

1 IN THE COURT OF COMMON PLEAS

2 CIVIL DIVISION

3 SUMMIT COUNTY, OHIO

4
5 KAREN WILSON, Administratrix, the) Case No.:

6 The Estate of GERALDINE BAILES,) CV-2002-06-3340

7 Plaintiff,)

8 vs.)

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

10 Defendants.)

11
12 The video teleconference deposition of
13 BARRY WENIG, M.D., called by the Defendants for
14 examination, taken before JOANNE H. RICHTER, a
15 Notary Public within and for the County of Cook,
16 State of Illinois, and a Certified Shorthand
17 Reporter of said state, No. 84-2082, at
18 Northwestern University, University Library,
19 1970 Campus Drive, Evanston, Illinois, on the
20 19th day of August, A.D. 2003, at 9:00 a.m.

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22
23
24 COPY

1 PRESENT:

2 FRIEDMAN, DOMIANO & SMITH CO., L.P.A.,

3 (Sixth Floor - Standard Building,

4 1370 Ontario Street,

5 Cleveland, Ohio 44113-1704,

6 216-621-0070), by:

7 MS. DONNA TAYLOR-KOLIS,

8 appeared on behalf of the Plaintiff;

9
10 BUCKINGHAM, DOOLITTLE & BURROUGHS, LLP,

11 (4518 Fulton Drive, NW,

12 Canton, Ohio 44735-5548,

13 330-492-8717), by:

14 MR. STEPHEN P. GRIFFIN,

15 appeared via video teleconference

16 on behalf of the Defendants

17 Youn Park, M.D., and Y.W. Park

18 M.D., Inc.

19
20 ALSO PRESENT:

21 (Via video teleconference)

22 YOUN PARK, M.D.

23
24 REPORTED BY: JOANNE H. RICHTER, C.S.R. 84-2082.

1 BARRY WENIG, M.D.,
2 called as a witness herein, having been first duly
3 sworn, was examined and testified as follows:

4 EXAMINATION

5 BY MR. GRIFFIN:

6 Q. State your name for the record, please.

7 A. Barry Lloyd Wenig.

8 Q. And your profession?

9 A. I am a physician.

10 Q. Any expertise of any particular area?

11 A. Yes.

12 Q. What area, sir? I don't have your --

13 A. Otolaryngology and head and neck
14 surgery.

15 Q. What positions do you hold
16 professionally currently?

17 A. I am professor of otolaryngology and
18 head and neck surgery at Northwestern University,
19 Feinberg School of Medicine and I am chief of
20 otolaryngology and head and neck surgery at
21 Evanston Northwestern Healthcare.

22 Q. How long have you held those positions?

23 A. I have been at Northwestern since
24 January 1, 1999. Same is true at Evanston.

1 Q. Are you board certified?

2 A. Yes, I am.

3 Q. In what area?

4 A. Otolaryngology and head and neck
5 surgery.

6 Q. When did you become board certified?

7 A. 1986.

8 Q. And this was your first testing
9 attempt --

10 A. Yes.

11 Q. -- In otolaryngology? I guess I can see
12 your educational and employment history in full on
13 your CV, is that correct?

14 A. That is correct.

15 Q. Does your CV also include any
16 publications that you have had through the years?

17 A. Yes, it does.

18 Q. Does it include any presentations you
19 have made through the years?

20 A. Yes, it does.

21 Q. Have you published anything with respect
22 to squamous cell carcinoma of the nasal vestibule?

23 A. Yes, I have.

24 Q. Can you tell me specifically by

1 identifying those particular writings if you like
2 by name or by number on your CV, so we can
3 reference those that you feel have particular
4 relevance to this case.

5 A. Yes, but I don't have my CV in front of
6 me right now, so I couldn't tell you at this very
7 moment, but I will get that information to you.

8 Q. Do you have, by recollection, any
9 articles in mind or any book chapters, et cetera,
10 that would be relevant to this case?

11 A. I recently -- I would say within the
12 last two to three years -- wrote an article on --
13 as a coauthor, on carcinoma of the nasal vestibule,
14 but I don't recall specifically where it was
15 published.

16 Q. You wrote it in the last two to three
17 years so that would make it by the year 2000 or so?

18 A. I would guess, yes.

19 Q. Do you represent that the material and
20 items that you wrote about in that 2000 article
21 would have been the standard of care in 1999 or the
22 year 2000?

23 A. Yes, I do.

24 Q. Is it usually typical for literature to

1 come out first before the standard of care is
2 adopted, to kind of catch up to the literature?

3 A. Not necessarily, no, but this was more a
4 review article dealing with clinical presentation
5 of disease, etiology, general treatment modalities
6 for this type of carcinoma and survival data. So I
7 don't think it is terribly relevant that it came
8 out possibly a year, year and a half after the
9 events that we are discussing here.

10 Q. Other than the fact that it would not
11 have been available to any clinician to utilize in
12 his practice unless they found the individual
13 studies that you cite?

14 A. That's correct.

15 Q. Are there any other articles off the top
16 of your head? You tell me you don't have your CV
17 there.

18 A. I will be very honest with you. I've
19 published close to 100 articles. I have written,
20 I think, 15 texts or parts of texts. I just can't
21 recall everything that I have written, and my
22 memory is going as I get older, so I apologize.

23 Q. Do you have any idea how many articles
24 Dr. Park would have written?

1 Dr. Park is here, by the way. I don't
2 know if your camera can see him.

3 Do you have any idea how much he has
4 contributed to the literature?

5 A. I have seen his CV, yes.

6 Q. So you are familiar with how much he has
7 contributed to the literature?

8 A. I have seen his CV, yes.

9 Q. What does that mean, "I have seen his
10 CV"?

11 A. I commend Dr. Park on his efforts to
12 publish, but the vast majority of Dr. Park's
13 publications are case reports dealing with isolated
14 clinical entities primarily in journals that are
15 addressed to emergency physicians and family
16 practitioners.

17 Based on the CV that I had, Dr. Park
18 published very few articles in the recent past
19 dealing in the otolaryngology literature in the
20 accepted peer review journals of our specialty.

21 That's not a knock on Dr. Park.
22 I commend him very much for being very academically
23 oriented, but in the traditional academic world,
24 these articles would not be considered, how shall I

1 say this, representative if someone submitted a
2 curriculum vitae such as Dr. Park's for clinical
3 status in an American university.

4 Q. You have read his deposition, I assume?

5 A. Yes, I have.

6 Q. You are aware that he has recently
7 finished authoring a book about head and neck
8 cancers, correct?

9 A. I know that he was in the process of
10 writing a book and looking for financial support
11 for publication of the text, yes.

12 Q. Okay. Very good. Dr. Wenig, what
13 caused the cancer in this patient?

14 A. Well, I can't tell you specifically what
15 caused it, but I can tell you that I am sure one of
16 the predisposing factors was Mrs. Bailes' use of
17 tobacco.

18 Q. And do you find anywhere in the medical
19 records that there were discussions with her by any
20 physicians about quitting the use of tobacco or
21 abuse of tobacco?

22 A. I don't specifically recall seeing that,
23 but then again, I was fairly limited in my review
24 of physicians notes.



1 Q. When you say you were fairly limited,
2 did that mean that you didn't want to read all the
3 records that were available on this patient, or did
4 you just look at Dr. -- what did you mean by that
5 statement?

6 A. Whatever records were supplied to me,
7 that's what I read.

8 Q. All right. Did you read the entirety of
9 Dr. Manning's chart?

10 A. Yes, I did.

11 Q. Then are you aware that on at least
12 three occasions, to my perusal over the last just
13 two minutes, that he had had discussions dating
14 back to her in the early '90s about quitting the
15 abuse of tobacco?

16 A. That's very possible, yes.

17 Q. Would the failure to quit have
18 contributed to the cause or the commencement of the
19 cancer on behalf of the patient?

20 A. I don't know if anyone would be able to
21 answer that question for you. The best way that I
22 could answer it is to tell you that tobacco use is
23 one of the etiological factors in the development
24 of a carcinoma of the head and neck region.



1 Q. Is it the leading cause, to the
2 scientists' knowledge at this point in time? What
3 is the medicine on that currently, Doctor?

4 A. It is one of the causes. A lot of
5 studies dealing with carcinoma of the head and neck
6 region are generalized studies without
7 site-specific locations relating to both the use of
8 alcohol and tobacco.

9 I can't tell you specifically if this is
10 the only factor dealing with carcinoma of the nasal
11 septum. I think it is a multifactorial disease of
12 which this is one.

13 Q. This is a leading factor?

14 A. I don't want to be argumentative, but
15 what do you mean by "leading"?

16 Q. Is it more of a cause, more of a known
17 cause to the carcinoma of the nasal septum than any
18 other cause?

19 A. I would say it is probably the most
20 easily identifiable cause. Whether --

21 Q. Were there any other -- excuse me, go
22 ahead.

23 A. Whether it leads or not, I can't
24 specifically say. There are other factors.

1 Q. Can you --

2 A. Environmental exposure, toxin exposure,
3 things of that nature, yes.

4 Q. Can you identify any other factor in
5 this plaintiff?

6 A. Well, some people with a history of
7 chronic rhinitis and chronic nasal irritation can
8 undergo a metaplastic process which could be a
9 setup for the development of carcinoma in the
10 future.

11 Now, what the triggering factor is at
12 that point that converts from a benign condition to
13 a malignant condition, I don't think anyone has any
14 good way of knowing.

15 Q. All right. Let me state it generally.
16 If the plaintiff had taken the advice of her
17 doctors and quit smoking, would that have been a
18 possible -- strike the way that question is worded.

19 If she had taken her doctor's advice and
20 quit smoking, would that have reduced the chances
21 that she would have contracted this nasal vestibule
22 cancer?

23 A. Well, I think there is, certainly, a
24 temporal relationship between the cessation of

1 smoking and the chances of developing a carcinoma.
2 Clearly, had she stopped, for argument sake,
3 15 years before she developed the carcinoma, then
4 her chances of developing the carcinoma would have
5 been much less than had she stopped a year before,
6 for example.

7 So I don't know specifically when she
8 was advised about stopping, and since this is a
9 prolonged process with respect to conversion from a
10 benign to a malignant condition, logically speaking
11 it makes sense that the chances would be less had
12 she stopped earlier than later.

13 Q. Do you advise your patients to quit
14 smoking?

15 A. When I see patients who have -- let me
16 rephrase that. The majority of patients that I see
17 have either been diagnosed with carcinomas or I am
18 the one who diagnoses them with carcinoma.

19 It is not that I see patients who have
20 benign conditions or general ENT problems and they
21 tell me that they smoke and I tell them that they
22 should stop smoking.

23 On my cancer patients, either previously
24 diagnosed or newly diagnosed, I explain to them



1 that smoking is one of the risk factors in the
2 development of cancer of the head and neck region
3 and I suggest to them that they consider stopping
4 the use of tobacco because of the possibility of
5 either getting a recurrence following treatment or
6 developing a second primary tumor following
7 treatment.

8 Q. So even in patients that have nasal
9 carcinoma, you still recommend that they stop at
10 that point in time that the diagnosis is made for
11 purposes of recurrence?

12 A. Recurrence or development of a new tumor
13 of the upper air or digestive track, yes. I think
14 it is obligatory on the physician treating the
15 patient to make the patient aware of the
16 cause-and-effect relationship between cigarette use
17 and head and neck cancer.

18 You can advise the patient and encourage
19 the patient and make the patient aware of that, but
20 you can't physically or forcibly make them stop.
21 That's up to them, but --

22 Q. That's your medical advice?

23 A. Yes, it is.

24 Q. A patient always has the option of

1 following your medical advice or disregarding your
2 medical advice, I think is the point you are
3 making?

4 A. That's correct.

5 Q. Doctor, how did you end up with this
6 case?

7 A. I was contacted by Ms. Taylor-Kolis who
8 asked me if I would look at the materials involved
9 in this case.

10 Q. And you received a telephone call from
11 Ms. Kolis?

12 A. Generally speaking, that's what
13 happened. I can't remember the specifics of this
14 case, but that's usually what happens.

15 Q. Have you kept a file concerning this
16 case?

17 A. Yes, I have.

18 Q. Have you kept all the letters that you
19 received from the attorney?

20 A. Yes, I have.

21 Q. Do you know when the first letter that
22 you received from the attorney was?

23 A. If you will give me a moment, I will
24 look and see if I can find it. I am not doing a



1 good job of finding it at this point. Let's see,
2 yes, July 25th, 2002.

3 MR. GRIFFIN: I just want to put something on
4 the record, Doctor. Excuse me a second. I am
5 going to ask that all correspondence within the
6 file of Dr. Wenig be produced.

7 BY MR. GRIFFIN:

8 Q. Dr. Wenig, this first letter, could you
9 briefly preview that for me? This is a starting
10 point for my questions.

11 A. Sure. It is a letter from
12 Ms. Taylor-Kolis to myself -- I am sorry, from
13 Thomas Conway to myself, where Mr. Conway said that
14 he represents the family of Geraldine Bailes.

15 She was diagnosed with a squamous
16 carcinoma in January 2001. She received radiation
17 therapy and chemotherapy and subsequently died
18 approximately one year later.

19 She had been seen by Dr. Park from
20 August 1986 until September of 2000. She had also
21 been treated by Dr. Manning. And subsequently
22 following her treatment by Dr. Park, she was
23 treated by Dr. Steinberger, who made the diagnosis.

24 And then there is a list of things that



1 are enclosed for my review and he asked me at that
2 point to determine if Dr. Park or any other medical
3 provider deviated from the standard of care and
4 determine, if that was -- if there was a deviation,
5 was that the proximate cause of Mrs. Bailes' death.

6 Q. That would have been presumptuous for
7 him to send you a letter with a stack of medical
8 records without having had a conversation or a
9 commitment from you that you were willing to review
10 the case, correct?

11 A. That's correct, yes.

12 Q. So you think you probably got a
13 telephone call first?

14 A. I assume I did, yes.

15 Q. Just out of the blue, or did you know
16 Mr. Conway or Ms. Kolis from prior occasions?

17 A. No, it was out of the blue.

18 Q. This case wasn't assigned to you by any
19 medical expert service?

20 A. No, it was not.

21 Q. Somehow they came up with your name and
22 you don't know how?

23 A. To the best of my knowledge, I really
24 have no idea how.



1 Q. Have you ever testified in the state of
2 Ohio on prior occasions, either at trial or given a
3 deposition for a case that was pending in the state
4 of Ohio?

5 A. I don't recall specifically. I think
6 not.

7 Q. Do you advertise your expert services at
8 all, Doctor?

9 A. No, I do not.

10 Q. Do you work for any medical expert
11 service, in other words, a service that is able to
12 locate an expert, kind of brokers between an
13 attorney and the expert based upon what the case
14 needs?

15 A. I don't work for any services, no. I am
16 listed with two -- three services as someone who
17 would be willing to review cases, but I don't work
18 for them.

19 Q. I understand. How did your name get on
20 these three lists?

21 A. I was contacted by each one of the
22 services to review -- to ask me if I would be
23 willing to review a case, and once I reviewed one
24 case, they kept me on the list as a possible

1 reviewer.

2 Q. Do you know the name of the services?

3 A. Yes, one is Pennsylvania Physicians for
4 Legal Review, one is Medquest, and one is something
5 American Forensics or something to that nature.

6 Q. How many cases do you currently have
7 that you are reviewing and rendering expert
8 services?

9 A. I get approximately, I would say, about
10 20 contacts a year from various and sundry
11 individuals whether I would be willing or not to
12 review a case. If I am not willing to review the
13 case for whatever reason, I will tell them right on
14 the spot. If I tell them based on the summary they
15 give me that the case doesn't appear to have any
16 merit to me, I will tell them that on the spot.

17 I wind up with about, I would say, 10
18 cases, 10 to 12 cases a year to review, actually to
19 review the case, and I think that's about a good
20 number -- I mean, a reasonable number for a year.

21 Q. How many do you have open currently?

22 A. I couldn't even begin to tell you.

23 Q. Your best estimate.

24 A. I would guess probably around 15.

1 Q. Of those 15, how many are you testifying
2 on behalf of a plaintiff?

3 A. Half.

4 Q. When is the last time you gave testimony
5 on behalf of the physician's standard of care?

6 A. I don't understand what you mean.

7 Q. When is the last time you rendered
8 testimony either by deposition or live in court on
9 behalf -- in support of the standard of care of a
10 physician?

11 A. That means to defend a physician, is
12 that what you are saying?

13 Q. Yes, sir.

14 A. I just wanted to clarify that. I wasn't
15 sure what you were saying.

16 Q. Sure.

17 A. Well, I know I have done two this year,
18 but I can't recall specifically when, what month it
19 was.

20 Q. By way of deposition or court
21 appearance?

22 A. I don't think I have been to court this
23 year. By deposition.

24 Q. Can you remember the names of the



1 physicians?

2 A. One is Brian Farrell here in Chicago.

3 Q. The other?

4 A. I can't recall. I just got a case last
5 week in defense of a physician, but I can't
6 remember the other one.

7 Q. Yes, sir. And Dr. Farrell's case, what
8 type of case was that? What was the general
9 allegation made against Dr. Farrell?

10 A. It was a case of obstructive sleep apnea
11 and the patient died following the surgery.

12 Q. And the other case that you cannot
13 recall the doctor's name?

14 A. I am sorry, I just can't remember.

15 Q. Can you recall ever an occasion where
16 you appeared in court at trial to testify on behalf
17 of a physician's standard of care?

18 A. Yes.

19 Q. In support of the standard of care?

20 A. Yes.

21 Q. How long ago was that?

22 A. I have been to court, to the best of my
23 recollection, three times to testify on the
24 standard of care on behalf of a physician. The



1 most striking one that I remember, because it was
2 here in Chicago is John McMahon was the physician,
3 and that was about, I would guess, eight or nine
4 years ago. I am sorry, I don't specifically recall
5 the case -- the other cases.

6 Q. The name of the attorney that
7 represented Dr. Farrell, do you recall his name?

8 A. No, I don't.

9 Q. Or his law firm?

10 A. I don't.

11 Q. Okay. Currently, what are your charges
12 for your expert services, Dr. Wenig?

13 A. I charge \$400 an hour for review of
14 materials and \$500 an hour for deposition time or
15 preparation time for depositions.

16 Q. What is your trial charge?

17 A. Out of Chicago it is \$5,000 a day plus
18 travel expenses.

19 Q. Do you have plans to come to Ohio the
20 week of September 8th for this trial?

21 A. I don't have any plans. If I need to I
22 will, but I would prefer not to.

23 Q. Doctor, have you reviewed the entire
24 chart of Dr. Park?

1 A. Yes, I have.

2 Q. Certainly, you don't believe this woman
3 had cancer in 1986, nasal carcinoma, do you?

4 A. No, I do not.

5 Q. Then do you believe that Dr. Park's
6 treatment and care that was rendered for a period
7 of time for sinus problems, or chronic sinus, or
8 rhinosinusitis, or those conditions through the
9 late '80s, that care was appropriate and to the
10 standard of care?

11 A. Yes, I do.

12 Q. Moving into the 1990s, Dr. Park treated
13 this patient for impacted cerumen and continued to
14 treat her for nose and sinus problems and
15 rhinosinusitis and vestibulitis.

16 Did his care and treatment up to 1993
17 meet the appropriate standard of care applicable to
18 physicians in his field of practice?

19 A. Yes.

20 Q. So up until 1993, at least, you believe
21 Dr. Park had an ability to conduct examinations,
22 identify problems, and treat them appropriately,
23 correct?

24 A. That's correct.



1 Q. And an ability to recognize and treat
2 vestibulitis and rhinosinusitis, correct?

3 A. Yes.

4 Q. He demonstrated that to you by virtue of
5 his care and treatment selected and the resolution
6 of her problems, correct?

7 A. Yes.

8 Q. And for the record, Doctor, can you
9 define for us what vestibulitis is?

10 A. It is an inflammatory process of the
11 nasal vestibule, which is, generally speaking,
12 secondary to an infection of one of the hair
13 follicles within the nasal vestibule usually as a
14 result of the bacterial organism staph aureus.

15 Q. What is the typical complaint, the
16 presenting complaint that the patient makes for
17 this condition?

18 A. Some soreness, some pain, usually they
19 feel a pimple or a bump, sometimes there is some
20 discharge in the area. Those are the typical
21 complaints.

22 Q. And I know this probably isn't the rule,
23 but if untreated, is it possible for this condition
24 to last indefinitely?



1 A. Generally speaking, it doesn't last
2 indefinitely. It will resolve eventually. What
3 that time frame is, I really can't answer it for
4 you. But most things of this nature would resolve.

5 They would be very bothersome to the
6 patient after a while, so I would assume they would
7 seek treatment, but if you leave anything alone
8 long enough, it generally goes away unless it is
9 something that's a chronic issue.

10 Q. In some cases the symptoms can be very
11 minimus and mild, I suspect, but in other cases the
12 symptoms can be more severe, correct?

13 A. They can be a little more dramatic. The
14 pain is a little more intense, yes, but that's
15 pretty much about it.

16 Q. Is it possible for ulcers to develop on
17 occasion on a more severe presentation of nasal
18 vestibulitis, in your opinion?

19 A. In my opinion, no.

20 Q. Do you know if it has been reported in
21 the medical literature, to your knowledge?

22 A. To the best of my knowledge, I can't --
23 I cannot tell you because I don't know every
24 article that's been written about nasal

1 vestibulitis.

2 Q. I am certain you try to stay up to date
3 with the current literature to the extent you can,
4 and my question is geared toward that type of
5 literature.

6 A. I don't recall seeing that as a
7 presenting symptom in nasal vestibulitis.

8 Q. I am going to move forward then to 1996,
9 where Dr. Park treated this patient for nasal
10 hypertrophy of the turbinates and rhinopharyngitis,
11 January 5 of 1996.

12 Did his care and treatment on that date
13 meet the standard of care, in your opinion?

14 A. For her condition at that time, yes.

15 Q. On February 17 of 1997, the plaintiff
16 complained of sinus infection, was on antibiotics,
17 with her ears stopped up, and again he treated her.

18 Was his care and treatment on
19 February 17, 1997 to the standard of care in your
20 opinion?

21 A. Yes.

22 Q. Doctor, in your opinion to a medical
23 degree of -- well, to a reasonable degree of
24 medical probability, was there nasal carcinoma

1 present in February of 1997 in the plaintiff?

2 A. No.

3 Q. On September 4 of 1998, the plaintiff
4 presented to Dr. Park's office and was treated for
5 rhinosinusitis, as well as the septal deviation.
6 She had her ears cleaned out.

7 Did his care and treatment on that date
8 meet the standard of care, in your opinion?

9 A. I just want to make one minor
10 correction, if you don't mind. It's semantics.
11 She was not treated for septal deviation. She was
12 identified as having an septal deviation.

13 Q. Right. With that correction, did his
14 care and treatment meet the standard of care on
15 September 4 of 1998?

16 A. Yes.

17 Q. Was there a nasal carcinoma present, in
18 your opinion, to a reasonable degree of medical
19 probability, in September of 1998 in the plaintiff?

20 A. No.

21 Q. I want to jump forward to November 15 of
22 1999. According to my records, that is the next
23 opportunity Dr. Park had to treat this patient.

24 Is that a correct assumption on my part

1 based upon the records you have in front of you?

2 A. Yes, that is correct.

3 Q. So over one year later she presents to
4 him with a complaint of "sore nose, ear plugged,
5 cheek hurts, sore," do you see that?

6 A. Yes.

7 Q. Now, Dr. Park made an illustration on
8 that particular office visit, did he not?

9 A. Yes.

10 Q. Did you see any such illustration in
11 Dr. Manning's chart prior to that visit with
12 Dr. Park?

13 A. No, I did not.

14 Q. Do you have any knowledge, Doctor,
15 whether or not Dr. Manning ever even telephoned
16 Dr. Park concerning his findings or concerns at any
17 time in this case as it unfolded?

18 A. To the best of my knowledge, there was
19 no contact between Dr. Manning and Dr. Park.

20 Q. All right. Do you know whether or not
21 Dr. Park ever knew that the patient was even being
22 informally referred by Dr. Manning for any reason?

23 A. I have no way of knowing that. I would
24 guess not.



1 Q. You have reviewed Dr. Park's chart. You
2 know that Dr. Manning's chart is not a part of
3 Dr. Park's chart, correct?

4 A. Correct.

5 Q. You have seen Dr. Manning's chart and
6 you know there was no letter that was ever authored
7 by Dr. Manning indicating any concern or finding to
8 Dr. Park, correct?

9 A. Correct.

10 Q. All right. Now, Dr. Park had an
11 impression of rhinosinusitis and vestibulitis on
12 November 15 of 1999, correct?

13 A. Correct.

14 Q. Did Dr. Park meet the standard of care
15 in his care and treatment of the plaintiff on
16 November 15 of 1999?

17 A. No.

18 Q. And tell us why?

19 A. Dr. Park, by his own diagram, diagnosed
20 a crust on the left side of the nose. And
21 crusting, in my opinion, is not an appropriate
22 finding for the diagnosis of vestibulitis.

23 Q. Doctor, how do you define "crust"?

24 A. The same way everyone else does.

1 Q. How does the medical literature define
2 "crust"?

3 A. It is a collection of congealed debris
4 over an area of irritation or inflammation.

5 Q. Does any medical literature define it as
6 dried mucous?

7 A. I could say that dry mucous is a
8 component of crusting in the nose, yes. We are
9 talking about the nose?

10 Q. I am not asking you whether it is a
11 component. I am asking you whether or not some
12 define "crust" as dried mucous, whether that is
13 found in the medical literature, or whether that is
14 common terminology used among your peers?

15 A. You cannot have dried mucous unless you
16 have an underlying condition that causes the mucous
17 to dry up and crust in that area. So on the one
18 hand, your supposition is correct. It is dried
19 mucous. But on the other hand, there has to be a
20 reason why there is dried mucous. It just doesn't
21 happen.

22 Q. Doctor, I have dry mucous in my nose
23 right now. Does that mean I have an underlying
24 carcinoma-type condition causing that?

1 A. I didn't say it is necessarily
2 carcinoma. I said an underlying change in the
3 standard or normal condition of the nose, yes.

4 You could have, living in Ohio, sinus
5 disease and that's enough to change the mucosa of
6 the nose and you can have some crusting there, yes.

7 Q. So everybody that has a dried crust or
8 dried mucous in their nose -- strike that.

9 What should have Dr. Park done on
10 November 15 of 1999?

11 A. I think at that point he should have
12 been aware that something other than his previous
13 diagnoses of vestibulitis is potentially going on,
14 and that he should treat the patient with local or
15 topical medication and see if this crusting would
16 resolve.

17 Q. He did treat the patient with a cream,
18 did he not?

19 A. Yes, he did.

20 Q. Was that the appropriate cream?

21 A. For that condition, yes.

22 Q. Well, then he met the standard of care
23 in prescribing the cream?

24 A. Yeah, I don't have any problems with

1 that.

2 Q. Then Dr. Park met the standard of care
3 on November 15, 1999?

4 A. By that definition, yes.

5 Q. There is nothing as far as symptoms
6 presenting on November 15 of 1999 that there was
7 bleeding, correct?

8 A. No, I didn't see any of that, no.

9 Q. And no ulcer advancing to necrosis on
10 that visit, correct?

11 A. Well, I can't answer that question
12 because the crusting could certainly have obscured
13 an ulcer advancing to necrosis. I mean, crusting,
14 as I told you, crusting just does not happen in and
15 of itself.

16 Q. Well, Doctor, I guess we can talk about
17 that more later. Let me finish my questions here.

18 Was there any mass that was identified
19 at any point in time by Dr. Manning or Dr. Park up
20 to November 15 of 1999?

21 A. How do you define a mass?

22 Q. How do you define a mass?

23 A. I asked you first.

24 Q. It doesn't matter how I define it. It



1 makes no difference how I define it. It matters
2 how you define it.

3 A. Based on the notes that I saw from
4 Dr. Park and Dr. Manning, there was no description
5 of a mass on any of the visits up to that point.

6 Q. Was there any presentation by the
7 plaintiff that complaint of losing weight?

8 A. No.

9 Q. Any nodule?

10 A. Nodule? Where?

11 Q. Anywhere in the nasal vestibule or
12 surrounding area.

13 A. Not by description, no.

14 Q. Any satellite lesions?

15 A. Not by description, no.

16 Q. Was she complaining of extreme pain?

17 A. No, just some discomfort.

18 Q. Did she have any deforming points to her
19 nose at that point in time?

20 A. No.

21 Q. Wouldn't all the signs and symptoms I
22 have just gone over been hallmark signs for
23 increasing suspicion for nasal carcinoma?

24 A. They are among them, except for the ones

1 that the patient did have, which you didn't
2 describe.

3 Q. Pardon me?

4 A. The patient did have one that is a
5 classical finding, which you didn't mention, and
6 was seen --

7 Q. Dried mucous?

8 A. No, the ulcer.

9 Q. What was it?

10 A. The ulcer that Dr. Manning found.

11 Q. Dr. Manning found an ulcer. Was there
12 any notation in Dr. Park's records that he found an
13 ulcer?

14 A. No. He found some crusting over the
15 ulcer.

16 Q. But you are saying, then, that there
17 was -- you are making the assumption, Dr. Wenig,
18 that there was an ulcer under this crusting,
19 correct?

20 A. I am making that assumption. That's the
21 basis for my opinion.

22 Q. And without that assumption, your whole
23 opinion fails, doesn't it?

24 A. That's correct.



1 Q. Okay. So let's move on then. I think
2 we have covered November 15.

3 The next date is November 23 of 1999.
4 Dr. Park saw her again eight days later in his
5 office. You had mentioned previously that
6 Dr. Park should have been watching her. Was eight
7 days to return to his office an appropriate amount
8 of time to have her back?

9 A. Yes.

10 Q. Would that suggest that Dr. Park was
11 increasing his surveillance of the patient and the
12 patient's condition?

13 A. Yes.

14 Q. Does his record show any signs of
15 finding any ulcerated area?

16 A. He makes no mention of it, no.

17 Q. Is your opinion that there was something
18 that he missed on examination on November 23 of
19 1999?

20 A. Yes.

21 Q. What did he miss, Dr. Wenig?

22 A. The carcinoma of her nasal vestibule.

23 Q. How do you know that, to a reasonable
24 degree of medical probability, without making a

1 flying assumption?

2 A. Because when she was diagnosed with
3 carcinoma, she was diagnosed with a carcinoma that
4 arose in this area. And if you hear hoof beats, it
5 is generally not zebras. And cancer shows up where
6 it is located, and this is the exact area that was
7 described by Dr. Manning as the ulceration. It is
8 the exact area that Dr. Park identified crusting
9 over what I believe was an ulceration, and this is
10 where the cancer was eventually, and this is where
11 it arose. And that's why I am saying that
12 Dr. Park missed the cancer that arose in the nasal
13 vestibule.

14 Q. Does cancer grow at a continuous
15 progressive rate?

16 A. Yes.

17 Q. You don't see signs of continuous
18 progressive rate of growth from November of 1999 to
19 the point of identifying by biopsy this cancer, do
20 you, Dr. Wenig?

21 A. It went from a smaller area to a larger
22 area. That's a progressive growth rate. The
23 growth rate for different cancers is different.
24 Some grow faster than others. This is a

1 particularly slow-growing cancer.

2 Q. But we can rest assured that physicians
3 in the area of treating cancers know that cancers
4 don't wax and wane, do they? They don't appear and
5 disappear, do they?

6 A. No, they do not.

7 Q. And your review of Dr. Manning's chart
8 would suggest even the area that he identified as
9 being an ulcer was waxing and waning and seeming to
10 improve?

11 A. Well, that doesn't mean that there are
12 areas of the underlying condition that can improve.
13 There is an inflammatory process around the primary
14 process, and with certain types of treatment like
15 the aquaphor that she was treated with by
16 Dr. Manning, and like the bacitracin that she was
17 treated with by Dr. Park, you can eliminate the
18 inflammatory component, but the underlying cancer
19 component remains.

20 When you look at it as an overall
21 picture, yeah, it may look a little smaller because
22 you have treated a portion of it and that's
23 responding, but the basic problem remains. It is
24 not that the cancer waxes and wanes. The cancer



1 remains and grows.

2 Q. Because we can rest assure that when you
3 testify you will be telling the ladies and
4 gentlemen of this jury cancer does not wax and
5 wane, it continues at a progressive rate?

6 A. That's correct.

7 Q. What is the difference between a
8 recurrent ulceration and a chronic ulceration as
9 used by Dr. Manning?

10 A. A recurrent ulceration is one that -- I
11 don't know how Dr. Manning uses it. I am going to
12 define how I would use it. A recurrent one is one
13 that was there, went away, and came back again.

14 Chronic ulceration is one that remains.
15 It may not be as large or significant as it was
16 when it was initially diagnosed, but it still does
17 remain, at least to some degree.

18 Q. All right. Recurrent ulceration would
19 be less concerning than a chronic ulceration, in
20 your opinion, then?

21 A. Well, to be quite honest with you, the
22 answer to that question is no, because we are,
23 after all, human beings and when we evaluate
24 something as physicians we may not be able to

1 appreciate the full extent of the condition.

2 And Dr. Manning or myself or any other
3 person, for that matter, may look at a problem and
4 say, "Yeah, it looks like it is almost all gone."

5 And then a while later it will come back
6 and we will say, "Well, now it is recurrent" as
7 opposed to being chronic, because we didn't
8 appreciate that it was not completely gone. So it
9 is very difficult for me to say what was in the
10 mind of somebody calling it recurrent or chronic.

11 Q. Well, just answer this question for me,
12 then. Why does medicine make a differentiation
13 between recurrent and chronic ulceration? Why is
14 there differentiation?

15 A. Because in an ideal world, which we hope
16 medicine is, when we know it is not, there is a
17 difference between the two, and that we are good
18 enough to tell the difference.

19 Q. Excuse me. So when a physician uses the
20 term "recurrent ulceration," that is different than
21 the word "chronic ulceration"?

22 A. It should be, but again --

23 Q. It should be?

24 A. We don't always make that distinction.



1 Q. And the differentiation is that
2 recurrent ulceration is less concerning for a sign
3 of potential cancer than chronic ulceration?

4 A. Yes, that is correct.

5 Q. I mean, anybody can have an ulceration
6 in their nose just from picking their nose or from
7 over rubbing it with a handkerchief?

8 A. That's true.

9 Q. A large majority of the population will
10 have ulcerations in their nose from time to time
11 based upon what their habits are?

12 A. I don't know about the large majority,
13 but a certain percentage will, sure.

14 Q. Did Dr. Park meet the standard of care
15 on November 23, 1999 based upon his office note?

16 A. You have put me in a very difficult
17 decision. To be very frank with you, I think his
18 office note is lacking in the sense that I think
19 that he did not appreciate what was going on and he
20 recorded what he did appreciate, but in my opinion,
21 this was -- it was not an appropriate appreciation
22 of the condition at that point, so --

23 Q. I see.

24 A. So --

1 Q. Although he had been treating her
2 appropriately and to the standards of care since
3 1986, suddenly in November of 1999 he falls off the
4 other end in failing to meet the standard of
5 care --

6 A. Yes.

7 Q. -- and not understanding or knowing his
8 patient, his long-term patient, that's your
9 opinion?

10 A. Not understanding or knowing the problem
11 that his long-term patient had.

12 Q. But you would agree that if all he found
13 was dried mucous and some swelling and some septal
14 thickening, that those were not signs or symptoms
15 of an underlying cancer for which he needed to be
16 alerted and obtain a biopsy?

17 A. In an isolated environment, in and of
18 themselves, I would answer your question saying no.
19 Given his previous history the week before, having
20 been seen, having the bacitracin treatment, having
21 no response whatsoever over the week, describing a
22 new finding of nasal thickening and erythema,
23 which was never described by him before, all those
24 things add up to me to him not having met the



1 standard of care in this particular instance.

2 Q. What is nasal hypertrophy?

3 A. If you are referring to turbinate
4 hypertrophy, it is swelling of the turbinates,
5 mucosa overlying the turbinates.

6 Q. Is that septal thickening?

7 A. No, the septum is a different anatomical
8 area than the turbinate.

9 Q. Doctor, let's move to September 5 of
10 2000. That is the last time Dr. Park ever had an
11 opportunity to see this patient, is that correct?

12 A. That's correct.

13 Q. So in other words, from November 23 of
14 1999 until September 5 of 2000, this patient never
15 presents to Dr. Park with any type of claim or
16 problem of ulceration or pain or bleeding or
17 anything, correct?

18 A. That's correct.

19 Q. And on the presentation of September 5
20 of 2000, she is complaining of a sore nose,
21 according to Dr. Park's office record, correct?

22 A. Yes, that's what Dr. Park wrote, yes.

23 Q. He found a mouth lesion at that point in
24 time, correct?

1 A. He found what he described as a mucosal
2 lesion, yes.

3 Q. A right buccal lesion, correct?

4 A. That's the description, yes.

5 Q. And it was his intent and ordered on a
6 surgery schedule form an excision of that lesion,
7 correct?

8 A. I don't know if it was excision, but
9 certainly a biopsy of the lesion, yes.

10 Q. And the patient canceled that biopsy
11 that he had requested in September of 2000,
12 correct?

13 A. Yes, to the best of my knowledge, yes.

14 Q. Do you do biopsies in your office?

15 A. Yes.

16 Q. When you do a biopsy, do you scope your
17 patient's ear, nose and throat?

18 A. Depends what I am doing the biopsy for.

19 Q. Let's say you are going to do a biopsy
20 of the right buccal lesion.

21 A. Well, is this the first time I am seeing
22 the patient? Is the patient coming back for a
23 scheduled biopsy, because all of that is important,
24 because I generally do a scope on the patient the

1 first time I see them, so --

2 Q. Let's do it in the circumstances that
3 present here in September of 2000. He sees a
4 lesion in her mouth, notes a lesion and shows an
5 inclination to biopsy a lesion, correct?

6 A. Okay. With the suspicion of carcinoma,
7 is that why he is doing the biopsy?

8 Q. You have read his deposition. I am not
9 here to testify for Dr. Park.

10 A. Okay.

11 Q. Now, this would be the first finding of
12 any lesion by Dr. Park at any time since 1986,
13 correct?

14 A. Yes.

15 Q. And it also shows an inclination on his
16 behalf to go ahead and perform biopsies of lesions
17 he identifies, does it not?

18 A. Yes.

19 Q. And that suggests he understands the
20 standard of care with respect to identifying a
21 lesion and having it biopsied, correct?

22 A. In this particular instance, yes.

23 Q. Now, under these circumstances, would
24 you have also scoped the patient when you were



1 conducting an excision or performing the biopsy?

2 A. Well, I tried to answer that question
3 for you. I wouldn't have taken the patient to the
4 operating room to do a buccal mucosal biopsy. I
5 think that's an unnecessary procedure.

6 I would have scoped the patient in my
7 office at some point in the course of my evaluation
8 of that patient, whether it would be at the time
9 that I biopsy the patient or at a time prior to
10 biopsying the patient when I first saw the patient,
11 but I would certainly not put the patient under
12 general anesthesia to scope them in the operating
13 room. There is no reason for that when you are
14 biopsying a buccal lesion. There is no reason to
15 biopsy them in operating room setting when you
16 biopsying a buccal lesion. There is no sense in
17 it.

18 MR. GRIFFIN: One moment.

19 (WHEREUPON, discussion was had
20 off the record.)

21 MS. TAYLOR-KOLIS: Let the record reflect that
22 the Mr. Griffin went off the record to talk to the
23 doctor.

24 MR. GRIFFIN: Still here. Thank you, I am



1 back.

2 BY MR. GRIFFIN:

3 Q. Dr. Wenig was making the assumption that
4 this patient would be put under some sort of
5 anesthesia.

6 If it was just being done by a local,
7 you wouldn't have a problem with that, would you,
8 Dr. Wenig?

9 A. Why do you have to take them to the
10 operating room to scope them?

11 Q. Are you saying this is out of the
12 standard of care to do that, or is that an exercise
13 of caution?

14 Let me ask you this, Doctor. Are we
15 arguing over nothing here, or is that part of your
16 standard of care criticism that he was planning on
17 doing a biopsy procedure on this patient? Do you
18 have a criticism, or is this just --

19 A. No, I have no criticism about his biopsy
20 of the buccal mucosal. I am just disputing the
21 issue of the scoping. I have no idea why he would
22 want to scope her in the operating room.

23 Q. All right. Let's say he does, would you
24 find criticism with that?



1 A. Well, you have to tell me what kind of
2 scope he wants to do.

3 Q. Let's just say a scope of the ear, nose
4 and throat.

5 A. You don't scope the ears. You look at
6 them in your office. You can scope the nose and
7 the throat in your office.

8 Could you explain to me the advantage of
9 scoping the patient in the operating room other
10 than charging more money for it?

11 Q. Dr. Wenig, all I am asking you is, is it
12 possible for a physician to do a scope procedure
13 along with conducting the biopsy -- I am not asking
14 you to bulge your veins out in your neck in yelling
15 at me. I am just asking you a simple question.

16 I am not asking you to ask me a
17 question, Dr. Wenig. I am inviting you to answer
18 mine. That's all.

19 MS. TAYLOR-KOLIS: I am going to object to
20 your commentary. The doctor's veins are not
21 bulging out of his neck. He is trying to
22 understand what you are asking him. Move along.

23 MR. GRIFFIN: If I had a videotape, that's
24 precisely what's going on.



1 BY THE WITNESS:

2 A. To answer your question, a patient can
3 be biopsied and scoped under local anesthesia in an
4 office setting, and a patient can be biopsied and
5 scoped under local anesthesia in a nonoffice
6 setting.

7 BY MR. GRIFFIN:

8 Q. All right. This patient canceled the
9 biopsy for whatever reason, correct?

10 A. That's correct.

11 Q. Dr. Park never had an opportunity to
12 conduct a biopsy of this lesion because of the
13 patient canceling the procedure, correct?

14 A. Correct.

15 Q. We will never know what Dr. Park would
16 have done or found if he had done this biopsy in
17 September of 2000 as he intended, correct?

18 A. Related to this particular lesion,
19 correct.

20 Q. When this cancer was diagnosed
21 eventually, what was it staged?

22 A. It was --

23 Q. By Dr. Sider?

24 A. It was staged as a T1 lesion of the

1 nasal vestibule.

2 Q. Do you know of any study concluding the
3 cancer mortality stage of disease is the result of
4 an initial professional diagnostic delay?

5 A. I don't understand your question. Could
6 you repeat it, please.

7 Q. Sure. I am asking you, if she was a
8 Stage 1, do you know of any study that has been
9 performed in your field that would relate mortality
10 of the Stage 1 cancer to a physician delay in
11 diagnosis?

12 A. Before I answer your question, I need to
13 understand a little better. Are you asking me is
14 there a study in the literature that says that if
15 you have a T1 cancer and you delay the diagnosis
16 and it becomes a later stage cancer, then the
17 mortality is greater than if you make it earlier?

18 I don't understand specifically what you
19 are asking me about "study."

20 Q. Let's have the court reporter read it
21 back.

22 A. I understand the English. I don't
23 understand the intent of the question. I don't
24 understand what you are asking me to respond to.



1 The language I understand.

2 Q. Patient was a Stage 1 when diagnosed,
3 correct?

4 A. Correct.

5 Q. The patient died, correct?

6 A. Correct.

7 Q. So Stage 1 mortalities, do you know of
8 any studies, Doctor, in the wealth of reading that
9 you have done, that relate mortality to physician
10 delay -- initial physician delay in diagnosis of
11 Stage 1 patients?

12 A. Off the top of my head, I don't know
13 any, no.

14 Q. Are you familiar with the median waiting
15 time from the referral after biopsy to the start of
16 radiotherapy in the United States for treatment of
17 cancer?

18 A. Yes.

19 Q. What is it?

20 A. In between three and four weeks.

21 Q. Are you familiar with any studies that
22 have found the median referral time to be ten days
23 in the United States?

24 A. Are we talking about referral to see a

1 radiation therapist or starting the radiation?

2 Q. From the referral to the start of
3 radiotherapy.

4 A. From the referral to the start being ten
5 days?

6 Q. Yes, sir.

7 A. I find that to be a little questionable.
8 Most times it takes a little longer than that to
9 get things set up. That's why I said three weeks.

10 Q. What was it in Mrs. Bailes' case, from
11 the referral to the start of radiotherapy?

12 A. I would have to look up that
13 information.

14 Q. I believe the date her treatment started
15 was March 13 of 2001.

16 A. Okay.

17 Q. We see the consultation sheet of
18 February 14 of 2001 to Dr. Sider from
19 Dr. Steinberger.

20 A. That would make it around a month, then,
21 right?

22 Q. Yes, sir.

23 A. Okay.

24 Q. Do you believe that there was an undue

1 delay?

2 A. No, I just told you. It usually takes
3 about three to four weeks.

4 Q. Is delaying radiotherapy associated with
5 a decrease in survival, to your knowledge,
6 generally speaking?

7 A. Well, I think depends on how much you
8 delay. If you delay a year, yes. If you delay a
9 month, no.

10 Q. What would be a delay in -- an undue
11 delay in your opinion? It is obviously greater
12 than a month.

13 A. I would say around six to eight weeks.

14 Q. So, what, about the four to six weeks,
15 is that the period in between where you don't have
16 an opinion of whether or not that's delay?

17 A. No, I don't think that that's a delay.
18 I have an opinion. Generally speaking -- for
19 example, in patients who receive combined therapy,
20 which is, for example, surgery followed by
21 radiation therapy, we know that the radiation is
22 much more effective within six weeks of the surgery
23 than it is if we wait longer than six weeks. So we
24 try and get that done in that four- to six-week



1 range to start radiation.

2 Q. Is delay in initiating radiotherapy
3 associated with a higher local failure rate in head
4 and neck cancer?

5 A. What is "delay?" I told you --

6 Q. You have defined it as six to eight
7 weeks.

8 A. Right. That's what I am saying.

9 Q. Others may define it is a much shorter
10 than that. You would acknowledge that, wouldn't
11 you?

12 A. No, I don't think that that's a delay.
13 I think that, realistically speaking, by the time
14 people get up and running and get simulated and get
15 prepared for radiation, people, meaning patients
16 and treating physicians, it is usually around four
17 to five weeks.

18 So you would expect that six weeks or so
19 would be the upper limit of the time you want to
20 wait to start the radiation. Anything more than
21 that would be considered a delay. Anything less
22 than that would be certainly within the framework
23 of acceptability.

24 Q. If I were to pull Dr. Wenig's charts,

1 what is your period that you shoot for as far as
2 initiating radiotherapy?

3 A. As a primary modality alone?

4 Q. Similar to this case.

5 A. Within four --

6 Q. This was her --

7 A. Within four weeks.

8 Q. And are you comfortable with that with
9 your patients, four weeks, or do you try to get
10 them in earlier?

11 A. Get them in earlier and starting
12 radiation are two different things. I am talking
13 about starting radiation within four weeks. I am
14 not talking about getting them in to see the
15 radiotherapist.

16 Q. I am talking about starting
17 radiotherapy.

18 A. The answer to your question is four
19 weeks is acceptable for me.

20 Q. If it was your wife, would four weeks be
21 acceptable to you?

22 A. Yes.

23 Q. Now, I am going to ask you -- and I am
24 just calling it "delay." You define delay as six



1 to eight weeks, and that's fine. But my question
2 still stands.

3 Is it delay in initiating radiotherapy
4 associated with a higher local failure rate in head
5 and neck cancers?

6 A. A delay of more than six to eight weeks
7 would be associated with a higher failure rate,
8 yes.

9 Q. And now I am going to ask you, since you
10 have defined "delay" six to eight weeks, what is
11 your medical evidence to support that that is an
12 appropriate -- or that is a delay, six to eight
13 weeks? What study, what textbooks can you refer me
14 to, what article? What are you basing that on?

15 A. My experience.

16 Q. And that's it, just your experience? No
17 articles? You don't have a base -- that opinion is
18 not based on any research that you can identify for
19 me right now?

20 A. I can identify for you what I told you
21 before. If you initiate radiation therapy after
22 six weeks of treatment of surgery, for example, the
23 literature clearly shows that there is a difference
24 in survival in that patient population.

1 You can extrapolate that out to the
2 patient population who was treated primarily with
3 radiation, if you would like to.

4 Q. All right. Again, I am asking for
5 citations to support your opinion that six to eight
6 weeks is a delay.

7 A. I just told you the answer to that
8 question.

9 Q. I wasn't sure I heard a citation.

10 A. You can look up a reference by Vikram,
11 V-i-k-r-a-m, published in the middle '80s -- I
12 think it was Head and Neck, the journal -- where
13 clearly he showed that a delay in initiation of
14 radiation therapy greater than six weeks is a worse
15 prognostic indicator than patients who receive
16 radiation prior to that.

17 Q. Do you subscribe to or read
18 International Journal of Radiotherapy Oncology
19 Biology Physicians?

20 A. Not as a regular journal. I do read it
21 on occasion.

22 Q. And is it a text that has reasonably
23 reliable articles and studies published therein?

24 A. Yes.



1 Q. Are you familiar with a 1995 article
2 about the median waiting time from the referral to
3 the start of therapy in the United States compared
4 to Canada?

5 A. No, I am not. You got me on that one.

6 Q. And if it was ten days reported in
7 there, that would be reasonably reliable research,
8 wouldn't it?

9 A. I don't know. I haven't read the study.
10 I don't know if it is a valid study. Just because
11 it appears in the literature doesn't mean it is
12 valid.

13 Q. Isn't it true that before commencing the
14 radiotherapy two months had gone by since the time
15 of the biopsy?

16 A. Yes.

17 Q. In your opinion, that was a reasonable
18 delay, not an undue delay?

19 A. Yes.

20 Q. Radiotherapy has failed on occasion for
21 your patients with nasal carcinomas, correct?

22 A. Yes.

23 Q. And at that point you proceed to salvage
24 surgery as an option, is that correct?

1 A. That's correct.

2 Q. What type of five-year survival rate do
3 you have for your patients that undergo salvage
4 surgery?

5 A. In this particular area?

6 Q. Yes, sir.

7 A. Not very good.

8 Q. Are you familiar with any research that
9 suggests that as long as salvage surgery is
10 conducted early and on a recognized recurrence,
11 that there is a 90-percent five-year survival rate?

12 A. In carcinomas of the nasal vestibule?

13 Q. Yes, sir.

14 A. That might appear in the literature, but
15 I don't know that reference. I am sorry.

16 Q. For Stage 1.

17 A. Stage 1 recurrence?

18 Q. Yes, sir.

19 A. In other words, you had a Stage 1 to
20 begin with? You radiated and the recurrence was
21 Stage 1 at that point?

22 Q. Yes.

23 A. It is possible. I am not disputing
24 that.



1 Q. For it to be possible, doesn't early
2 diagnosis of the recurrence have to occur?

3 A. Yes.

4 Q. Is it your belief that repeat biopsies
5 are going to be necessary if there is any
6 concerning lesion that emerges after the
7 radiotherapy?

8 A. Yes, and that's true in any area.

9 Q. Is it going to require a heightened
10 level of investigation to follow a patient after
11 radiotherapy to determine if there is recurrence?

12 A. I don't think it is any more heightened
13 than any other area of the head and neck region. I
14 think the standard acceptable routine follow-up in
15 the absence of any physical findings or complaints
16 is appropriate. In other words, you don't have to
17 do a CAT scan every week, in other words.

18 Q. What I am trying to get at is time is of
19 the essence in identifying the recurrence in order
20 for that patient to have a good chance of -- or a
21 good prognosis after a recurrence, correct?

22 In other words, the salvage surgery has
23 to be done quickly?

24 A. Not exactly the way you put it, but the

1 earlier the diagnosis is made, the greater the
2 likelihood of curing the patient in the recurrent
3 environment.

4 Q. This starts by biopsying concerning
5 areas, correct?

6 A. Correct.

7 Q. Now, you have reviewed the records of
8 the plaintiff after the radiotherapy, have you not?

9 A. Yes.

10 Q. And you noticed that there was a
11 reappearance of an ulcer following radiotherapy,
12 correct?

13 A. I didn't recently review the particular
14 information, so I will have to accept your word for
15 it.

16 Q. Let's back up. Tell me, did you notice
17 any numerous steadily progressing and persistent
18 signs and symptoms of reoccurrence of cancer in
19 this patient in retrospect?

20 I am going to help you along. I am
21 going to point you to May 30th of 2001.

22 MS. TAYLOR-KOLIS: Whose records?

23 BY MR. GRIFFIN:

24 Q. Dr. Manning's records.

1 A. May 30th of 2001? Okay.

2 Q. Let's look at May 30th, 2001 of
3 Dr. Manning's records.

4 MS. TAYLOR-KOLIS: One second, Steve. We have
5 them in reversed chronological -- wait.

6 BY MR. GRIFFIN:

7 Q. Before I ask that question, as you are
8 looking through there, let me ask Dr. Wenig whether
9 or not I am correct in reviewing these medical
10 records, that the physicians that were treating her
11 had a plan to utilize salvage surgery in the event
12 radiotherapy didn't work? In other words, if she
13 had a recurrence, that was the plan with her?

14 A. There was a note to that effect, yes.

15 Q. Am I also correct in my recollection of
16 these records that these physicians were under the
17 assumption there was a complete resolution of her
18 cancer following the radiotherapy?

19 A. That's correct.

20 Q. Now, what I am referring to on May 30th
21 of Dr. Manning's records is that she was
22 complaining of pain along the cheek bone of the
23 left side and the left side of her nose.

24 MS. TAYLOR-KOLIS: Steve, I apologize to you.



1 If you could read us the note, we have May 7th,
2 2001, and on that page then there are some phone
3 messages and the next page that we have is August.

4 MR. GRIFFIN: All right. Everybody has
5 corrected me. It is in Dr. Manning's records, but
6 it is Dr. Sider's consult report of May 30, 2001.

7 MS. TAYLOR-KOLIS: Just for brevity sake,
8 would you like to read that to us because I am
9 not -- he doesn't have his records separated by
10 office notes and correspondence.

11 MR. GRIFFIN: Sure. "The patient, however,
12 has had resolution of her disease and her face has
13 healed up quite nicely in the past several weeks."

14 We go on and it says, "However, there
15 are still two small ulcers secondary to her
16 radiation, which are healing." That's on May 30th
17 of 2001.

18 BY MR. GRIFFIN:

19 Q. Do you note that?

20 A. We don't note it, but we accept your
21 reading.

22 MS. TAYLOR-KOLIS: Go ahead.

23 BY MR. GRIFFIN:

24 Q. Now, I am going to go to Dr. Sider's



1 consult of a month later, of June 27, 2001, where
2 he states, "Continues to have bleeding and pain in
3 the radiation area."

4 MS. TAYLOR-KOLIS: June 27th letter?

5 MR. GRIFFIN: Yes.

6 MS. TAYLOR-KOLIS: We are reading a letter,
7 Summa Radiology Department, Michael Sider, June 27,
8 2001. Is that what you are looking at?

9 MR. GRIFFIN: Yes.

10 BY MR. GRIFFIN:

11 Q. The area I am going to ask you about is
12 a month later he finds on exam, quote, "Examination
13 of the left nasal septum shows there to still be an
14 area in the mucosa which is draining."

15 A. Yes, I see that.

16 Q. So in May and June she has an ulcer in
17 the left septum or an area in the mucosa that is
18 draining, an open sore?

19 A. Correct.

20 Q. A lesion?

21 A. Correct.

22 Q. No biopsies were taken in May, no
23 biopsies were taken in June, correct?

24 A. Correct.



1 Q. Two days later Dr. Steinberger sees this
2 patient, so we go from Sider to Steinberger, 6/29
3 of 2001.

4 MS. TAYLOR-KOLIS: Once again, we will ask you
5 to read it because all of ours are out of order.
6 We have got June 27. We found that one.

7 BY MR. GRIFFIN:

8 Q. All right. I am going to read a couple
9 of portions of that note, that office note.

10 His findings were, quote, "At this time
11 she continues to have soreness in the nasal
12 columella and vestibule region. It is
13 particularly worse on left, where there is an
14 obvious ulceration that persists following her full
15 treatment with radiation. Apparently has seen
16 Dr. Sider and has been encouraged that this has
17 been free of malignancy."

18 Later on he states, "There was an
19 ulceration of the crural septal area in the nose on
20 the left, which was quite prominent."

21 Again, Dr. Steinberger doesn't order a
22 biopsy, to your knowledge, does he?

23 A. Not based on what you just read, no.

24 Q. And Dr. Sider had already encouraged her

1 that it was free of malignancy based on no testing,
2 correct?

3 A. Correct.

4 Q. I am going to move to August 1,
5 approximately over a month later when
6 Dr. Steinberger is seen again.

7 Dr. Steinberger identifies, quote,
8 "A satellite lesion on the upper lip and some mild
9 possible changes on the right septum."

10 Later he states, "Left side does show a
11 scab. This area was treated with a Q-tip to try to
12 create a cytological smear and sent to City
13 Hospital."

14 Now, Dr. Steinberger is concerned enough
15 in August 2001 that he wants to do a smear with a
16 Q-tip of the lesion.

17 Is that an appropriate biopsy method, in
18 your opinion, Dr. Wenig? Would that be enough
19 tissue to biopsy to determine if there was a
20 recurrence of cancer to use a Q-tip?

21 A. In an ideal world, you want to be able
22 to have something to biopsy. And I have no idea if
23 he thought that there was enough tissue there or an
24 area that he could comfortably biopsy that would be



1 representative.

2 I think in the absence of that, perhaps
3 he thought that he could obtain a cytological
4 preparation which would be indicative of a tumor
5 recurrence. Not being there, I can't tell you
6 specifically.

7 Q. Did he biopsy the satellite lesion?

8 A. No, he did not.

9 Q. Should he have biopsied the satellite
10 lesion to determine if a recurrence had occurred?

11 A. It would have been a more definitive way
12 of diagnosing tumor and -- well, we can argue about
13 the use of the word "recurrence." I would just say
14 "tumor spread."

15 Q. Dr. Wenig, you would have done a biopsy
16 of the satellite lesion, wouldn't you?

17 A. In all probability, yes.

18 Q. On 8/1 the pathology report suggests
19 that it was a scant specimen with rare, markedly
20 degenerated, atypical squamous cells,
21 nondiagnostic.

22 The pathologist suggested a repeat
23 specimen in early August of 2001. Was that done,
24 to your knowledge?

1 A. No.

2 Q. Should it have been done?

3 A. It would have been very helpful to have
4 it done, yes.

5 Q. Would Dr. Wenig have done it?

6 A. Dr. Wenig probably would not have needed
7 to have done it because the -- I would have done a
8 fine needle aspiration biopsy of the satellite
9 lesion and that would have been enough.

10 But to answer your question, if I have
11 atypical squamous cells after radiation therapy in
12 an area, I would have certainly investigated that
13 particular area.

14 Q. On August 3, then, we go back to
15 Dr. Sider, who identifies that she has developed
16 extreme tenderness in the nose and an examination
17 of the area revealed not only the swelling, but
18 nodules at the base of the nose and a small focus
19 of necrosis.

20 Dr. Sider concluded that it was a
21 reaction secondary to her treatment and that it was
22 a secondary infected with nodules, probably
23 secondary to the infection.

24 In retrospect, do you believe that she



1 was having a reaction secondary to the radiation
2 and/or infection or a recurrence?

3 A. Recurrence. Actually, if you would like
4 to be technically correct, this is not a
5 recurrence. This is a persistence with local
6 spread.

7 The primary tumor, despite the
8 descriptions of it having gone away, apparently
9 never really went away, so in technical
10 terminology, speaking from an oncological
11 perspective, this is a persistence of disease. It
12 never went away to come back, and subsequently
13 spread to the surrounding soft tissue.

14 Q. Moving to August 18 of 2001 where
15 Dr. Sider sees her again, apparently he has a
16 conversation with Dr. Steinberger who informed him
17 that the biopsy showed only necrotic material.
18 They, therefore, concluded that it was a probable
19 radiation reaction.

20 First of all, is that accurate that the
21 biopsy that was done on 8/1 only showed necrotic
22 material?

23 A. No.

24 Q. It also shows that Dr. Sider attempted



1 to drain the lesion on the lip, but it would not
2 drain on that date.

3 What would that indicate to you?

4 A. That it is not an area that has liquid
5 or fluid in it. That it was a solid area.

6 Q. And on the level of concern for
7 recurrence or persistence, or however you term it,
8 what would it mean to you?

9 A. It would certainly indicate to me that
10 the tumor had spread to the surrounding tissue.

11 Q. By August 29 of 2001 she was having a
12 large amount of necrosis based on the examination
13 by Dr. Sider, whose impression was slow improvement
14 in radiation reaction.

15 In retrospect, was his impression
16 accurate?

17 A. No.

18 Q. On September 13, 2001, the next month,
19 Dr. Steinberger consults again. At this point in
20 time she is having some deformity of the nose.

21 Dr. Steinberger admits her for
22 evaluation by infectious disease, whose impression
23 was she was -- strike that.

24 I want to point out that at this point,

1 on September 13 of 2001, Dr. Steinberger identifies
2 on his consult note that she is certainly at risk
3 for recurrence of carcinoma.

4 Would you agree with that statement?

5 A. Yes.

6 Q. If that was his impression -- or your
7 impression on September 13 of 2001, would you have
8 then have ordered surgical consult for a biopsy?

9 A. No, if I was Dr. Steinberger, I would
10 have done it myself.

11 Q. You would have -- there was reason to do
12 a biopsy at that point, is my question.

13 A. Yes.

14 Q. Was one done, to your knowledge?

15 A. It doesn't appear to have been done.

16 Not until --

17 Q. Was that a failure of the standard of
18 care not to perform a biopsy on September 13, 2001?

19 A. I am not here to comment on the standard
20 of care of Dr. Steinberger or any other physician.

21 Q. Dr. Steinberger is in the same area of
22 practice as yourself?

23 A. Yes.

24 Q. I am asking you whether or not in



1 reviewing this chart it was a departure from the
2 standard of care in failing to order a biopsy on
3 September 13, 2001 when the physician identified a
4 risk for recurrence of carcinoma?

5 A. We are not going to go through the
6 technical issues of ordering or not ordering. That
7 the biopsy was not done at this point was certainly
8 a failure of the standards of care.

9 Q. She was hospitalized at Akron City and
10 treated for recurrence of infection.

11 Are you aware whether or not a biopsy
12 was ever taken or whether or not any of these
13 physicians explored the possibility of recurrence
14 of or persistence of her carcinoma?

15 A. I know that the biopsy was eventually
16 performed the following month, so I am assuming
17 during this hospitalization nothing was done.

18 Q. On September 28 -- strike that. Do you
19 know who finally ordered the biopsy?

20 MS. TAYLOR-KOLIS: You are allowed to look at
21 your records, if you want to look at your Akron
22 City chart.

23 BY MR. GRIFFIN:

24 Q. I can ask it a different way so you

1 don't have to hunt through the records.

2 Were you aware that it was Dr. Manning
3 that ordered the biopsy, not Dr. Steinberger and
4 not Dr. Sider?

5 A. I didn't recall that so I will just have
6 to accept your word for it.

7 MR. GRIFFIN: Take a break for a minute and
8 then when we come back, I will be very close to
9 being complete.

10 MS. TAYLOR-KOLIS: Can we be gone like five
11 minutes?

12 MR. GRIFFIN: Sure.

13 (WHEREUPON, a recess was had.)

14 BY MR. GRIFFIN:

15 Q. Doctor, I was asking you about the
16 pathology. That biopsy was actually taken by
17 Dr. Manning 9/27/01. The biopsy results were not
18 reported until October 3 of 2001, which identified
19 no evidence of an infectious process, but did
20 identify the squamous cell carcinoma.

21 Are you aware, then, of whether or not
22 -- strike that.

23 I am going to point you now to a visit
24 she had with Dr. Tanti on October 9 of 2001.



1 MS. TAYLOR-KOLIS: First name is Tanti.
2 Devi-Drased, T-a-n-t-i, D-e-v-i-D-r-a-s-e-d.

3 BY MR. GRIFFIN:

4 Q. His first name is Devi. His last name
5 is Tanti.

6 Now, he makes a finding and gives the
7 opinion that at that point, approximately more than
8 a week after the biopsy was taken -- about a week
9 after the biopsy was available, his feeling was
10 that she was no longer -- she was nonresectable at
11 that time.

12 He states, Doctor, "When I saw her about
13 a week ago, she did not have the subcutaneous
14 nodules."

15 What is he referring to? Why would the
16 presence of subcutaneous nodules make her
17 nonresectable?

18 A. It doesn't make her nonresectable. It
19 makes her incurable. You can resect anything, but
20 you can't get around all of the tumor spread. And
21 the fact that the tumor has spread through the
22 subdermal layer to implant itself in multiple sites
23 in the skin makes the feasibility of surgery
24 infeasible, basically.

1 Q. And these subcutaneous nodules presented
2 in a week's time, what does that tell you about the
3 velocity of this cancer?

4 A. That following the radiation therapy,
5 which is not uncommon, the tumor was growing in a
6 rather aggressive manner.

7 Q. Dr. Steinberger consulted -- I take that
8 back. Correspondence on October 10 of 2001 from
9 Dr. Tanti to Dr. Manning states, "She has reached a
10 stage in just one week where the disease has spread
11 subcutaneously to multiple areas on the face." I
12 will give you time to digest that.

13 A. I digested it.

14 Q. Do you disagree with that statement as
15 medically unfounded or would you tend to agree with
16 that finding?

17 A. No, I have seen it happen.

18 Q. Do you know Dr. Steinberger, by any
19 chance?

20 A. No.

21 Q. Do you know Dr. Sider?

22 A. No, I don't know any of the doctors
23 involved here, except for the defense experts.

24 Q. Which of the defense experts do you



1 know? Dr. Koch?

2 A. I know Dr. Koch, Dr. Stepnick and who
3 is -- there was a third. And Peter Lavertu.

4 Q. You know them all?

5 A. I know them all.

6 Q. By reputation or by --

7 A. Personally.

8 Q. Personally?

9 A. Yes.

10 Q. And you are not offended that they take
11 issue with your opinions, are you, Dr. Wenig?

12 A. As I hope they are not offended that I
13 take issue with their opinions.

14 Q. Professionals in the same field can
15 disagree on issues, can they not?

16 A. Not only in medicine, in every area,
17 yes.

18 Q. In every area. Do you know Dr. Koch by
19 reputation?

20 A. I told you. I know him personally and
21 by reputation.

22 Q. And what is your impression of
23 Dr. Koch's abilities in the field of medicine?

24 A. Oh, I can't comment in the field of



1 medicine, but I can comment in the field of head
2 and neck surgery. I think Dr. Koch is a very
3 reputable, well-respected head and neck surgeon as
4 is Dr. Stepnick and is Dr. Lavertu.

5 Q. Would it be fair for me to encapsulize
6 your criticism of Dr. Park that it is your opinion
7 that he should have identified an ulcer that was in
8 her nose, but failed to identify it?

9 A. Failed to identify it and subsequently
10 biopsy it, to diagnose the squamous carcinoma, yes,
11 that is correct.

12 Q. It is your opinion that it was there?
13 He just failed to see it?

14 A. Correct.

15 Q. And therefore, it is really your opinion
16 that he conducted a faulty examination?

17 A. I wouldn't say "faulty," but an
18 examination that was below the standard of care.

19 Q. Can you identify with specificity what
20 he should have done in his exam differently -- and
21 I know you have read his deposition -- which would
22 have then brought him within the standard of care
23 so that he would have identified the lesion as you
24 believe it was there?

1 A. I think that having seen the
2 ulceration -- sorry, having seen the crusting along
3 the nasal septum in a patient with a history of
4 tobacco use, and having attempted to treat it for a
5 week, and I think having identified certain
6 physical findings that were not present previously,
7 and failing to identify what I believe was a
8 persistent ulceration in her nose as the underlying
9 cause of the crusting, I think in the best case
10 scenario had he not biopsied the patient at that
11 point, he should have had the patient back,
12 continue to treat the patient for a short period of
13 time, a week or two, reevaluate the patient, and
14 then seeing no change in the situation, then going
15 ahead and performing a biopsy.

16 Q. I am going also to ask you the question:
17 If you take Dr. Park's office chart at its face
18 value, without adding in Dr. Manning's chart or any
19 other information that you glean from the record,
20 but you just take his chart and the way he treated
21 this patient, what he diagnosed, and her reactions
22 to his diagnosis, would you then be of the opinion
23 that he met the standard of care?

24 A. In November or in September?



1 Q. Yes. Well, either.

2 A. I quite honestly don't think that he
3 did, taking his chart at face value.

4 Q. Let me ask you, then, what, in his
5 chart, from those three notes that you are
6 referring to, the two in November, what is in that
7 chart that you hang your hat on, so to speak, where
8 he failed the standard of care on his chart?

9 A. The fact that he identified by his own
10 drawing a crusting on the nasal septum on
11 November 15th and called that vestibulitis; the
12 nasal septum not being the vestibule. It is the
13 septum. It is a different anatomical area. The
14 patient not having the symptoms of vestibulitis.

15 On November 23rd, the patient having
16 septal thickening with erythema, which is redness,
17 on the septum, not in the vestibule, and calling it
18 rhinitis.

19 And the patient in September having a
20 sore nose and not making a single comment about the
21 nose other than "septal deviation with
22 vestibulitis."

23 Those to me are inconsistent. And if we
24 are looking at this chart in and of itself without

1 any other information, the inconsistencies are
2 glaring. And to someone who is as well trained and
3 knowledgeable as Dr. Park in the area of head and
4 neck cancer, by his own admission, I think that --
5 I think that these were factors that to me would
6 indicate that his conduct with Mrs. Bailes was
7 below the standard of care.

8 Q. You used the word "glaring." Let me ask
9 you if it is glaring on November 23 that there is
10 no mention of any crust whatsoever, so whatever
11 crust would have been there that you are relying on
12 on November 15, it is not even mentioned --
13 glaringly not mentioned on November 23, correct?

14 A. Yes, but all of a sudden there is septal
15 thickening with erythema that never existed before.
16 Maybe that's the description of how the crusting
17 looked like to him. I don't know.

18 Q. That's not a description of ulceration,
19 is it?

20 A. In and of itself, no, it is not.

21 Q. Thank you. Doctor, why do not all
22 Stage 1 cancer patients survive?

23 A. Well, there are several factors. One
24 factor is that the disease itself doesn't respond

1 to the selected therapy for whatever reason. Cells
2 may not be -- may be very aggressive.

3 The treatment itself may not encompass
4 removal or treatment of all the cells. There may
5 be a few residual cells left behind.

6 The other possibility is that the
7 treatment selected for the tumor is inappropriate
8 in the sense that the tumor may be understaged and
9 not fully appreciated, so that the treatment area
10 is less than the area that needed to be treated.
11 There are several factors.

12 Q. Have you read the deposition of
13 Dr. Makk?

14 A. Yes, I have.

15 Q. Are you going to give any pathological
16 testimony with respect to what the slides showed or
17 what the pathology results were?

18 A. I wasn't planning on it.

19 Q. All right. Do you have any opinions in
20 addition to what Dr. Makk has given in his
21 deposition on any of those subjects --

22 A. No --

23 Q. -- as far as what his findings were on
24 the slides?



1 A. No, I can just make a comment that the
2 two slides he compared, he described the histology
3 as being equal. In other words, there was no
4 change in the histological appearance of the tumor
5 prior to treatment and then following treatment,
6 so --

7 Q. What's the relevance of that
8 observation?

9 A. It wasn't as if the tumor cells began
10 growing wild and became undifferentiated in between
11 the two biopsies.

12 Q. Doctor, if you could recount for me what
13 it is you have reviewed before rendering your
14 testimony here in the way of medical records and
15 depositions.

16 A. Okay. The records are a July 25th, 2002
17 letter that I told you I received from Mr. Conway,
18 in which included the following: Medical records
19 of Dr. Thomas Cooper, medical records of Dr. -- as
20 described here -- Tanti Devi-Drased, medical
21 records of Dr. Manning, medical records of
22 Dr. Park, medical records of Dr. Sider, medical
23 records of Dr. Steinberger, medical records of
24 Dr. Trockleman, medical records of Dr. Wood,



1 medical records of Akron General Hospital for five
2 different time periods, as well as three deposition
3 records, one of Dr. Manning, one of Dr. Makk and
4 one of Dr. Park, plus the expert reports.

5 Q. All right. Are you relying on any
6 research for rendering your opinions today, any
7 written articles, et cetera?

8 A. No, I am not.

9 Q. Did you mention a Dr. Cooper?

10 A. It says here "Medical records of
11 Dr. Thomas Cooper of the Cleveland Clinic." That's
12 what the letter said.

13 MR. GRIFFIN: We will make a request for those
14 records. We don't have those records. And that
15 goes to Donna, not you, Doctor.

16 BY MR. GRIFFIN:

17 Q. Doctor, have you had an opportunity to
18 render your opinions that you will be expressing to
19 the jury in this case at some point in time during
20 the deposition?

21 A. Yes, I have.

22 MR. GRIFFIN: I am going to ask that you read
23 the deposition. I have no further questions.

24 MS. TAYLOR-KOLIS: I just have a comment in

1 terms of he has rendered opinions as to all the
2 questions you have asked him. I do not believe
3 that you ever asked him a causation question, but
4 that could just be my recollection. So he is going
5 to testify on causation.

6 MR. GRIFFIN: I understand.

7 MS. TAYLOR-KOLIS: Okay.

8 MR. GRIFFIN: Now, Donna, I don't know that I
9 have ever asked you this: Are you bringing any
10 physicians in live, obviously, other than Dr. Wenig
11 to testify at trial?

12 MS. TAYLOR-KOLIS: Dr. Manning, I am assuming.
13 I will -- Steve, I will fax you this page. I
14 believe that you do have it. It may be in the
15 Dr. Woods records.

16 MR. GRIFFIN: Okay.

17 MS. TAYLOR-KOLIS: Because Woods and Cooper
18 are in association of some sort doing evaluations
19 in this kind of case. It is a one-page note from
20 October 8, 2001, but I will fax that to you.

21 Do you want me to identify the
22 correspondence or do you trust me that I will copy
23 it?

24 MR. GRIFFIN: I absolutely trust you.



1 MS. TAYLOR-KOLIS: Okay.

2 MR. GRIFFIN: Should I not?

3 MS. TAYLOR-KOLIS: You should.

4 MR. GRIFFIN: What was the date, October 8 of
5 2000?

6 MS. TAYLOR-KOLIS: 2001. Hold on one second.
7 Let me see what date Woods saw her. It may have
8 just become separated, because it was really just
9 short.

10 MR. GRIFFIN: I have it.

11 MS. TAYLOR-KOLIS: We just separated it out
12 when we indexed the record because it had a
13 different doctor's name on it. It should be in
14 Woods.

15 MR. GRIFFIN: Don't bother. We have a
16 "Dr. Colper." We probably spelled it wrong.

17 MS. TAYLOR-KOLIS: You did. That's what it
18 is. It is a one-pager. Thanks.

19 MR. GRIFFIN: Thank you.

20 FURTHER DEPONENT SAITH NOT.

21

22

23

24

1 IN THE COURT OF COMMON PLEAS
 2 CIVIL DIVISION
 3 SUMMIT COUNTY, OHIO
 4

5 KAREN WILSON, Administratrix, the) Case No.:
 6 The Estate of GERALDINE BAILES,) CV-2002-06-3340
 7 Plaintiff,)
 8 vs.)
 9 YOUN PARK, M.D., et al.,)
 10 Defendants.)
 11

12 I hereby certify that I have read the
 13 foregoing transcript of my deposition given at the
 14 time and place aforesaid, consisting of Pages 1 to
 15 83, inclusive, and I do again subscribe and make
 16 oath that the same is a true, correct and complete
 17 transcript of my deposition so given as aforesaid,
 18 and includes changes, if any, so made by me.
 19

20 BARRY WENIG, M.D.,
 21 SUBSCRIBED AND SWORN TO
 22 before me this day
 23 of , A.D. 2003.
 24

Notary Public



1 STATE OF ILLINOIS)

2) SS:

3 COUNTY OF C O O K)

4 I, JOANNE H. RICHTER, a Notary Public
5 within and for the County of Cook, State of
6 Illinois, and a Certified Shorthand Reporter of
7 said state, do hereby certify:

8 That previous to the commencement of the
9 examination of the witness, the witness was duly
10 sworn to testify the whole truth concerning the
11 matters herein;

12 That the foregoing deposition transcript
13 was reported stenographically by me, was thereafter
14 reduced to typewriting under my personal direction
15 and constitutes a true record of the testimony
16 given and the proceedings had;


17 That the said deposition was taken
18 before me at the time and place specified;

19 That I am not a relative or employee or
20 attorney or counsel, nor a relative or employee of
21 such attorney or counsel for any of the parties
22 hereto, nor interested directly or indirectly in
23 the outcome of this action.

24 IN WITNESS WHEREOF, I do hereunto set my



1 hand and affix my seal of office at Chicago,
2 Illinois, this 20th day of August, 2003.

3
4
5
6 
7 Notary Public, Cook County, Illinois.
8 Commission expires October 22, 2005.



11 C.S.R. Certificate No. 84-2082.
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I N D E X

WITNESS

EXAMINATION

BARRY WENIG, M.D.,

By Mr. Griffin

3

E X H I B I T S

NUMBER

MARKED FOR ID

NO EXHIBITS MARKED.

A	air 13:13	15:18 18:9	attempt 4:9	began 80:9	Brian 20:2
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