IN THE COURT OF COMMON PLEAS

CIVIL DIVISION

SUMMIT COUNTY, OHIO

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

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

PRESENT:

FRIEDMAN, DOMIANO & SMITH CO., L.P.A.,
(Sixth Floor - Standard Building,
1370 Ontario Street,
Cleveland, Ohio 44113-1704,
216-621-0070), by:
MS. DONNA TAYLOR-KOLIS,
appeared on behalf of the Plaintiff;

BUCKINGHAM, DOOLITTLE & BURROUGHS, LLP,
(4518 Fulton Drive, NW,
Canton, Ohio 44735-5548,
330-492-8717), by:
MR. STEPHEN P. GRIFFIN,
appeared via video teleconference
on behalf of the Defendants
Youn Park, M.D., and Y.W. Park
M.D., Inc.

ALSO PRESENT:

(Via video teleconference)
YOUN PARK, M.D.

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

BARRY WENIG, M.D.,

called as a witness herein, having been first duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. GRIFFIN:

Q. State your name for the record, please.

A. Barry Lloyd Wenig.

Q. And your profession?

A. I am a physician.

Q. Any expertise of any particular area?

A. Yes.

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

A. Otolaryngology and head and neck surgery.

Q. What positions do you hold professionally currently?

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

Q. How long have you held those positions?

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

Q. Are you board certified?
A. Yes, I am.
Q. In what area?
A. Otolaryngology and head and neck surgery.
Q. When did you become board certified?
A. 1986.
Q. And this was your first testing attempt --
A. Yes.
Q. -- In otolaryngology? I guess I can see your educational and employment history in full on your CV, is that correct?
A. That is correct.
Q. Does your CV also include any publications that you have had through the years?
A. Yes, it does.
Q. Does it include any presentations you have made through the years?
A. Yes, it does.
Q. Have you published anything with respect to squamous cell carcinoma of the nasal vestibule?
A. Yes, I have.
Q. Can you tell me specifically by

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

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

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

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

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

A. I would guess, yes.

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

A. Yes, I do.

Q. Is it usually typical for literature to

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

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

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

A. That's correct.

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

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

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

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

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

A. I have seen his CV, yes.

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

A. I have seen his CV, yes.

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

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

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

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

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

Q. You have read his deposition, I assume?

A. Yes, I have.

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

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

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

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

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

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

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

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

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

A. Yes, I did.

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

A. That's very possible, yes.

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

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

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

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

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

Q. This is a leading factor?

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

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

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

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

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

Q. Can you --

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

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

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

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

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

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

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

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

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

Q. Do you advise your patients to quit smoking?

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

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

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

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

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

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

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

Q. That's your medical advice?

A. Yes, it is.

Q. A patient always has the option of

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

A. That's correct.

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

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

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

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

Q. Have you kept a file concerning this case?

A. Yes, I have.

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

A. Yes, I have.

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

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

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

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

BY MR. GRIFFIN:

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

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

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

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

And then there is a list of things that

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

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

A. That's correct, yes.

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

A. I assume I did, yes.

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

A. No, it was out of the blue.

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

A. No, it was not.

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

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

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

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

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

A. No, I do not.

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

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

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

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

reviewer.

Q. Do you know the name of the services?

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

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

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

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

Q. How many do you have open currently?

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

Q. Your best estimate.

A. I would guess probably around 15.

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

A. Half.

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

A. I don't understand what you mean.

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

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

Q. Yes, sir.

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

Q. Sure.

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

Q. By way of deposition or court appearance?

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

Q. Can you remember the names of the

physicians?

A. One is Brian Farrell here in Chicago.

Q. The other?

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

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

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

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

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

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

A. Yes.

Q. In support of the standard of care?

A. Yes.

Q. How long ago was that?

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

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

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

A. No, I don't.

Q. Or his law firm?

A. I don't.

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

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

Q. What is your trial charge?

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

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

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

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

A. Yes, I have.

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

A. No, I do not.

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

A. Yes, I do.

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

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

A. Yes.

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

A. That's correct.

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

A. Yes.

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

A. Yes.

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

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

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

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

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

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

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

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

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

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

A. In my opinion, no.

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

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

vestibulitis.

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

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

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

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

A. For her condition at that time, yes.

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

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

A. Yes.

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

present in February of 1997 in the plaintiff?

A. No.

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

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

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

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

A. Yes.

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

A. No.

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

Is that a correct assumption on my part

based upon the records you have in front of you?

A. Yes, that is correct.

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

A. Yes.

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

A. Yes.

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

A. No, I did not.

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

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

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

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

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

A. Correct.

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

A. Correct.

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

A. Correct.

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

A. No.

Q. And tell us why?

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

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

A. The same way everyone else does.

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Yes, he did.

Q. Was that the appropriate cream?

A. For that condition, yes.

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

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

that.

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

A. By that definition, yes.

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

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

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

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

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

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

A. How do you define a mass?

Q. How do you define a mass?

A. I asked you first.

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

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

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

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

A. No.

Q. Any nodule?

A. Nodule? Where?

Q. Anywhere in the nasal vestibule or surrounding area.

A. Not by description, no.

Q. Any satellite lesions?

A. Not by description, no.

Q. Was she complaining of extreme pain?

A. No, just some discomfort.

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

A. No.

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

A. They are among them, except for the ones

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

Q. Pardon me?

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

Q. Dried mucous?

A. No, the ulcer.

Q. What was it?

A. The ulcer that Dr. Manning found.

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

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

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

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

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

A. That's correct.

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

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

A. Yes.

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

A. Yes.

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

A. He makes no mention of it, no.

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

A. Yes.

Q. What did he miss, Dr. Wenig?

A. The carcinoma of her nasal vestibule.

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

flying assumption?

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

Q. Does cancer grow at a continuous progressive rate?

A. Yes.

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

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

particularly slow-growing cancer.

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

A. No, they do not.

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

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

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

remains and grows.

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

A. That's correct.

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

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

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

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

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

appreciate the full extent of the condition.

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

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

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

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

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

A. It should be, but again --

Q. It should be?

A. We don't always make that distinction.

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

A. Yes, that is correct.

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

A. That's true.

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

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

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

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

Q. I see.

A. So --

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

A. Yes.

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

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

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

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

standard of care in this particular instance.

Q. What is nasal hypertrophy?

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

Q. Is that septal thickening?

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

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

A. That's correct.

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

A. That's correct.

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

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

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

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

Q. A right buccal lesion, correct?

A. That's the description, yes.

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

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

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

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

Q. Do you do biopsies in your office?

A. Yes.

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

A. Depends what I am doing the biopsy for.

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

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

first time I see them, so --

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

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

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

A. Okay.

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

A. Yes.

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

A. Yes.

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

A. In this particular instance, yes.

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

conducting an excision or performing the biopsy?

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

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

MR. GRIFFIN: One moment.

(WHEREUPON, discussion was had off the record.)

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

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

back.

BY MR. GRIFFIN:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

BY THE WITNESS:

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

BY MR. GRIFFIN:

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

A. That's correct.

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

A. Correct.

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

A. Related to this particular lesion, correct.

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

A. It was --

Q. By Dr. Sider?

A. It was staged as a T1 lesion of the

nasal vestibule.

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

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

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

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

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

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

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

The language I understand.

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

A. Correct.

Q. The patient died, correct?

A. Correct.

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

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

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

A. Yes.

Q. What is it?

A. In between three and four weeks.

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

A. Are we talking about referral to see a

radiation therapist or starting the radiation?

Q. From the referral to the start of radiotherapy.

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

Q. Yes, sir.

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

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

A. I would have to look up that information.

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

A. Okay.

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

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

Q. Yes, sir.

A. Okay.

Q. Do you believe that there was an undue

delay?

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

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

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

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

A. I would say around six to eight weeks.

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

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

range to start radiation.

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

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

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

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

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

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

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

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

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

A. As a primary modality alone?

Q. Similar to this case.

A. Within four --

Q. This was her --

A. Within four weeks.

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

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

Q. I am talking about starting radiotherapy.

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

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

A. Yes.

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

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

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

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

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

A. My experience.

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

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

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

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

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

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

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

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

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

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

A. Yes.

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

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

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

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

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

A. Yes.

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

A. Yes.

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

A. Yes.

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

A. That's correct.

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

A. In this particular area?

Q. Yes, sir.

A. Not very good.

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

A. In carcinomas of the nasal vestibule?

Q. Yes, sir.

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

Q. For Stage 1.

A. Stage 1 recurrence?

Q. Yes, sir.

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

Q. Yes.

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

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

A. Yes.

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

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

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

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

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

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

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

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

Q. This starts by biopsying concerning areas, correct?

A. Correct.

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

A. Yes.

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

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

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

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

MS. TAYLOR-KOLIS: Whose records?

BY MR. GRIFFIN:

Q. Dr. Manning's records.

A. May 30th of 2001? Okay.

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

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

BY MR. GRIFFIN:

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

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

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

A. That's correct.

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

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

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

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

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

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

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

BY MR. GRIFFIN:

Q. Do you note that?

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

MS. TAYLOR-KOLIS: Go ahead.

BY MR. GRIFFIN:

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

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

MS. TAYLOR-KOLIS: June 27th letter?

MR. GRIFFIN: Yes.

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

MR. GRIFFIN: Yes.

BY MR. GRIFFIN:

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

A. Yes, I see that.

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

A. Correct.

Q. A lesion?

A. Correct.

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

A. Correct.

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

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

BY MR. GRIFFIN:

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

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

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

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

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

Q. And Dr. Sider had already encouraged her

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

A. Correct.

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

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

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

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

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

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

representative.

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

Q. Did he biopsy the satellite lesion?

A. No, he did not.

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

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

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

A. In all probability, yes.

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

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

A. No.

Q. Should it have been done?

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

Q. Would Dr. Wenig have done it?

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

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

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

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

In retrospect, do you believe that she

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

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

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

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

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

A. No.

Q. It also shows that Dr. Sider attempted

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

What would that indicate to you?

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

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

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

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

In retrospect, was his impression accurate?

A. No.

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

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

I want to point out that at this point,

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

Would you agree with that statement?

A. Yes.

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

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

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

A. Yes.

Q. Was one done, to your knowledge?

A. It doesn't appear to have been done. Not until --

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

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

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

A. Yes.

Q. I am asking you whether or not in

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

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

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

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

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

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

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

BY MR. GRIFFIN:

Q. I can ask it a different way so you

don't have to hunt through the records.

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

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

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

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

MR. GRIFFIN: Sure.

(WHEREUPON, a recess was had.)

BY MR. GRIFFIN:

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

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

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

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

BY MR. GRIFFIN:

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

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

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

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

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

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

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

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

A. I digested it.

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

A. No, I have seen it happen.

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

A. No.

Q. Do you know Dr. Sider?

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

Q. Which of the defense experts do you

know? Dr. Koch?

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

Q. You know them all?

A. I know them all.

Q. By reputation or by --

A. Personally.

Q. Personally?

A. Yes.

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

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

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

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

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

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

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

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

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

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

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

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

A. Correct.

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

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

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

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

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

A. In November or in September?

Q. Yes. Well, either.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Yes, I have.

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

A. I wasn't planning on it.

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

A. No --

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

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

Q. What's the relevance of that observation?

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

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

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

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

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

A. No, I am not.

Q. Did you mention a Dr. Cooper?

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

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

BY MR. GRIFFIN:

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

A. Yes, I have.

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

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

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

MR. GRIFFIN: I understand.

MS. TAYLOR-KOLIS: Okay.

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

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

MR. GRIFFIN: Okay.

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

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

MR. GRIFFIN: I absolutely trust you.

MS. TAYLOR-KOLIS: Okay.

MR. GRIFFIN: Should I not?

MS. TAYLOR-KOLIS: You should.

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

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

MR. GRIFFIN: I have it.

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

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

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

MR. GRIFFIN: Thank you.

FURTHER DEPONENT SAITH NOT.

IN THE COURT OF COMMON PLEAS

CIVIL DIVISION

SUMMIT COUNTY, OHIO

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

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

BARRY WENIG, M.D.,

SUBSCRIBED AND SWORN TO
before me this day
of , A.D. 2003.

Notary Public

STATE OF ILLINOIS)
) SS:
COUNTY OF C O O K)

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

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

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

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

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

IN WITNESS WHEREOF, I do hereunto set my

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

Notary Public, Cook County, Illinois.

Commission expires October 22, 2005.

OFFICIAL SEAL
JOANNE H RICHTER
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES: 10/22/05

C.S.R. Certificate No. 84-2082.

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.