A. No. For the sake of argument, when you had asked  
9 if it was detectable in biopsy, it was certainly  
10 smaller because tumors grow. It may not have  
11 even been present. Again, nothing -- none of us  
12 know when it was something physically present  
13 that somebody could have seen and biopsied.

14 Q. As these type of nasal, the ones we are talking  
15 about grow and spread, does that increase the  
16 risk of dermal involvement that microscopically  
17 spreads the cancer as its growing?

18 A. No. It's related more to biological behavior  
19 than what you're describing.

20 Q. You base that opinion on what?

21 A. Base that opinion more on literature or patients  
22 that come outside of our own specialty from  
23 dermatology where they're seeing hundreds and  
24 hundreds and thousands of skin cancers that are  
25 often sort of whittled and picked away and that

1 does not lead to an increase dermal metastasis.

2 Q. Have you personally spoken to Dr. Park about this  
3 case?

4 A. No, I have not.

5 Q. Once again you use a sentence in your report, you  
6 can look for it. I think it may be the second  
7 page, maybe it's still on the first page. You  
8 say it's unclear as to whether earlier diagnosis  
9 would have had truly impacted the curability. I  
10 think that's the way you stated it unless I got  
11 you confused with somebody else.

12 A. I think we just discussed that issue.

13 Q. Dr. Stepnick, were you able to ascertain either  
14 from Dr. Park's deposition or his office note as  
15 to whether or not in his November 1999 visit he  
16 explored the nose to the extent he could  
17 determine what was under the crusting he saw in  
18 Mrs. Bailes' nose.

19 A. I'm sorry, November 15th?

20 Q. Yes.

21 A. Well, not to give you a hard time.

22 Q. That's all right. You're allowed.

23 A. There are different types of crusts. There's  
24 adherent crusts that obscure what is underneath  
25 them, crusts that is translucent that you can see

1 through, crusts not translucent sitting in the  
2 nasal cavity. So not knowing specifically what  
3 it is he saw, if indeed that he examined the area  
4 as it appears he has because he made comments  
5 about some different things, one can assume he  
6 was satisfied that he was examining the nose  
7 appropriately. If there is a crust that  
8 potentially is hiding a physical finding and the  
9 crust doesn't go away, then it may be appropriate  
10 to remove the crust. There are other times when  
11 removing a crust is going to cause the nose to  
12 bleed. You may want to see the patient back in  
13 follow-up to see if indeed there's a crust there.

14 Q. You have a recollection that Dr. Park testified  
15 that Mrs. Bailes had had vestibulitis ongoing  
16 over a large number of years?

17 A. Yes.

18 Q. How many years do you think he said she had  
19 vestibulitis?

20 MR. GRIFFIN: How many years she  
21 had it?

22 Q. Right. How many years did he diagnose that to be  
23 her condition?

24 A. It was approximately ten years.

25 Q. And Mrs. Bailes did come back to see Dr. Park, is

1           that right, following the November 15th visit?

2       A.   Yes.

3       Q.   And Dr. Park makes no mention of a finding in her  
4           nose on that visit; is that right?

5                       MR. GRIFFIN:   Finding of crust,  
6                       you mean?

7       Q.   Right.

8                       MS. TAYLOR-KOLIS:   Thanks for  
9                       correcting me, Steve.

10      A.   He makes no mention of crust, that is correct.

11      Q.   Okay.   From your recollection or you can look at  
12           it, when I talked to him at his deposition about  
13           the November 15th, 1999 visit that was the first  
14           time he had drawn her left nostril with a finding  
15           of crusting in that entire time period that he  
16           had been taking care of her.   Do you agree with  
17           that?

18      A.   I see the drawing here in the notes.   I'm  
19           reviewing. He has a little drawing back in July  
20           of 1989.

21      Q.   Do you recall reading his deposition what he said  
22           that drawing represented?

23      A.   No, I don't recall specifically what he said that  
24           represented.

25      Q.   Okay.   Do you think that's a well-documented

1           medical chart, Dr. Stepnick?

2   A.   It's unfortunately what a lot of practitioners  
3       are used to.  If I had to compare that to my own,  
4       it's not a well-documented chart although it's  
5       not unusual.

6   Q.   Your notes are dictated, I'm going to assume?

7   A.   Yes.

8   Q.   Okay.  In September of 2000 Mrs. Bailes returns  
9       to Dr. Park, correct?

10  A.   Yes.

11  Q.   Prior to that visit had she been, once again, to  
12       see Dr. Manning, am I right, in late August or  
13       early September?

14  A.   I'm reviewing my notes and not the actual things  
15       but my notes said it looks like she was to  
16       Dr. Manning in August of 2000.

17  Q.   Right.

18  A.   28th.

19  Q.   Yeah.

20  A.   Yes.

21  Q.   Do you recall what his findings were at that  
22       time?

23  A.   My notes indicate recurrent ulceration, septum,  
24       no bleeding.

25  Q.   Okay.  And he's calling it an ulceration, correct?

1 A. Yes.

2 Q. Let me ask you a couple questions about  
3 semantics. Let's talk about semantics. Assuming  
4 that in August of 2000 Mrs. Bailes had vestibular  
5 cancer, I'm going to ask you to assume that.

6 A. Yes.

7 Q. When she experienced an ulceration in her nose,  
8 if she was given topical treatments, even if  
9 there was cancer underlying that area, could she  
10 not experience some sort of clinical improvement  
11 in the area?

12 A. To some degree, yes.

13 Q. Because truly her cancer, as someone else said,  
14 doesn't wax and wane?

15 A. Correct.

16 Q. It's there?

17 A. Correct.

18 Q. The outward clinical manifestation of  
19 vestibulitis of the nasal cavity can change  
20 depending upon if you apply a product to it,  
21 would you agree with that?

22 A. If there's a significant component of associated  
23 infection, then the product could help with that  
24 but it won't do anything with the underlying  
25 cancer.

1 Q. I always hate when I ask stupid questions. The  
2 underlying cancer isn't visible -- was the  
3 underlying cancer invisible at the time  
4 Mrs. Bailes was diagnosed in January of 2001?

5 A. As best I can tell from the records, yes.

6 Q. It manifested itself in what way?

7 A. I would only be reading Dr. Steinberger's  
8 records.

9 Q. That's okay. That was the ulceration with  
10 granulation tissue we were discussing?

11 A. Correct.

12 Q. So at a time before it got to that, it may have  
13 had some appearance but not the same as that?

14 A. Yes.

15 Q. Okay. Because the ulceration isn't the cancer,  
16 it's what's underneath it, correct?

17 A. The ulceration is the absence of tissue because  
18 the cancer has destroyed the normal tissues.

19 Q. Fair enough. So this note from August 28th, 2000  
20 there's a description once again from Dr. Manning  
21 of ulceration of the nasal septum, correct?

22 A. Yes.

23 Q. And, again, his history is saying many years she  
24 had this ulceration problem, correct?

25 A. My notes says times two years.

1 Q. I think you're right, two years. He uses the  
2 phrase many years in that particular note?

3 A. I see that.

4 Q. As part of appropriate history taking relative to  
5 a complaint of a sore in a nose, doesn't the  
6 otolaryngologist want to know the duration of  
7 that sore?

8 A. Yes.

9 Q. Do you see anywhere in Dr. Park's notes that he  
10 elicited from Mrs. Bailes in relation to the  
11 complaint of her sore in her nose the duration of  
12 the time of those sores?

13 A. I would have to go back and look through it. I'm  
14 assuming you're asking the question because it's  
15 not there. But I think that given we have  
16 already said that there are varying degrees of  
17 documentation by various physicians, I would  
18 think that a physician who feels he knows a  
19 patient very well and sees her as many times as  
20 Dr. Park does, may not have included that in his  
21 record. I'm just speculating he may not have  
22 included that in his record because he sort of  
23 knows how things progressed. It's probably not  
24 in there. That doesn't necessarily mean he  
25 wasn't satisfied he knew when there were

1 ulcerations there.

2 Q. Along the lines of, you know, as you're having  
3 the conversation with me sometimes a person goes  
4 along with the patient, feels they know them so  
5 well you don't have to put down things because  
6 they have seen them over a period of time.  
7 Sometimes a physician who practices in ears, nose  
8 and throat have seen a patient on number of  
9 occasions over the years with wax in their ears,  
10 runny nose, things of that nature perhaps they  
11 get a little lax because they think they know  
12 what the problem is going to be?

13 MR. GRIFFIN: Object.

14 A. That potentially could happen. I don't know  
15 about this case.

16 Q. Just as likely a doctor not document something  
17 because he knows the patient.

18 He has shallow ulceration in the left nasal  
19 septum. Would you expect that a practitioner of  
20 internal medicine would know vestibulitis as a  
21 diagnosis?

22 A. I would like to think so but I also recognize  
23 that in many medical schools that ear, nose and  
24 throat isn't even taught to most physicians. In  
25 fact, it's only recently we had medical students

1           regularly spending time with us. As scary as  
2           that may sound, I'm not commenting on  
3           Dr. Manning, a lot of people don't know more than  
4           taking a flashlight and looking up the nose.

5   Q. Does he describe around that area of ulceration  
6       anything that says pus, mucous, crusting?

7   A. Could I have the date again?

8   Q. August 28th, 2000. I'm going to ask how he  
9       describes the ulceration and the area around it.

10                               - - - -

11                               (Thereupon, a recess was had.)

12                               - - - -

13   Q. Back to where we were. I believe I had asked you  
14       just before I asked to have a short break, to  
15       look at the note that Dr. Manning wrote on August  
16       28th, 2000. He describes this finding in  
17       Mrs. Bailes' nose as a shallow ulceration,  
18       correct?

19   A. Yes.

20   Q. Okay. He says it does not appear infected.

21   A. Yes.

22   Q. I know you can't think what he meant by when a  
23       physician says does not appear infected. Does it  
24       not to you indicate that this doesn't look like a  
25       vestibulitis?

1 A. Yes.

2 Q. Doesn't have anything about swelling, redness,  
3 crusting, just has shallow ulceration, agreed?

4 A. Correct.

5 Q. And at the conclusion of that visit, once again,  
6 referral to ENT for further evaluation of the  
7 nasal septum, right?

8 A. Yes.

9 Q. That was in his plan. She goes back to Dr. Park  
10 and I think it's September 5th, correct?

11 A. Yes.

12 Q. And that's about seven, seven to eight days, I  
13 can't remember if there's 31 days in August,  
14 seven to eight days later after that visit with  
15 Dr. Manning, right?

16 A. Approximately, yes.

17 Q. Okay. At that particular visit Dr. Park, once  
18 again, finds vestibulitis. Would you agree with  
19 that, that's what his notes said as well as his  
20 deposition testimony?

21 A. I'm looking at his summary of his notes and -- I  
22 will look at his notes.

23 Q. Okay.

24 A. It appears he says vestibulitis, yes.

25 Q. In looking at Plaintiffs' Exhibit B, which you

1           kindly handed to me, the transcription of his  
2           office notes for 9-5 complaints of sore nose,  
3           mouth lesion, ear clogged up. That's the  
4           transcription that you received, correct?

5   A.   Yes.

6   Q.   Okay.

7   A.   That's what I see here on the note.

8   Q.   Okay. When Mrs. Bailes went to see Dr. Manning a  
9           week prior to this visit she was complaining of a  
10          sore in the nose, not a sore nose, would you  
11          agree with that?

12  A.   It appears to be, yes.

13  Q.   And Dr. Park doesn't record any complaint of sore  
14          in the nose, right?

15  A.   I don't know how accurate, if he's a semanticist  
16          as I am. It says sore nose.

17  Q.   Okay. What he does seem to be concerned about in  
18          that visit is a buckle lesion, correct?

19  A.   Yes.

20  Q.   And he orders a biopsy of this right buckle  
21          lesion, correct? You've seen the order for that?

22  A.   Yes.

23  Q.   He wasn't going to do it in his office, correct?

24  A.   It appears that he was going to do it elsewhere  
25          from the surgery schedule thing I'm looking at.

1 Q. Can an ENT do a buckle lesion biopsy in their  
2 office especially if they're going to use local  
3 anesthetic?

4 A. Can they, yes.

5 Q. Would you know the reason why he wanted it to be  
6 performed at Barberton Citizens Hospital?

7 A. No. I would be speculating. He may have looked  
8 at it and felt it was vascular and concerned it  
9 might bleed. He may not have had the equipment  
10 there that particular day. There are a vary of  
11 reasons.

12 In general, as you asked, can you do a  
13 biopsy, the answer is yes. But sometimes you  
14 chose otherwise.

15 Q. Based upon the note which he placed in the chart  
16 and then his order for his biopsy, you don't see  
17 he had any intention of evaluating her  
18 vestibulitis, do you?

19 A. I don't see any evidence of that, no.

20 Q. Okay. You expected a doctor would include that  
21 in their chart if they were going to evaluate  
22 vestibulitis other than observing it, wouldn't  
23 you?

24 A. I would think so.

25 Q. Okay. Doctor, when you were evaluating the case,

1 I think you told me sometimes you turn pages  
2 down --

3 A. Yes.

4 Q. -- if you think they're significant?

5 A. Yes.

6 Q. I'm going to steal this from you, borrow, I will  
7 return it. I am going to ask you about a few  
8 pages that you dog-eared I suppose. We are going  
9 to be trading this back and forth but that's all  
10 right.

11 I'm looking at a rather large compendium of  
12 medical records. I assume you didn't index  
13 these?

14 A. No, I did not.

15 Q. They came to you in this form, I'm sure?

16 A. Yes.

17 Q. Your dog-eared page June 27th, 2001 written by  
18 Dr. Sieder. You know who Dr. Sieder is?

19 A. I do now.

20 Q. Is he the radiation oncologist?

21 A. Yes.

22 Q. Can you tell me if you know what reason you  
23 dog-eared that page?

24 MR. GRIFFIN: It looking like a  
25 cow ear.

1 MS. TAYLOR-KOLIS: Let the record  
2 reflect that that's a large turn down.

3 A. At this point in time I was trying to clarify in  
4 my mind the physical findings which would  
5 correlate with the progression of her tumor.

6 Q. Okay.

7 A. So I dog-eared this one or cow-eared this one as  
8 the eight week follow-up visit because I was  
9 interested as I then compared to some of the  
10 subsequent notes to see what it was that he was  
11 seeing and what she was complaining of. And at  
12 that point the indication was that she continued  
13 to have bleeding and pain in the radiation area  
14 which is not unexpected in his words and  
15 continued to have some discharge from the left  
16 nasal septum.

17 Q. And was that -- what significance did that have  
18 for you at the eight week marker?

19 A. It didn't really have significance by itself. It  
20 was only significant in relationship to the other  
21 notes from Dr. Sieder.

22 Q. It was significant in the what?

23 A. It was significant in relationship to his other  
24 notes. It wasn't significant necessarily in  
25 itself.

1 Q. Okay. When did Steve Griffin contact you first  
2 about reviewing this case?

3 A. I don't know.

4 Q. Do you have some way of knowing based upon your  
5 file.

6 A. No, because I pulled these together for  
7 preparation of this.

8 Q. All right. We know it would have been before  
9 April 18th because that's when you wrote the  
10 report?

11 A. Correct.

12 - - - -

13 (Thereupon, Plaintiffs' Exhibit C  
14 was marked for purposes of identification.)

15 - - - -

16 Q. What's now marked Plaintiffs' Exhibit C these are  
17 your handwritten notes. At the top does that say  
18 April 13th?

19 A. I says 4-13.

20 Q. Under that is that a 2?

21 A. It's 30.

22 Q. 30 m?

23 A. Yes.

24 Q. You spent 30 minutes on the file April 13th.  
25 April 15 you spent another 30 minutes on the

1 file?

2 A. Yes.

3 Q. So it took you about an hour to go through the  
4 charts of Dr. Manning and Dr. Park and -- is that  
5 right? The way you have this listed Manning is  
6 running down the side with pretty clear notations  
7 about what it says and opposite side Dr. Park?

8 A. I think that was just -- wasn't necessarily all  
9 of the time I spent reviewing the files. It was  
10 then after I reviewed the files, the time I spent  
11 correlating those particular points and putting  
12 it down.

13 Q. You were doing a correlation what one found and  
14 the other one found?

15 A. Yes.

16 Q. I have to ask the question because God knows what  
17 we'll talk about at trial.

18 What did you make of the fact Dr. Manning  
19 found an ulceration and Dr. Park didn't?

20 A. I probably overused the word semantics many times  
21 in this deposition. But it wasn't clear to me if  
22 the word ulceration was being used synonymously  
23 by the two. I wasn't sure if the two of them  
24 were using the word as the same condition.

25 Q. Is the condition of vestibulitis characterized by

1 a sore in the nose?

2 A. Not classically. Although the nasal septum,  
3 which is very, very close, few millimeters away  
4 which is where it appears that this ulceration  
5 was, is an area that not uncommonly will have  
6 excoriation or ulceration as a result of usually  
7 drying and other processes. So while the  
8 vestibulitis may not have been related to the  
9 ulceration, that certainly it wouldn't be unusual  
10 if there was excoriation or dryness of that area.  
11 It's right in the same location, right adjacent,  
12 right next to the vestibule.

13 Q. Do you understand Dr. Park's testimony to be that  
14 he never saw a sore in her nose in 1999 or 2000?

15 A. His testimony is there.

16 Q. In his deposition?

17 A. Is there a specific area you recall or you want  
18 me to look through the whole --

19 Q. I'm going to ask it this way. You may still have  
20 to look through it.

21 My recollection of my recent review of  
22 Dr. Park's, both his office chart and his  
23 deposition, is that he never saw a sore in  
24 Mrs. Bailes' nose in 1999 or 2000. I am asking  
25 if you have information to the contrary?

1 A. I may be missing something because I'm reading  
2 this very quickly. I see what is page 34 of  
3 Dr. Park's deposition when he was questioned, did  
4 you see actual sore or did you just see an area  
5 that looks inflamed. He said exactly that's why  
6 I instead of describing it wrote down my clinical  
7 impression, nasal vestibulitis which is saying  
8 there's inflammatory changes. The question was  
9 then asked of him, so it is at that point you saw  
10 inflammatory change and ulceration or lesion he  
11 said -- correct, he said no, so I don't know if  
12 no means yes or no.

13 Q. Your ability to interpret my question and his  
14 answer, I suppose?

15 A. From my reading of that right at the moment,  
16 again my interpretation, I'm interpreting for  
17 Dr. Park and I can't answer for him, it doesn't  
18 look like he saw an ulceration according to that  
19 question.

20 Q. In his transcribed notes or handwritten note you  
21 never see anyplace he describes ulceration in  
22 1999 or 2000, correct?

23 A. He did not use the word ulceration as best I can  
24 tell.

25 Q. Let's make sure we have covered our bases so I

1 don't get mad at anyone, which I should not get  
2 mad.

3 At trial you are going to opine that Dr. Park  
4 met the accepted standard medical care in his  
5 care and treatment of Geraldine Bailes; is that  
6 correct?

7 A. Yes.

8 Q. And you believe that he met pararepiolite  
9 standard of care for her for what reason?

10 A. He met the standard of care because he dealt with  
11 the problems she presented. He examined the  
12 patient, appears to have documented pertinent  
13 physical findings, he appears to have treated  
14 what he believes are the problems she had, he  
15 arranged for follow-up to make sure that the  
16 problems resolved.

17 Q. Okay. Have I covered everything you're going to  
18 say about Dr. Park as it regards his examination  
19 and care of treatment of Mrs. Bailes?

20 MR. GRIFFIN: Objection.

21 A. Just answering the question off the top my head,  
22 I would say yes.

23 Q. Okay. Are you going to render criticisms at the  
24 trial that other physicians who cared for  
25 Mrs. Bailes during the calendar years 1999, 2000

1 or 2001 deviated from accepted standard medical  
2 care?

3 A. As we talked about before I think that if I were  
4 asked questions -- of course I would not respond  
5 unless I were asked questions. If I were asked  
6 questions about ultimately the outcome of  
7 Mrs. Bailes and was asked about Dr. Park's care  
8 versus some the other care that was subsequently  
9 rendered, I would be certainly critical of some  
10 of the subsequent care although I'm sure I would  
11 testify that the nature of the disease may be  
12 such that it would not have made -- made a change  
13 in the outcome.

14 Q. I want to be real specific. Whose subsequent  
15 care did you feel was irregular, Dr. Sieder,  
16 Dr. Steinberg, who?

17 A. I think there were -- I think that they were both  
18 involved at that point in time and I think most  
19 physicians would have biopsied her sooner, which  
20 may or may not have changed the outcome.

21 Q. To a reasonable degree of medical probability,  
22 I'm assuming you're familiar with that phrase?

23 A. Yes.

24 Q. Did the irregularities of Dr. Sieder and  
25 Dr. Steinberger in the summer of 2001 cause or

1 contribute to Mrs. Bailes' death?

2 A. Again, that's difficult to say. My true belief  
3 the nature and biological make up of that tumor  
4 changed during the radiation therapy. And the  
5 possibility exists, and I understand what you're  
6 asking about to a reasonable degree of medical  
7 certainty, the possibility exists. But if the  
8 biological behavior stayed the same, I would  
9 testify something differently but I can't say  
10 based on the change of biological behavior.

11 Q. One again to use a favorite phrase by an  
12 old-timer, Burt Fisher, you are not going to  
13 state these irregularities affected the outcome  
14 of the case?

15 MR. GRIFFIN: Object.

16 A. I think that her course of disease would have  
17 changed if it were diagnosed sooner. Whether she  
18 would have ultimately survived or not, I probably  
19 can't say.

20 Q. Doctor, you didn't write anything in your initial  
21 report about these deviations that you're  
22 perceiving, correct?

23 A. Correct.

24 Q. So to paraphrase what you said, I know it will  
25 come out in the transcript, you're saying it's

1 not possible for you to know that based upon the  
2 change in biology of Mrs. Bailes' tumor?

3 MR. GRIFFIN: Object.

4 A. It's not possible to know with certainty.

5 Q. So it's not more likely than not?

6 MR. GRIFFIN: Object.

7 A. I'm not sure you can say that.

8 Q. Okay.

9 MS. TAYLOR-KOLIS: I think I have  
10 asked you enough questions and we made it  
11 in two hours.

12 MR. GRIFFIN: He'll read.

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DAVID W. STEPNIK, M.D.

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1  
2 C E R T I F I C A T E

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

6 I, Tami A. Mitchell, a Notary Public within  
and for the State of Ohio, authorized to  
7 administer oaths and to take and certify  
depositions, do hereby certify that the  
8 above-named witness was by me, before the giving  
of their deposition, first duly sworn to testify  
the truth, the whole truth, and nothing but the  
9 truth; that the deposition as above-set forth was  
reduced to writing by me by means of stenotypy,  
10 and was later transcribed into typewriting under  
my direction; that this is a true record of the  
11 testimony given by the witness; that said  
deposition was taken at the aforementioned time,  
12 date and place, pursuant to notice or stipulation  
of counsel; and that I am not a relative or  
13 employee or attorney of any of the parties, or a  
relative or employee of such attorney, or  
14 financially interested in this action; that I am  
not, nor is the court reporting firm with which I  
15 am affiliated, under a contract as defined in  
Civil Rule 28(D).  
16

17 IN WITNESS WHEREOF, I have hereunto set my  
hand and seal of office, at Cleveland, Ohio, this  
18 29th day of August A.D. 20 03.  
19

20 

21 Tami A. Mitchell, Notary Public, State of Ohio  
1750 Midland Building, Cleveland, Ohio 44115  
22 My commission expires October 23, 2004  
23  
24  
25



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**LAWYER'S NOTES**

[illegible]