IN THE COURT OF COMMON PLEAS

SUMMIT COUNTY, OHIO

KAREN WILSON,

Plaintiff,

-vs-

JUDGE MURPHY
CASE NO. CV-2002-06-3340

YOUN PARK, M.D., et al.,

Defendants.

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

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Youn Park, M.D. and
Youn Park, M.D., Inc.;

W I T N E S S I N D E X

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

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

CROSS-EXAMINATION OF DAVID W. STEPNICK, M.D.

BY MS. TAYLOR-KOLIS:

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

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

A. That's correct.

Q. I received an expert report that was apparently authored by yourself dated April 18, 2003. Doctor, to the best of your knowledge, is this the only report you authored in this matter?

A. To the best of my knowledge, yes.

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

today, correct?

A. Correct.

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

A. Yes.

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

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

A. Yes.

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

A. I will do so.

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

A. Not to my knowledge.

Q. How frequently do you review medical legal matters?

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

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

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

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

A. Yes.

Q. How many times have you given a deposition?

A. I would estimate six to eight.

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

A. As in a deposition?

Q. Yes.

A. Yes.

Q. Okay. And did you do so in your capacity as a subsequent treating physician or expert witness?
A. I'm sorry. You asked if I testified for the patient. You mean if there is a lawsuit, testifying for the attorney representing the patient?
Q. Yes.
A. Yes.
Q. We got a yes, yes?
A. Yes.

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

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

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Q. As an expert witness?
A. As an expert witness.
Q. How many occasions, please?
A. Of the depositions probably three-quarters of those on the basis of the patient.
Q. Okay. And have you ever rendered testimony in Cuyahoga County on behalf of a patient as an expert witness?
A. Yes, I have.

Q. What plaintiffs attorneys have you worked with?
A. Plaintiffs attorneys?
Q. Plaintiffs, attorney representing the patient.
A. I don't recall the names to be honest.
Q. When is the last time you testified, either by deposition or in a court of law, on behalf of a patient?
A. I would say by deposition maybe two years ago on behalf -- in a court of law it's been many more years than that.
Q. When is the last time you testified in a trial?
A. The trial was about ten years ago, if I remember.
Q. Okay. At present how many cases are you currently reviewing?
A. This one and then there's another case that's on behalf of the plaintiff that's representing the patient which I'm the treating physician.
Q. You're the treating physician. What attorney is representing the patient?
A. I don't recall.
Q. Okay. You know Dr. Lavertu, correct?
A. I do.
Q. During the course of your analysis of this case were you provided with a copy of the expert report that was written by Pierre?

A. No.
Q. For purposes of brevity, I will state for the record in reviewing your CV I have no doubt you're qualified as an expert witness in this matter. Just to make certain, you're currently licensed in the state of Ohio, correct?
A. Yes, I am.
Q. I would assume from what I'm able to glean from these numerous pages, at least 50 percent of your professional time is in the active, clinical practice of medicine?
A. Yes.
Q. You also teach?
A. I do.
Q. Are you teaching at the medical school or by way of rounding the residents here?
A. Primarily the residents.
Q. Do you teach any classes at the medical school?
A. No.
Q. What textbooks do you refer your residents to in terms of supplementing their hands-on learning in otolaryngology?
A. It depends on the specific area of otolaryngology and also depends on the specific procedure. In the area of facioplastic, if it's a face lift,

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

Q. Can you name those textbooks for me?

A. All of them?

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

A. No, I'm not.

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

A. Probably not a single textbook, no.

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

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

Q. Yes.

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

Q. Had you done a literature search in anticipation

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

A. No.

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

A. No.

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

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

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

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

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

A. That's correct.

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

A. No. I have many actually.

Q. Tell me where all your offices are.

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

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

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

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

Q. Or doing surgeries.

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

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

doing, am I correct?

A. Correct.

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

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

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

A. Yes.

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

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

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

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

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

Q. I didn't take it.

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

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

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

MR. GRIFFIN: I have an unhighlighted copy.

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

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

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

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

Q. Whatever was part of their chart?

A. Yes.

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

A. Yes, I have.

Q. Can you tell me what you subsequently reviewed?

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

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

Q. His deposition this past week, Wednesday?

A. Yes.
Q. And the deposition of Dr. -- the pathologist Dr. Makk?
MR. GRIFFIN: M-a-k-k.
Q. Has the reading or evaluation of the additional materials that you just discussed with me changed any opinion that you initially rendered?
A. No.
Q. Has it caused you to have additional opinions other than listed in this report?
A. Just that I think I agree with what I said there more.
Q. All right. Doctor, have you ever been sued?
A. Yes.
MS. TAYLOR-KOLIS: Objection for the record, of course.
Q. How many times have you been sued?
A. Perhaps half a dozen, six.
Q. And of those half dozen or six did any of them have to do with failure to diagnose nasal vestibular cancer?
A. No.
Q. Were payments made on your behalf of any of those six cases?
A. No.

Q. Who is your insurance carrier?
A. This week?
Q. Yeah, this week.
A. I think Mutual Assurance but I could be wrong.
Q. Are you a member of a group?
A. I'm a member of the group here at University Hospitals which is University Faculty Practice Associates which has a carrier.
Q. Did you go to the lecture which Jim Malone gave? You might have, you may not have. I thought he did that, gave a big lecture to the University Family Group not long ago regarding who your carrier was.

Prior to this litigation did you know Dr. Park?

A. I knew of him.
Q. How did you know of Dr. Park?
A. I have taken care of patients he's taken care of. He's referred some patients.
Q. He referred patients to you?
A. Yes.
Q. Okay. Dr. Park I assume, to the best of your knowledge, does not do surgery on head and neck tumors?
A. He may well.

Q. But you don't know that one way or the other?
A. I don't know that one way or the other.
Q. Why did he end up referring the patients to you, to the best of your knowledge?
A. Community physicians will often take care of head and neck cancer patients. If they feel that it is a cancer that requires more expertise, because that's what training you receive as an otolaryngologist, on occasion if someone feels they need more expertise on other occasions when somebody wants to deal with the intricacies of the treatment, radiation, chemotherapy and whatnot or some patients -- some physicians simply will refer because they're not interested in dealing with the patient.

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

Q. Describe your team approach towards tumor.
A. University Hospitals has the Ireland Cancer Center which is a National Cancer Institute

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

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

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

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

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

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

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

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

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

A. Can you read that back?

Q. I talk fast.

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

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

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

A. Roughly, yes.

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

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

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

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

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

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

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

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

A. Correct.

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

A. That's my recollection, yes.

Q. Same characteristics?

A. That is my recollection, yes.

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

A. As far as I recall.

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

A. I have not.

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

A. Probably not.

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

A. Yes.

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

her growth rate changed?

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

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

A. Are you asking what the nodules came from?

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

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

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

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

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

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

A. Yes.

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

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

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

Could you please rephrase that?

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

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

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

A. Correct.

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

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

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

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

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

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

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

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

Q. Okay. Doctor, do you treat vestibulitis?

A. Yes.

Q. Give me your definition of vestibulitis.

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

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

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

A. Yes, it can.

Q. One can be an infected hair follicle?

A. Correct.

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

A. Yes.

Q. Could those get blocked or clogged?

A. Yes.

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

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

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

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

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

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

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

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

diagnosis of vestibulitis.

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

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

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

A. Yes.

Q. What would been within your differential?

A. Any time you have an ulceration, as obviously

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

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

A. Yes, that's correct.

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

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

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

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

Q. Did you actually read their depositions?

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

Q. Did reading the family depositions add any factual information for you to consider?
A. I don't believe so. I think that's why I'm not recalling them right off the top of my head until I look at the depositions themselves.
Q. You are aware that Dr. Manning indicates by his office note that in November of 1999 he examined Mrs. Bailes in her nasal vestibule left side and describes an ulceration. Would you agree with that?
A. That's my recollection, yes.
Q. Mrs. Bailes presents to Dr. Park approximately how many days later? You can look at your notes. It's not a memory contest.
A. Which date was that you just referred to, Dr. Manning?
Q. Dr. Manning's visit of November 8th, 1999.
A. I think it would be November 15th if that's what you're referring to.
Q. Yes. November 15th, 1999.
A. Do you want to help me find it?
Q. Did you want to look at Dr. Manning November examination or Dr. Park?
MR. GRIFFIN: What do you want him to look at?

Q. I asked if he had a recollection of what was described by Dr. Manning in his November 1999 visit. It's November 8th.
A. I'm looking at one page of notes I've taken. It looks like from my notes that the nurse wrote sore in nasal passage and Dr. Manning wrote sore gotten bit better but not completely gone.
Q. Okay.
A. Scab over lesion nasal septum left. Sore appears to be improving.
Q. He wanted her to see an ENT; is that correct?
A. See ENT, yes.
Q. He describes it as an ulceration, correct?
A. I don't see that.
Q. Okay. I guess we'll go backwards. He sees her on October 11th, 1999, correct?
A. Yes.
Q. What does he observe in that visit?
A. Patient has a sore on left part of the septum of nose which has been there on and off for about one year.
Q. Okay. That gives you the history of how long the sore has been there, correct?
A. Yes.
Q. And then on examination he finds a shallow

ulceration in the left septum, correct?
A. Correct.
Q. He doesn't use the word excoriation?
A. No.
Q. And then she returns per his instructions in approximately four weeks. Are we in agreement with that?
A. Yes.
Q. Okay. And on that point he doesn't say that it's gone away. He says it looks better, correct?
A. Correct.
Q. But it's not gone. Would you agree with that?
A. Yes. According to his exam.
Q. Okay. Do you think that he didn't know how to conduct a physical examination of the patient's nose?
A. I don't know Dr. Manning so I don't know his capabilities. I know I have been asked to see things from other physicians that sometimes they have an accurate sense of and other sense not.
Q. Is the premise of any opinion you're rendering in this case Dr. Manning was unable to recognize an ulceration in the nose?
A. No.
Q. And Dr. Manning, in fact, filled out a referral

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

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

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

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

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

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

A. Yes.

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

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

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

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

MR. GRIFFIN: Object. Go ahead.

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

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

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

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

looking for?

A. Yes.

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

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

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

MR. GRIFFIN: January 22, '01.

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

MR. GRIFFIN: January 10, '01.

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

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

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

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

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

MR. GRIFFIN: Object. Go ahead.

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

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

A. Yes.
Q. Do you know when you got that transcription of his office notes?
A. No.
Q. Did you request a transcription of the office notes prior to rendering your opinion because you could not read his office notes?
A. I really don't recall the proximity of when I received those.

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

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

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Q. Doctor, in looking at Dr. Park's chart could you actually read what Dr. Park's chart said without a transcript or his deposition testimony?
A. Let me look again. I can read most of it. There are certainly words here difficult to make out.
Q. So I can gather the transcription aided you and assisted you determining what the sum total of all those notes said?
A. Yes.
Q. Do you know who prepared this transcript?

A. No.
Q. Did it come with a cover letter that you're aware of? I didn't see one. It might be in your stack.
A. I'm sure it did. As you can see everything has been separated at this point in time.
Q. Dr. Stepnick, how many hours have you spent evaluating medical records and testimony and preparing in this case?
A. I would have to go back and look. I would guess 12.
Q. Okay. Do you think -- I shouldn't you use that word. To a reasonable degree of medical probability as of September 1998 through January of 2001 was there a clear epidemiological correlation between cigarette smoking and nasal vestibular cancer?
A. I think nasal vestibular cancers are not considered to be like other sites in the head and neck in that sites such as oral cavity, tongue, larynx, pharynx, there's a clear epidemiological link between cigarette smoking and cancer.
Q. If I read my literature correctly, that is the answer I was looking for. Maybe Dr. Koch is going to be one of our experts. Do you know

Dr. --

MR. GRIFFIN: One of yours?

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

MR. GRIFFIN: I highly doubt it.

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

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

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

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

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

MR. GRIFFIN: Objection. Move to strike.

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

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

A. No.

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

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

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

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

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

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

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

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

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

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

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

MR. GRIFFIN: Object to form but go ahead.

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

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

MR. GRIFFIN: Object.

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

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

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

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

MR. GRIFFIN: Object to form.

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

Q. Of course.

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

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

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

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

MR. GRIFFIN: Place an objection.

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

Q. What was significance of finding granular tissue

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

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

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

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

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

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

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

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

A. Yes.

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

MR. GRIFFIN: Object.

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

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

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

not necessarily translate to a different prognosis.

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

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

A. Yes.

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

A. Yes.

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

A. Yes.

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

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

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

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

A. Yes.

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

MR. GRIFFIN: Object to the form.

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

A. Yes.

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

A. It's by site.
Q. Nasal vestibular or nasal septal cancer, whichever would you prefer to use?
A. I don't frankly know there are enough cases one would come up with a specific number like that. We used, quote, 12,000 of laryngeal cancer and there's certainly more sub sites. That's, as you said, a rare sub site. So our experience in that area is largely based upon the response of other T-1 tumors in the head and neck.
Q. Would you -- at that point would you have known what the statistical experience was?
A. Can you ask that a different way?
Q. Have you read studies within your specialty that would aid and assist you in knowing what the approximate statistical survivability was with the T-1 nasal vestibular or septal cancer?
A. Probably in the past. In general, in general a T-1 cancer carries with it a fair prognosis, 80 to 90 percent chance of cure.
Q. Would you suspect that rate of cure would improve if the person -- let me withdraw the question.

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

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

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

Q. With what you wrote in your report --

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

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

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

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

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

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

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

Q. You base that opinion on what?

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

does not lead to an increase dermal metastasis.
Q. Have you personally spoken to Dr. Park about this case?
A. No, I have not.
Q. Once again you use a sentence in your report, you can look for it. I think it may be the second page, maybe it's still on the first page. You say it's unclear as to whether earlier diagnosis would have had truly impacted the curability. I think that's the way you stated it unless I got you confused with somebody else.
A. I think we just discussed that issue.
Q. Dr. Stepnick, were you able to ascertain either from Dr. Park's deposition or his office note as to whether or not in his November 1999 visit he explored the nose to the extent he could determine what was under the crusting he saw in Mrs. Bailes' nose.
A. I'm sorry, November 15th?
Q. Yes.
A. Well, not to give you a hard time.
Q. That's all right. You're allowed.
A. There are different types of crusts. There's adherent crusts that obscure what is underneath them, crusts that is translucent that you can see

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

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

A. Yes.

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

MR. GRIFFIN: How many years she had it?

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

A. It was approximately ten years.

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

that right, following the November 15th visit?
A. Yes.
Q. And Dr. Park makes no mention of a finding in her nose on that visit; is that right?
MR. GRIFFIN: Finding of crust, you mean?
Q. Right.
MS. TAYLOR-KOLIS: Thanks for correcting me, Steve.
A. He makes no mention of crust, that is correct.
Q. Okay. From your recollection or you can look at it, when I talked to him at his deposition about the November 15th, 1999 visit that was the first time he had drawn her left nostril with a finding of crusting in that entire time period that he had been taking care of her. Do you agree with that?
A. I see the drawing here in the notes. I'm reviewing. He has a little drawing back in July of 1989.
Q. Do you recall reading his deposition what he said that drawing represented?
A. No, I don't recall specifically what he said that represented.
Q. Okay. Do you think that's a well-documented

medical chart, Dr. Stepnick?

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

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

A. Yes.

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

A. Yes.

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

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

Q. Right.

A. 28th.

Q. Yeah.

A. Yes.

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

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

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

A. Yes.
Q. Let me ask you a couple questions about semantics. Let's talk about semantics. Assuming that in August of 2000 Mrs. Bailes had vestibular cancer, I'm going to ask you to assume that.
A. Yes.
Q. When she experienced an ulceration in her nose, if she was given topical treatments, even if there was cancer underlying that area, could she not experience some sort of clinical improvement in the area?
A. To some degree, yes.
Q. Because truly her cancer, as someone else said, doesn't wax and wane?
A. Correct.
Q. It's there?
A. Correct.
Q. The outward clinical manifestation of vestibulitis of the nasal cavity can change depending upon if you apply a product to it, would you agree with that?
A. If there's a significant component of associated infection, then the product could help with that but it won't do anything with the underlying cancer.

Q. I always hate when I ask stupid questions. The underlying cancer isn't visible -- was the underlying cancer invisible at the time Mrs. Bailes was diagnosed in January of 2001?
A. As best I can tell from the records, yes.
Q. It manifested itself in what way?
A. I would only be reading Dr. Steinberger's records.
Q. That's okay. That was the ulceration with granulation tissue we were discussing?
A. Correct.
Q. So at a time before it got to that, it may have had some appearance but not the same as that?
A. Yes.
Q. Okay. Because the ulceration isn't the cancer, it's what's underneath it, correct?
A. The ulceration is the absence of tissue because the cancer has destroyed the normal tissues.
Q. Fair enough. So this note from August 28th, 2000 there's a description once again from Dr. Manning of ulceration of the nasal septum, correct?
A. Yes.
Q. And, again, his history is saying many years she had this ulceration problem, correct?
A. My notes says times two years.

Q. I think you're right, two years. He uses the phrase many years in that particular note?
A. I see that.
Q. As part of appropriate history taking relative to a complaint of a sore in a nose, doesn't the otolaryngologist want to know the duration of that sore?
A. Yes.
Q. Do you see anywhere in Dr. Park's notes that he elicited from Mrs. Bailes in relation to the complaint of her sore in her nose the duration of the time of those sores?
A. I would have to go back and look through it. I'm assuming you're asking the question because it's not there. But I think that given we have already said that there are varying degrees of documentation by various physicians, I would think that a physician who feels he knows a patient very well and sees her as many times as Dr. Park does, may not have included that in his record. I'm just speculating he may not have included that in his record because he sort of knows how things progressed. It's probably not in there. That doesn't necessarily mean he wasn't satisfied he knew when there were

ulcerations there.

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

MR. GRIFFIN: Object.

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

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

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

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

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

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

A. Could I have the date again?

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

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(Thereupon, a recess was had.)

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

A. Yes.

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

A. Yes.

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

A. Yes.
Q. Doesn't have anything about swelling, redness, crusting, just has shallow ulceration, agreed?
A. Correct.
Q. And at the conclusion of that visit, once again, referral to ENT for further evaluation of the nasal septum, right?
A. Yes.
Q. That was in his plan. She goes back to Dr. Park and I think it's September 5th, correct?
A. Yes.
Q. And that's about seven, seven to eight days, I can't remember if there's 31 days in August, seven to eight days later after that visit with Dr. Manning, right?
A. Approximately, yes.
Q. Okay. At that particular visit Dr. Park, once again, finds vestibulitis. Would you agree with that, that's what his notes said as well as his deposition testimony?
A. I'm looking at his summary of his notes and -- I will look at his notes.
Q. Okay.
A. It appears he says vestibulitis, yes.
Q. In looking at Plaintiffs' Exhibit B, which you

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

A. Yes.

Q. Okay.

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

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

A. It appears to be, yes.

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

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

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

A. Yes.

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

A. Yes.

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

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

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

A. Can they, yes.

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

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

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

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

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

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

A. I would think so.

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

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

A. Yes.

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

A. Yes.

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

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

A. No, I did not.

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

A. Yes.

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

A. I do now.

Q. Is he the radiation oncologist?

A. Yes.

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

MR. GRIFFIN: It looking like a cow ear.

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

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

Q. Okay.

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

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

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

Q. It was significant in the what?

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

Q. Okay. When did Steve Griffin contact you first about reviewing this case?
A. I don't know.
Q. Do you have some way of knowing based upon your file.
A. No, because I pulled these together for preparation of this.
Q. All right. We know it would have been before April 18th because that's when you wrote the report?
A. Correct.

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

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Q. What's now marked Plaintiffs' Exhibit C these are your handwritten notes. At the top does that say April 13th?
A. I says 4-13.
Q. Under that is that a 2?
A. It's 30.
Q. 30 m?
A. Yes.
Q. You spent 30 minutes on the file April 13th. April 15 you spent another 30 minutes on the

file?

A. Yes.

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

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

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

A. Yes.

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

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

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

Q. Is the condition of vestibulitis characterized by

a sore in the nose?

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

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

A. His testimony is there.

Q. In his deposition?

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

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

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

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

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

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

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

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

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

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

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

A. Yes.

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

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

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

MR. GRIFFIN: Objection.

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

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

or 2001 deviated from accepted standard medical care?

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

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

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

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

A. Yes.

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

contribute to Mrs. Bailes' death?

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

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

MR. GRIFFIN: Object.

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

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

A. Correct.

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

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

MR. GRIFFIN: Object.

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

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

MR. GRIFFIN: Object.

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

Q. Okay.

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

MR. GRIFFIN: He'll read.

DAVID W. STEPNICK, M.D.

CERTIFICATE

The State of Ohio,) SS:
County of Cuyahoga.)

I, Tami A. Mitchell, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the 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 truth; that the deposition as above-set forth was reduced to writing by me by means of stenotypy, and was later transcribed into typewriting under my direction; that this is a true record of the testimony given by the witness; that said deposition was taken at the aforementioned time, date and place, pursuant to notice or stipulation of counsel; and that I am not a relative or employee or attorney of any of the parties, or a relative or employee of such attorney, or financially interested in this action; that I am not, nor is the court reporting firm with which I am affiliated, under a contract as defined in Civil Rule 28(D).

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

Tami A. Mitchell

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

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LAWYER'S NOTES

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